

**Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division**

Countryside Rehabilitation and Health Center
Docket No. A-17-109
Decision No. 2853
February 27, 2018

**FINAL DECISION ON REVIEW OF
ADMINISTRATIVE LAW JUDGE DECISION**

Countryside Rehabilitation and Health Center (Countryside), a Florida skilled nursing facility (SNF), has appealed the Administrative Law Judge's (ALJ's) June 9, 2017 decision, which rejected Countryside's challenge to an enforcement action by the Centers for Medicare & Medicaid Services (CMS). *Countryside Rehab. & Health Ctr.*, DAB CR4861 (2017) (ALJ Decision). The primary issue in this case is whether Countryside took adequate measures to ensure that its residents – and one resident in particular, whom we call Resident 2 – were free from sexual abuse by another resident whom we call Resident 1. The ALJ concluded that Countryside failed to do so and thereby violated five Medicare participation requirements. The ALJ also sustained CMS's determination that Countryside's noncompliance was serious enough to place residents in "immediate jeopardy" from December 8, 2012, through April 3, 2013, and that Countryside remained out of "substantial compliance" (but below the immediate-jeopardy level of seriousness) from April 4 through April 19, 2013. Finally, the ALJ sustained enforcement remedies imposed by CMS against Countryside, which included per-day civil money penalties (CMPs) spanning the period of noncompliance.

In this appeal, Countryside contends that the ALJ's decision must be reversed because it rests on an unsupported finding that Resident 2 was a foreseeable victim of sexual abuse by Resident 1. According to Countryside, the ALJ unreasonably rejected or disregarded facts and evidence – including testimony by Resident 1's psychologist and by a professor of psychiatric nursing who testified as an expert witness – that undermined his analysis. However, substantial evidence supports the ALJ's conclusion that Countryside did not take adequate measures to avoid exposing vulnerable residents (including Resident 2) to unwanted sexual contact from Resident 1, who had a 2008 conviction for a sex offense and a diagnosed psychosexual disorder.

As we explain below, finding no merit in Countryside’s contention that the exposure of Resident 2 to abuse was unforeseeable, we affirm the ALJ’s conclusion that Countryside was not in substantial compliance with Medicare participation requirements beginning on December 8, 2012. We also affirm the ALJ’s conclusions regarding other deficiencies, CMS’s immediate-jeopardy determination, and the reasonableness of the CMPs imposed by CMS. We also uphold CMS’s determination concerning the duration of the immediate jeopardy.

I. Legal Background

To participate in the Medicare program, a SNF must be in “substantial compliance” with the participation requirements in 42 C.F.R. Part 483, subpart B (sections 483.1-.75).¹ 42 C.F.R. §§ 488.400, 483.1. A SNF is not in substantial compliance when it has a “deficiency” – that is, a failure to meet a participation requirement – that creates the potential for more than minimal harm to one or more residents. *Id.* § 488.301 (defining “substantial compliance”). The term “noncompliance,” as used in the applicable regulations, is synonymous with lack of substantial compliance. *Id.* § 488.301 (defining “noncompliance”).

Compliance with Medicare participation requirements is verified through onsite surveys performed by state health agencies. *Id.* §§ 488.10(a), 488.11. A state survey agency reports any deficiency (failure to meet a participation requirement) it finds in a Statement of Deficiencies. *Id.* §§ 488.325(f)(1), 488.331(a).

CMS may impose enforcement “remedies,” including CMPs (civil money penalties), on a SNF that is found to be not in substantial compliance. *Id.* §§ 488.400, 488.402(b), (c), 488.406. When CMS elects to impose a CMP, it sets the CMP amount based on, among other factors, the “seriousness” of the SNF’s noncompliance. *Id.* §§ 488.404(a), (b), 488.438(f). Seriousness is a function of the noncompliance’s scope (whether it is “isolated,” constitutes a “pattern,” or is “widespread”) and severity (whether it has created a “potential for” harm, resulted in “[a]ctual harm,” or placed residents in “immediate jeopardy”). *Id.* § 488.404(b). The most serious noncompliance is that which puts one or more residents in “immediate jeopardy.” *Id.* § 488.438(a) (authorizing the highest CMPs for immediate-jeopardy-level noncompliance); *Woodland Oaks Healthcare Facility*, DAB No. 2355, at 2 (2010) (citing authorities).

¹ On October 4, 2016, CMS issued a final rule that amended the Medicare participation requirements for long-term care facilities published in 42 C.F.R. Part 483. Final Rule, *Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities*, 81 Fed. Reg. 68,688 (Oct. 4, 2016). Our analysis and decision are based on the version of the participation requirements in effect during the period from March through May 2013, when the compliance surveys supporting CMS’s enforcement action were performed. *Carmel Convalescent Hosp.*, DAB No. 1584, at 2 n.2 (1996) (applying the regulations in effect on the date of the survey and resurvey).

A SNF may appeal a CMS determination of noncompliance that has resulted in the imposition of a CMP or other enforcement remedy. 42 C.F.R. §§ 488.408(g)(1), 498.3(b)(13). During a hearing in such an appeal, a SNF may challenge the reasonableness of the amount of any CMP imposed. *Lutheran Home at Trinity Oaks*, DAB No. 2111, at 21 (2007).

II. Case Background

From March 26 through March 29, 2013, the Florida Agency for Health Care Administration (AHCA or state survey agency) performed a compliance survey of Countryside after receiving a report that Resident 1, then 68 years old, had sexually abused his roommate, Resident 2. CMS Ex. 2, at 1-4; CMS Ex. 7, at 1; CMS Ex. 51, at 1.

Resident 1 became a resident of Countryside in December 2011. CMS Ex. 2, at 6-7. His admission followed a hospitalization for treatment of a brain hemorrhage. CMS Ex. 17, at 1, 4, 41. When he arrived at Countryside, he was wearing an electronic tracking device on his ankle, a condition of his probation for sexual battery of a minor, a crime for which he also served six months in prison. CMS Ex. 2, at 7-8; CMS Exs. 20-22; P. Ex. 4; P. Ex. 24, at 92, 100. (He was released from probation on May 31, 2012. CMS Ex. 2, at 8.) Resident 1's medical history included diagnoses of depression and an unspecified intellectual disability. CMS Ex. 2, at 7; CMS Ex. 17, at 2. He used a wheelchair to move around the facility. Transcript of July 28, 2015 Hearing (Tr.) at 49.

Resident 2 was 56 years old at the time of the March 2013 survey. CMS Ex. 18, at 1. His diagnoses included quadriplegia (paralysis of all four limbs), limb contractures, and depression. *Id.* He had been Resident 1's roommate since September 2012. CMS Ex. 17, at 70; P. Ex. 15, ¶ 12.

During a survey interview, Resident 2 stated that, on March 18, 2013, Resident 1 touched his inner thigh and genitalia in an inappropriate manner. CMS Ex. 2, at 4-5. Further investigation revealed that Resident 2 immediately reported the unwanted contact to a certified nursing assistant (CNA); that Countryside responded by moving Resident 1 to a new room and monitoring him "one-to-one"; and that Resident 1 was arrested and removed from the facility on March 20, 2013 after admitting to the arresting officer that he had touched Resident 2 inappropriately. *Id.* at 4-7; CMS Ex. 10; CMS Ex. 11; CMS Ex. 14, at 4; CMS Ex. 17, at 88-89; CMS Ex. 18, at 4; CMS Ex. 20, at 4. (Authorities charged Resident 1 with having committed "lewd or lascivious battery upon an elderly person or disabled person" but later decided not to prosecute him. CMS Ex. 20, at 4; P. Ex. 31.)

After completing its compliance survey, which reviewed Resident 1's entire stay at Countryside, AHCA issued a Statement of Deficiencies which cited Countryside for noncompliance with multiple Medicare participation requirements based on its purported failure to: (1) "provide the necessary intervention and services to prevent the sexual assault" of Resident 2; (2) thoroughly investigate incidents of alleged sexual abuse; (3) institute and implement written policies and procedures prohibiting sexual abuse; and (4) revise its plan of care for Resident 1 to "manage and contain" his "sexual predatory behaviors." CMS Ex. 1, at 2, 21, 33, 45. AHCA also determined that Countryside was in a state of noncompliance at the immediate-jeopardy level as of September 4, 2012, and that the noncompliance was "ongoing" at that level when the survey ended on March 29, 2013. CMS Ex. 1, at 1; CMS Ex. 5, at 1.

On April 16, 2013, CMS notified Countryside that it concurred with AHCA's noncompliance and immediate-jeopardy findings. CMS Ex. 5, at 1. CMS also notified Countryside that it was imposing a \$6,850 per-day CMP effective September 4, 2012 until it returned to substantial compliance. *Id.* at 2. In addition, CMS warned Countryside that a denial of payment for new admissions (DPNA) would take effect if it did not return to substantial compliance by April 18, 2013. *Id.* at 3.

On April 19, 2013, AHCA performed a revisit survey which found that Countryside had abated the immediate jeopardy on April 4, 2013 but remained out of substantial compliance (at a lower level of severity). CMS Ex. 6, at 1. CMS concurred with those findings and imposed a \$100 per-day CMP effective April 4, 2013. *Id.* at 2. On May 15, 2013, AHCA performed a second revisit survey which found that Countryside had returned to substantial compliance as of April 20, 2013. CMS Ex. 7, at 1.

Based on these events, Countryside became subject to the following remedies: a \$6,850 per-day CMP from September 4, 2012 through April 3, 2013 (the immediate-jeopardy period); a \$100 per-day CMP from April 4 through April 19, 2013 (the period of non-immediate-jeopardy-level noncompliance); and a DPNA for April 18 and 19, 2013. *See* CMS Exs. 6 and 7. (The legality of the DPNA is not at issue in the case.)

During May 2013, Countryside and AHCA engaged in informal dispute resolution (IDR). CMS Ex. 2, at 1. As a result of the IDR process, AHCA revised the Statement of Deficiencies. *Id.* As revised, the Statement of Deficiencies cited Countryside for immediate-jeopardy-level noncompliance with 42 C.F.R. § 483.13(b),² which states that

² The citation alleging noncompliance with section 483.13(b) is identified as tag F223 in the revised Statement of Deficiencies. CMS Ex. 2, at 3. Tag F223 alleged noncompliance with section 483.13(c)(1)(i), which states that a "facility must . . . [n]ot use verbal, mental, sexual, or physical abuse" CMS did not ask the ALJ to sustain its finding that Countryside violated section 483.13(c)(1)(i).

each SNF resident has the right to be free from sexual (and other types of) abuse. *Id.* at 3. In addition, the revised Statement of Deficiencies cited Countryside for immediate-jeopardy-level noncompliance with 42 C.F.R. §§ 483.13(c), 483.13(c)(1)(ii-iii), 483.13(c)(2-4), 483.20(k)(2), 483.20(k)(3)(ii), and 483.75.³ *Id.* at 21, 34, 45, 54, 69.

In support of these citations, the revised Statement of Deficiencies alleged that, prior to March 18, 2013, Countryside's staff knew or should have known that Resident 1 was "at high risk of re-offending" (CMS Ex. 2, at 16) because he had "exhibited predatory behaviors" (*id.* at 4) during the last four months of 2012. The revised Statement of Deficiencies notes two incidents, the first in September 2012 and the second in December 2012, in which Resident 1 was reported to have inappropriately touched (or attempted to inappropriately touch) a male nurse and a male CNA. *Id.* at 11, 18. In addition, the revised Statement of Deficiencies referred to records showing that Countryside was concerned about Resident 1's interest in a young African-American male resident known as Resident 4 and quotes Resident 1's psychologist as stating, during a survey interview, that "we were all concerned [in September 2012 that] he would re-offend with this young man as he was lurking around his room." *Id.* at 12-13. (Resident 4, then 24 years old, had severe physical, cognitive, and speech impairments stemming from a brain injury suffered in a motor vehicle accident and depended on staff to help him with most aspects of daily living. *Id.* at 10-11; CMS Ex. 19, at 1, 15.)

In June 2013, Countryside requested a hearing before an ALJ to contest CMS's enforcement action. The parties subsequently exchanged documentary evidence and written direct testimony. Countryside introduced written direct testimony from several employees and two others: Lynn M. Henderson, Psy.D., Resident 1's treating psychologist between September 2012 and February 2013; and Ann Wolbert Burgess, DNSc, RNCS, FAAN, a professor of psychiatric nursing at Boston College with expertise in the identification, prevention, and treatment of elder abuse (including sexual abuse). *See* P. Exs. 2, 3, and 22.

Dr. Henderson testified that, during the course of her treatment of Resident 1 (from September 2012 through February 2013), it was her "professional opinion that the only potential risk for Resident 1 to re-offend that may have existed was with Resident 4" and that she "did not believe Resident 1 was a risk to re-offend with any other resident at Countryside." P. Ex. 22, ¶ 6. Dr. Henderson also stated that Resident 1's incidents of

³ Under tag F280, the revised Statement of Deficiencies alleged noncompliance with 42 C.F.R. § 483.10(k)(2). This is an apparent typographical error: tag F280's text indicates that Countryside violated requirements stated in section 483.20(k)(2), not section 483.10(k)(2). Tag F280 also cites 42 C.F.R. § 483.20(d)(3), but this too appears to be a typographical error because the regulatory text that appears directly below the citation ("The resident has the right to . . . participate in planning care and treatment or changes in care and treatment") is found in section 483.10(d)(3).

inappropriate behavior with the male nursing staff were “isolated” events and not “predictors of a sexual assault of Resident 2 by Resident 1 in March of 2013.” *Id.*, ¶¶ 6, 12, 14. In addition, Dr. Henderson stated that she treated Resident 2 (for depression) during the six-month period that she treated Resident 1 (September 2012 through February 2013); that the residents were roommates throughout that period; that Resident 2 “never complained of any attempted advances by Resident 1 toward him”; and that Resident 2’s “only complaint about Resident 1 was they had nothing to do with each other.” *Id.*, ¶¶ 15-16.

Dr. Burgess testified that not all sex offenders present the same risk of re-offending and that “[f]actors that can make the resident a low risk to reoffend include the length of time since the resident’s crime, the absence of any inappropriate behaviors by the resident since the initial offense, the absence of individuals in the nursing home who fit the profile of the offender’s ‘target’ in his crime, treatments the resident has received, particularly medications given to decrease male libido, and limitations created by the Resident’s clinical condition.” P. Ex. 2, ¶ 10. Dr. Burgess further testified that Resident 1’s incidents with the male nurse and CNA during September and December 2012 were inaccurately described in the Statement of Deficiencies and by CMS in its pre-hearing brief as “sexual assaults” or “molestations,” and that those incidents did not “portend” that residents were at risk of being assaulted by Resident 1. *Id.*, ¶¶ 9, 15-19, 24. In addition, Dr. Burgess testified that Dr. Henderson’s “assessment that Resident #1’s only risk for re-offense was with Resident #4 was accurate and reasonable” and that making Resident 2 a roommate of Resident 1 did not create “a risk of sexual assault.” *Id.*, ¶¶ 21, 26. Based on the records she reviewed, which included the Statement of Deficiencies and Resident 1’s nursing and psychological treatment records, Dr. Burgess concluded that “the care and services provided by staff at Countryside to Resident #1 were reasonable and adequate to address any foreseeable risks he posed to other residents” and that “[t]he incident between Resident #1 and Resident #2 on March 18, 2013, to the extent that it occurred as alleged by Resident #2, was not reasonably foreseeable and did not occur because of the failure of Countryside to provide a required intervention.” *Id.*, ¶ 9.

On July 28, 2015, the ALJ held a hearing during which Countryside cross-examined two CMS witnesses, surveyors Pamela Aromola and Susan Morton. CMS did not ask to cross-examine either Dr. Henderson or Dr. Burgess. At the start of the hearing, CMS confirmed that it had shortened the duration of the CMP by pushing forward the penalty’s starting date from September 4 to December 8, 2012. Tr. at 11-13; *see also* Jan. 2, 2015 Stipulation Regarding the Duration of the CMP.

In its post-hearing brief to the ALJ, CMS contended that Countryside had failed to: (1) implement adequate measures to protect Resident 2 from sexual abuse; (2) “thoroughly investigate” all allegations of abuse; (3) adequately train its staff to prevent Resident 1 from sexually abusing other residents; (4) develop care plans to manage Resident 1’s “high risk sexual behaviors”; and (5) “effectively administer” its facility in order prevent sexual abuse. CMS’s Oct. 9, 2015 Post-Hearing Brief (CMS Post-H Br.) at 3, 10, 11, 13, 15. CMS further contended that these failures constituted noncompliance with 42 C.F.R. §§ 483.13(b), 483.13(c), 483.13(c)(3), 483.20(d), 483.20(k), and 483.75. *Id.* In addition, CMS asked the ALJ to find that Countryside had failed to “adequately supervise” Resident 1 in violation of 42 C.F.R. § 483.25(h). *Id.* at 2 n.1, 16-17. (Although the revised Statement of Deficiencies did not cite a violation of section 483.25(h), Countryside did not object to CMS’s request that the ALJ find it noncompliant with that provision.)

III. The ALJ Decision

Based on the record before him, the ALJ made the following findings of fact:

On or about September 4, 2012, a psychiatric nurse practitioner performed a “Behavioral Health Consultation” concerning Resident 1 after a male nurse reported that Resident 1 had tried to grab his penis. ALJ Decision at 7; *see also* P. Ex. 24, at 98-99. The nurse practitioner determined that Resident 1’s inappropriate behavior was “generally controlled” and that the incident with the nurse was an “isolated event.” ALJ Decision at 7 (quoting P. Ex. 24, at 99). The nurse practitioner made no medication changes – Resident 1 was then taking Premarin (hormone medication) to suppress his libido – but recommended that the facility’s staff redirect Resident 1 if he attempted to engage in inappropriate behavior. *Id.*; *see also* CMS Ex. 17, at 7; P. Ex. 24, at 101.

Resident 1’s inappropriate behavior with the nurse – and concerns about his interest in, or attraction to, Resident 4 – prompted Countryside to refer Resident 1 to Dr. Henderson, who examined him and issued a report of her initial assessment on September 6, 2012. ALJ Decision at 7. The report recounted the incident with the nurse and stated that Resident 1 had been seen “lurking” around Resident 4’s room. *Id.* at 7-8 (citing and quoting CMS Ex. 17, at 6; P. Ex. 24, at 100, 135); *see also id.* at 8 n.5. Dr. Henderson diagnosed Resident 1 as having Frotteurism, a psychosexual disorder whose diagnostic elements include “recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving touching and rubbing against a non-consenting person.” *Id.* at 8 (quoting the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition). Dr. Henderson also determined that Resident 1 was at “risk of re-offending.” *Id.*; *see also* CMS Ex. 17, at 10.

On September 10, 2012, Countryside moved Resident 1 to Resident 2’s room so that he was farther away from Resident 4. ALJ Decision at 8, 13.

On September 16, 2012, Countryside issued a plan for managing Resident 1's "sexually inappropriate" behavior. *Id.* at 8-9, 15 (citing P. Ex. 24, at 98-99 and CMS Ex. 17, at 102). The plan stated that Resident 1 was "'sexually inappropriate at times, comments about wanting to have sex with other male residents.'" *Id.* at 15 (quoting CMS Ex. 17, at 102). The plan called on Countryside's staff to take the following measures: administer Premarin as ordered; encourage Resident 1 to verbalize feelings in an appropriate setting; provide him with one-to-one "social services" when necessary; provide him supportive counseling when necessary; check on him every 15 minutes; monitor and document his behavior; and redirect him when he was socially or sexually inappropriate. *Id.* at 9 (citing CMS Ex. 17, at 102).

From September 10, 2012 through February 28, 2013, Dr. Henderson met with Resident 1 and completed weekly progress notes – all of which indicated that the resident had diagnoses of "Frotteurism, Depression NOS" and was "'at risk of re-offending.'" *Id.* at 8 (citing or quoting P. Ex. 24, at 106-116, 118-120, 122-28).

"On September 20, 2012, Dr. Henderson reminded Resident 1 to stay away from Resident 4" (it is unclear what prompted that admonition), and Resident 1 agreed that going near Resident 4 put him at risk for re-offending. *Id.* at 9.

"On November 8, 2012, Dr. Henderson wrote that Resident 1 'was found on two occasions to be lurking around [Resident 4's] room of which there is concern that he may sexually reoffend.'" *Id.* (citing and quoting CMS Ex. 17, at 18 and P. Ex. 24, at 113).

On November 14, 2012, Countryside revised the plan for managing Resident 1's behavior. *Id.* at 15 (citing CMS Ex. 17, at 44). As revised, that plan noted Resident 1's history of "sexual inappropriateness" with other males and the diagnosis of Frotteurism. *Id.* at 9. It called for Countryside's staff to take measures similar to those specified in the September plan, including: providing Resident 1 positive feedback when he acted appropriately; offering psychological counseling; administering Premarin as ordered; encouraging Resident 1's involvement in group activities; redirecting him when necessary to prevent inappropriate behavior; and monitoring and documenting his behavior. *Id.* The revised care plan did not instruct the staff to perform 15-minute checks of Resident 1. CMS Ex. 17, at 44. The record contains documentation of 15-minute checks but shows no such monitoring after October 4, 2012. ALJ Decision at 15-16. Countryside's MDS (minimum data set) coordinator, who wrote Resident 1's plan of care, indicated during the March 2013 survey that 15-minute checks were stopped because Resident 1 had exhibited no further problematic behavior, but there is no

documentation that the checks were stopped for that reason. ALJ Decision at 16. “In December 2012, Resident 1 attempted to inappropriately touch a male CNA while the CNA provided personal care to Resident 1.” *Id.* at 9. “The CNA was able to move out of the way of Resident 1’s attempt to touch him, but Resident 1 made the CNA feel uncomfortable.” *Id.* The CNA reminded Resident 1 not to touch anyone inappropriately and reported the incident to a Licensed Practical Nurse (LPN); however, the LPN did not further report or document this incident.” *Id.* During a survey interview, the LPN indicated that the CNA had reported that Resident 1 had attempted to “grope” him and she (the LPN) should have reported the incident as inappropriate sexual behavior. *Id.* at 16.

“On January 10, 2013, Dr. Henderson wrote [in a progress note] that Countryside staff continued to have concerns that Resident 1 would re-offend with Resident 4.” *Id.* at 9 (citing P. Ex. 17, at 24 and P. Ex. 24, at 120). “Dr. Henderson continued to emphasize stopping and redirection techniques.” *Id.*

“On February 28, 2013, Dr. Henderson transferred Resident 1 to the care of another psychologist, and indicated [that] Resident 1’s status at that time of transfer was stable and that he was compliant with treatment.” *Id.* at 10 (citing P. Ex. 24, at 129). “By March 2013, Resident 1 had been roommates with Resident 2 for over six months.” *Id.*

Although Resident 1 independently used a wheelchair to move about the facility, he was “capable of reaching out and touching other residents.” *Id.* at 12, 13.

Based on the foregoing findings of fact, the ALJ analyzed whether Countryside was, as CMS determined, not in substantial compliance with Medicare participation requirements in 42 C.F.R. Part 483 from December 8, 2012, through April 3, 2013.⁴ ALJ Decision at 10-18. The ALJ first considered whether Countryside was out of substantial compliance with section 483.13(b), which states that a “resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.” *Id.* at 10-14. The ALJ concluded that Countryside was not in substantial compliance with that regulation during the relevant period because it “failed to take necessary precautions to prevent” Resident 1 “from engaging in sexually abusive conduct toward at least one other resident” (Resident 2). *Id.* at 11; *see also id.* at 14 (stating that Countryside violated the regulation because it “did not take appropriate action to ensure that Resident 2 was free of sexual abuse”).

⁴ The ALJ stated that he had not evaluated the merits of other deficiencies alleged by CMS in its hearing presentation because the noncompliance he found was “sufficient to justify . . . the imposition of the remedies proposed by CMS” ALJ Decision at 6 n.3. Countryside takes no issue with the ALJ’s election not to make findings regarding certain alleged deficiencies, nor does it contend that the absence of such findings necessitates an adjustment to the CMPs imposed in this case.

In support of that conclusion, the ALJ rejected the suggestion (which Countryside does not press in this appeal) that Resident 2, whose diagnoses included psychoses, had falsely accused Resident 1 of sexual abuse. *Id.* at 11-13. The ALJ also found that in light of Resident 1's criminal history, diagnosis of Frotteurism, sexually inappropriate behavior toward male staff members, reports of his attraction to Resident 4, and observations of him near Resident 4's room, it was "reasonably foreseeable that Resident 1 would re-offend as a sexual abuser[.]" *Id.* at 13. The ALJ further found that Countryside's "actions to prevent . . . re-offense" were "insufficient" to protect Resident 2's rights under section 483.13(b), and Countryside "ought not to have placed Resident 1" with Resident 2. *Id.* at 13-14. The ALJ noted that although Resident 2, like Resident 4, had physical limitations that made him "exactly the type of victim Resident 1 would have sought since Resident 2 could neither run nor resist[.]" Countryside "never considered the potential for Resident 1 to abuse Resident 2" and "failed to consistently carry out even the few interventions" – most notably 15-minute checks of Resident 1 – that the nursing staff had "identified as necessary in Resident 1's care plan." *Id.* at 12, 14.

In reaching his conclusion that Countryside had violated section 483.13(b), the ALJ acknowledged Dr. Burgess' testimony that making Resident 1 and Resident 2 roommates "did not create a risk of sexual assault" but proceeded to note that Dr. Henderson had "admitted to surveyors [during a survey interview] that assigning Resident 1 a quadriplegic roommate (Resident 2) 'may have been poor judgment.'" *Id.* at 14 (citing P. Ex. 2, at 5 and quoting CMS Ex. 15, at 2). The ALJ found unpersuasive Dr. Henderson's opinion that Resident 1's interest in Resident 4 and incidents with staff in September and December 2012 were not "predictors" of the incident that occurred on March 18, 2013. *Id.* To the contrary, said the ALJ, those circumstances – together with Resident 1's prior conviction for a sexual offense, Resident 2's physical vulnerability (a trait he shared with Resident 4), and the September 2012 diagnosis of Frotteurism, which indicated that Resident 1 had a "predilection" for the type of sexually inappropriate behavior he exhibited with male staff in September and December 2012 – constituted "ample evidence . . . that Resident 2 might be abused by Resident 1." *Id.* "Resident 1's conduct," said the ALJ, "did not involve isolated incidents, but rather recurring efforts to touch the genitals of male staff and Resident 4." *Id.*

The ALJ next considered CMS's contention that Countryside had violated 42 C.F.R. §§ 483.20(d) and 483.20(k)(2), which specify requirements for resident assessments and care plans. The ALJ concluded that Countryside was not in substantial compliance with those regulations because it "failed to appropriately update Resident 1's care plan to prevent re-offense and failed to update Resident 2's care plan to prevent victimization by Resident 1." ALJ Decision at 15. In support of that conclusion, the ALJ found that Resident 1's inappropriate conduct with the male CNA in December 2012, and concerns

by staff during January 2013 that Resident 1 “was again attempting to offend with Resident 4,” provided “clear evidence” that “current interventions had failed to curb Resident 1’s inappropriate sexual behavior” but that Countryside failed to revise Resident 1’s plan of care after November 2012. *Id.* at 16.

Next, the ALJ concluded that the evidence that Countryside was noncompliant with sections 483.13(b), 483.20(k)(2), and 483.20(d) also established that Countryside was noncompliant with sections 483.25(h) and 483.75 during the relevant time frame (December 8, 2012 through April 3, 2013). *Id.* at 17-18. The ALJ then sustained, as “not clearly erroneous,” CMS’s determination that Countryside’s noncompliance with sections 483.13(b), 483.20(d), 483.20(k)(2), 483.25(h), and 483.75 placed Resident 2 (and other residents) in “immediate jeopardy” from December 8, 2012 through April 3, 2013. *Id.* at 18-19.

Finally, the ALJ determined that the daily CMP amounts imposed by CMS for the immediate-jeopardy and non-immediate-jeopardy periods of noncompliance (\$6,850 per day for the former, \$100 per day for the latter) were “reasonable.” *Id.* at 19-20.

IV. 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*, available at <https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/participation/index.html>; *Batavia Nursing & Convalescent Inn*, DAB No. 1911, at 7 (2004), *aff’d*, *Batavia Nursing & Convalescent Ctr. v. Thompson*, 143 F. App’x 664 (6th Cir. 2005).

V. Discussion

- A. *Substantial evidence supports the ALJ’s conclusion that Countryside was not in substantial compliance with 42 C.F.R. § 483.13(b) as of December 8, 2012.*

42 C.F.R. § 483.13(b) states that a SNF resident “has the right to be free from,” among other things, sexual, physical, and mental abuse. The Board has held that “[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.” *Western Care*

Mgmt. Corp., d/b/a Rehab Specialties Inn, DAB No. 1921, at 12 (2004). As noted earlier, the ALJ concluded that Countryside violated section 483.13(b) because it “did not take appropriate action to ensure that Resident 2 was free of sexual abuse[.]” ALJ Decision at 14.

Countryside “agrees that most” of the ALJ’s findings of fact supporting that conclusion “are essentially accurate[.]” Request for Review (RR) at 2. In addition, Countryside does not challenge the ALJ’s finding that Resident 1 sexually abused Resident 2 on March 18, 2013. *Id.* Countryside submits that it brought the appeal “primarily” to challenge what it says was the ALJ’s finding that Resident 1’s assault of Resident 2 was “foreseeable.” RR at 2; *see also id.* at 4 (stating that the ALJ found it foreseeable that Resident 1 would assault Resident 2 because Resident 1 “had a predilection to commit an assault and that Resident 2 would be a likely target of Resident 1”).

Countryside contends that, prior to March 2013, it reasonably relied upon “outside experts” – namely, Dr. Henderson and a psychiatric nurse practitioner – to assess and “provide insight” into Resident 1’s psychosexual disorder, identify the risk he posed to other residents, and help determine whether the risk could be mitigated by medication, counseling, supervision, or other interventions. RR at 7; *see also id.* at 20 (stating that it was “entitled to rely” on Dr. Henderson’s expertise because “[n]o one on Countryside’s staff was qualified to make the required assessment or even to second guess the psychologist”). According to Countryside, those mental health professionals “reviewed Resident 1’s care and behaviors between September and December of 2012, and determined that whatever possible risk for re-offense he presented was with Resident 4,” and they “further concluded [that] the incidents with staff and Resident 4 were not behaviors that suggested that other residents, including Resident 2, were at risk of an assault by Resident 1.” RR at 10; *see also id.* at 9 (stating that the psychiatric nurse practitioner’s assessment “clearly indicated that she did not perceive the incident [involving the male nurse in September 2012] [as] portend[ing] that residents would be assaulted,” calling the incident “isolated,” and that Resident 1’s medication regimen was “effective to address that risk”). Countryside asserts that “[n]one of [Dr. Henderson’s] descriptions of her [psychotherapy] sessions with [Resident 1] in the six months she treated him describe him as being in the throes of sexual urges, indicate that he [had] identified any other individual besides Resident 4 in whom he had an interest, or otherwise describe anything that would indicate he was manifesting signs of re-offending.” RR at 8 (citing P. Ex. 24, at 85-129). Countryside further asserts that Dr. Henderson was “aware of the placement of Resident 1 and Resident 2 as roommates” but “opined [in her declaration] that she did not believe that [that circumstance] created any

risk that Resident 1 would assault Resident 2” because “Resident 1 never expressed any interest in Resident 2” and they “had little to do with each other,” and because “Resident 2 did not fit Resident 1’s previous target profile, as he was not a younger, African American male but was a 50 year old Caucasian male.” RR at 9.

In short, Countryside believes that its management of Resident 1 prior to March 18, 2013 cannot be faulted because it had no reason to think Resident 1 posed a danger to any resident except Resident 4. That belief appears to rest on the following allegations: first, that Dr. Henderson and the psychiatric nurse practitioner determined in September 2012 that Resident 1 did not present a risk of harm to any resident except Resident 4; second, that these professionals communicated that risk assessment to Countryside; and third, that its nursing staff relied on that assessment in focusing its attention on protecting Resident 4. *See* RR at 21 (asserting that there was no basis to conclude that Countryside “knew or should have known of Resident 1’s risk for re-offense included Resident 2 *after it secured a professional assessment that his risk was limited to Resident 4*” (italics added)).

The record fails to substantiate the latter two allegations, however. Although Dr. Henderson testified that, during the six months when Resident 1 was under her care, she believed that he posed no risk of harm to any resident except Resident 4,⁵ she conspicuously failed to say that she conveyed that supposed belief to Countryside’s nursing staff. In addition, her asserted belief that only Resident 4 was at risk of harm is nowhere reflected in Countryside’s records from the period. Dr. Henderson’s initial assessment report for Resident 1 states that he was “[a]t risk of reoffending,” but the report does not say that only Resident 4, or only male residents who fit a specific age and race profile, might become the target of Resident 1’s sexually inappropriate behavior; the report merely acknowledges that *staff* had expressed its concerns about Resident 1’s apparent interest in Resident 4.⁶ CMS Ex. 17, at 10. Nor does the record disclose any request from Countryside to Dr. Henderson for an opinion about what risks Resident 1 might pose to other facility residents. Similarly, Countryside’s plan of care for Resident 1 describes his behavioral problem as being “sexually inappropriate” with “other males” or “other male residents” without further specifying which “male residents” were at risk of becoming targets of that behavior. CMS Ex. 17, at 102; *see also id.* at 44.

⁵ Dr. Henderson stated in her declaration that it was her “professional opinion that the only potential risk for Resident 1 to re-offend that may have existed was with Resident 4” and that she “did not believe Resident 1 was a risk to re-offend with any other resident at Countryside.” P. Ex. 22, ¶ 6.

⁶ Dr. Henderson’s initial assessment and subsequent progress notes show that her focus was on treating Resident 1 and curbing his “high risk behavior,” rather than on identifying residents who might need to be protected from that behavior. *See, e.g.*, CMS Ex. 17, at 12.

Jennifer Catanzaro, LPN, the Countryside employee who wrote Resident 1's plan of care, testified that she "was aware of [Resident 1's] status as a sexual offender" and further stated:

When I wrote [Resident 1's] care plan, I had not heard and was otherwise unaware of any interest Resident #1 had expressed in any other resident at Countryside. To the extent the care plan suggests or asserts that Resident #1 expressed interest in other residents, it is incorrect. The care plan I drafted was in [sic] solely in response to the discussions staff was having about Resident #1 and Resident #4 at that time.

P. Ex. 7, ¶ 6. On its face this testimony does not support Countryside's claims that it relied on the judgment of mental health professionals in deciding how to manage Resident 1's behavior. Nurse Catanzaro did not say that Resident 1's care plan reflected input from Dr. Henderson or the nurse practitioner. Nor did she claim that those persons assured the staff that the risk of harm to residents other than Resident 4 was negligible or nonexistent. No other Countryside employee came forward to explain the reasoning behind Resident 1's care plan or the decision to place Resident 1 in a room with a male resident who was physically incapable of warding off sexually inappropriate behavior. If anything, Nurse Catanzaro's testimony implies that Countryside's nursing staff made its *own* judgment, *without* the benefit of "insight" from mental health professionals, that Resident 1 would not engage in such behavior with any person except the one resident (Resident 4) for whom he had expressed an attraction, even though the nursing staff was, as Countryside concedes, unqualified to make the "required assessment." RR at 20. That judgment, if any was made, should have been reexamined after the December 2012 incident. Not only did that incident signal that Resident 1's sexual urges were not fully controlled despite psychotherapy, medication, and other attempts to divert him, it showed that Resident 1 might attempt to engage in sexually inappropriate behavior with persons other than Resident 4 (including persons who did not fit the narrow profile of age and race that Countryside focused on based on the victim of Resident 1's prior crime).

Thus, Countryside has not shown that it sought needed expert input about measures at the time it was needed no matter how supportive Dr. Henderson's after-the-fact opinions about Resident 1's likelihood of repeating his sexual behaviors. The ALJ, furthermore, did not find Dr. Henderson's opinions reliable. ALJ Decision at 14 (ALJ does "not credit Dr. Henderson's views completely"). We defer to the ALJ's assessment of witness credibility and determination of the weight to accord to specific evidence, absent compelling reasons not to do so. *Avalon Place Trinity*, DAB No. 2819, at 9 (2017), and cases cited therein. Dr. Henderson's testimony raised questions, as the ALJ pointed out. For example, Dr. Henderson did not deny having told surveyors that placing Resident 1

as roommate with a paraplegic resident “may have been poor judgment.” ALJ Decision at 14, quoting CMS Ex. 15, at 2. Yet in her later testimony, she denied that Resident 1’s inappropriate behavior with two staff members and expressions of sexual interest in Resident 4 (who was incapacitated) constituted any “predictors” of future inappropriate behavior with Resident 2. P. Ex. 22, at ¶ 14. She relied on the observation that nursing home residents with behavioral issues “typically” show a pattern of escalating behaviors close in time to a negative event and asserted that the episodes were too “remote in time” to raise concerns. *Id.* These general comments are not consistent with her own treatment records showing that she repeatedly assessed Resident 1 as at “risk of re-offending.” CMS Ex. 17, at 10-31. We see no compelling reason to decline to defer to the ALJ’s view of Dr. Henderson’s credibility and the weight to accord to her testimony.

Countryside asserts that the ALJ should nevertheless have relied – but did not rely – upon expert testimony, or evidence from some other authoritative source, to support his foreseeability finding. RR at 13, 14. According to Countryside, the ALJ improperly based his decision “solely on his personal interpretation of the meaning of the incidents involving Resident 1, as well as his belief that Resident 2’s physical vulnerability qualified him as a probable victim of Resident 1.” RR at 13. In a similar vein, Countryside faults CMS for failing to demonstrate that Resident 2 (or other residents) had specific traits that made him a potential target of Resident 1. RR at 11-12; Reply at 3.

We see no error by the ALJ. He identified facts and evidence – including the results of Dr. Henderson’s initial assessment of Resident 1 – sufficient to put Countryside on notice during 2012 that Resident 1 might “reoffend” in its facility and that it needed to determine (with the help of mental health professionals) the extent to which he posed a risk of harm to residents. Countryside does not point to specific findings of fact to support its claim that the ALJ relied on a “personal interpretation” of events. Furthermore, the ALJ had a basis to suppose that Resident 2’s physical incapacity was a relevant risk factor.⁷ Dr. Burgess testified that physical vulnerability is a factor in judging whether a person might become the victim of sexual abuse, stating that “[s]exual assaults or molestations are actions taken by a perpetrator against *vulnerable* victims,” and that the vulnerability exploited is “usually” the victim’s “physical inferiority.” P. Ex. 2, ¶ 16 (*italics added*).

⁷ The ALJ did not, as Countryside suggests, say that the March 18, 2013 “assault” was foreseeable or that Resident 2’s physical incapacity was the only factor that made it so. Although he stated that Resident 2 was “exactly the type of victim Resident 1 would have sought since Resident 2 could neither run nor resist,” ALJ Decision at 12, the ALJ later made it clear that Resident 2’s being “immobile” was merely one circumstance among several (including Resident 1’s criminal history and diagnosis of Frotteurism) that put Countryside on notice that Resident 2 (and perhaps others) might be at risk of harm from Resident 1, *id.* at 14.

Countryside's suggestion that CMS presented inadequate evidence of specific residents' vulnerability fails to recognize the nature of Countryside's obligation at the point it learned that Resident 1 was at "risk of reoffending." Once Dr. Henderson made that determination, in September 2012, it was Countryside's responsibility under the regulations to determine whether Resident 1 posed a risk of harm to other residents, the circumstances under which such harm might occur, and the precautions necessary to minimize the assessed risk and ensure that residents remained free from sexual abuse. *Cf. Columbus Nursing & Rehab. Ctr.*, DAB No. 2247, at 10 (2009) (noting that section 483.13(b)'s goal would be "meaningless" if the regulation is not read as imposing certain obligations to prevent "risks" of abuse). Countryside's failure to meet those fundamental obligations prior to March 18, 2013 cannot be cured, or excused, by a post-survey risk assessment. *Cf. Carrington Place of Muscatine*, DAB No. 2321, at 17 (2010) (noting that a current assessment, and not a "retrospective assessment" of a resident's nutritional status and needs, was "precisely what the nursing staff, in consultation with the dietician and physician, should have performed (but failed to perform)" prior to the compliance survey).

Countryside attributes to Dr. Henderson the view that Resident 2's race and age were the *only* relevant "predictors of Resident 1's likely targets for re-offense." RR at 9. But Dr. Henderson did not testify that a resident's physical or other inability to ward off sexually inappropriate behavior would have been irrelevant to any timely and adequate assessment of the risk posed by Resident 1 to Countryside's residents. Nor did Dr. Henderson assert that the risk of harm to male residents other than Resident 4 was zero or that closer supervision or monitoring of Resident 1 was unnecessary to ensure the safety of those residents. Certainly, there is no evidence that Dr. Henderson offered – or was asked for – any such opinions to Countryside at the time when it should have been planning appropriate care measures to control for risks to its residents.

Given Resident 1's criminal history, his diagnosis of Frotteurism, the fact that Dr. Henderson found him to be at "risk for re-offending," his presence near Resident 4's room during November 2012 despite prior warnings to stay away, and his sexually inappropriate behavior with staff in September and December 2012, the ALJ reasonably concluded that Countryside should have recognized the possibility that Resident 1 might engage in sexually inappropriate behavior with Resident 2 or other vulnerable male residents and that staff should have taken reasonable steps – including performing an adequate risk assessment – to ensure that all residents remained free from sexual abuse. In disputing that Resident 1 presented a foreseeable risk to vulnerable residents, Countryside frames its responsibility as arising only if the particular assault was predictable. *See, e.g.*, RR at 2-4, 12. This misunderstands the facility's responsibility. Countryside did not have to be able to predict the victim or circumstances that ultimately resulted from Resident 1's behavior. It was hardly beyond foresight to recognize that an

individual who wearing an ankle bracelet and taking libido-suppressing medications on admission after a sexual misconduct conviction may present a risk to residents who are physically vulnerable. Where the issue is avoiding resident-on-resident misconduct, the Board has long applied “the principle that facility staff must make *all reasonable efforts* to protect residents from foreseeable adverse incidents.” *Springhill Senior Residence*, DAB No. 2513, at 15 (2013) (italics added). We conclude that Countryside’s arguments that the sexual assault on Resident 2 was not foreseeable are without merit, and turn to whether Countryside took all reasonable measures to protect its residents from foreseeable risks of such sexual misconduct.

Countryside’s other arguments do not persuade us that it met its obligation to ensure that residents were free from sexual abuse. In her declaration, Surveyor Aromola identified various precautions that Countryside could have taken but failed to take prior to March 18, 2013, including: (1) not putting Resident 1 in a room with a male resident incapable of protecting himself from sexual abuse; (2) limiting Resident 1’s “access” to other vulnerable residents (besides Resident 4); (3) conducting timely “in-service” training to ensure that staff (a) knew about Resident 1’s psychosexual disorder and associated behavior, (b) were aware of updates to Resident 1’s plan of care, and (c) understood how to “monitor” for problematic behavior and to “redirect” the resident from situations that might increase the risk of re-offending; (4) “assess[ing] Resident 1’s behavior patterns to identify circumstances that triggered his sexually aggressive or inappropriate behavior”; and (5) reporting and investigating the incidents of inappropriate behavior. CMS Ex. 50, ¶¶ 23, 27, 29-30, 33, 35, 36, 37. Countryside made no attempt at the hearing level to establish that it implemented these measures prior to the March 18, 2013 incident, focusing instead on the fact that it provided general training to its staff on abuse prevention. Countryside nevertheless contends that the measures it did take to reduce the risk that Resident 1 might reoffend – including psychotherapy, the administration of Premarin, increased supervision, and encouraging Resident 1 to participate in social activities – were effective and adequate given the infrequency of Resident 1’s inappropriate or suspicious behavior between September 2012 and March 2013. RR at 16-17. In support of that proposition, Countryside asserts that when Resident 1 was seen near Resident 4’s room in November 2012, the nursing staff “intervened” and reported the observations to Dr. Henderson, who then discussed the matter with Resident 1 in subsequent therapy sessions. RR at 17. Countryside also points to the ALJ’s finding that “Resident 1 was finally dissuaded from attempting inappropriate contact with Resident 4” by December 2012, ALJ Decision at 13, and notes that after the incident with the CNA that month, there were no further reported incidents of inappropriate behavior with staff or observations of Resident 1 near Resident 4’s room. RR at 22-23.

This line of argument presumes that Countryside’s planned interventions reflected an informed judgment that residents other than Resident 4 were at no risk of harm, but that presumption is unfounded: as discussed, there is no evidence that Countryside even considered the possibility that Resident 1 might attempt to “reoffend” with residents other than Resident 4. Furthermore, the infrequency of Resident 1’s inappropriate behavior, or the absence of reported abuse, does not necessarily mean that the risk of harm to Resident 2 (and others) was negligible or non-existent. *Fal-Meridian, Inc. v. U.S. Dep’t of Health & Human Servs.*, 604 F.3d 445, 450 (7th Cir. 2010) (“It’s the nature of a risk, compared to a certainty, that one can have a run of luck.”). It could simply mean that staff had succeeded in closing off some outlets for Resident 1’s problematic behavior or even that its failure to closely monitor Resident 1 caused it to miss evidence of behavior that residents were unable or unwilling to report. Section 483.13(b) required staff to do more – to make all reasonable efforts to achieve the regulatory goal to keeping residents “free from” sexual abuse. *Western Care Mgmt.* at 14 (noting that the “goal of section 483.13(b) is to keep residents free from abuse” and that “[t]his goal cannot be achieved if a facility could be found in compliance even though it failed to take reasonable steps to protect residents from potentially injurious acts”).

Finally, Countryside contends that the ALJ failed to discuss, or unreasonably rejected, favorable testimony by Dr. Henderson and Dr. Burgess, who, it asserts, were the only two witnesses with the background and training to assess Resident 1’s “risk for re-offense.” RR at 10, 12-13, 18-20. Countryside submits that CMS did not rebut that testimony, noting that it failed to “call any witness with any background in the assessment, care or treatment of sex offenders[,] . . . a strong indication that it relied heavily on public fears [that sex offenders are certain to re-offend] to fill in the gaps of its case presentation.” RR at 10-13, 14 n.5.

The ALJ could have been more expansive in weighing the testimony of Drs. Burgess and Henderson, but it appears he rejected their opinions in part because they were incompatible with Dr. Henderson’s unguarded statement to the surveyors that putting Resident 2 and Resident 1 in the same room may have been “poor judgment.” The ALJ was not unreasonable in taking that view. Furthermore, the ALJ was not bound to accept the opinions expressed by Dr. Burgess on ultimate legal issues, such as the adequacy of Resident 1’s plan of care and whether Countryside took sufficient steps to keep its residents free from sexual abuse.⁸ *Agape Rehab. of Rock Hill*, DAB No. 2411, at 16 (2011) (“Whether a facility is in substantial compliance is a legal issue, and an ALJ is not required to accept expert testimony on legal issues.”).

⁸ On those questions, Dr. Burgess asserted that the “care and services provided by staff at Countryside to Resident #1 were reasonable and adequate to address any foreseeable risks he posed to other residents” and that Resident 1’s plan of care was “adequate to address Resident 1’s perceived risk for re-offense.” P. Ex. 2, ¶¶ 9, 14, 23.

Finally, any failure by the ALJ to discuss specific opinions expressed by Dr. Burgess and Dr. Henderson in more detail is harmless error in these circumstances. Those opinions, viewed in their totality, constitute a retrospective assessment of the risk that Resident 2 might become a target of Resident 1's sexually inappropriate behavior. Regardless of its substantive reasonableness, that assessment is legally immaterial because it does not overcome the fact that Countryside did not, prior to March 18, 2013, meet its obligation under section 483.13(b) to assess the risk of harm to residents from Resident 1's known propensity to engage in sexually inappropriate behavior and take reasonable precautions to compensate for any lack of understanding about the nature and extent of that risk. Countryside notes that Dr. Burgess's declaration "demonstrated" that the "existence and extent of the risk" posed by Resident 1 could not be determined without a "comprehensive consideration of a variety of factors by someone trained to assess that risk." RR at 14. Such "consideration" of risk factors is precisely what Countryside (in consultation with trained professionals) needed, but failed, to perform in 2012 in order to ensure that its residents remained free from sexual abuse.

Besides the risk-assessment failure, there are other ways (mentioned earlier) in which Countryside did not take "adequate" measures to mitigate the risk of harm posed by Resident 2. Surveyor Aromola testified that it was important that all employees know the "potential for abuse" because they were the "first line of defense in preventing any type of abuse" but that Countryside failed to ensure that its staff were timely and adequately informed about Resident 1's criminal history, diagnosis of Frotteurism, misbehavior with staff, and how to recognize or respond to such behavior. *See* CMS Ex. 50, ¶¶ 14-15, 17, 23-24, 30; *see also* CMS Ex. 2, at 9, 26-29 (revised Statement of Deficiencies); CMS Ex. 14, at 5-7, 23-27 (surveyor notes). That testimony was un rebutted. Although Resident 1's plan of care expressly noted his "past Hx [history] of sexual inappropriateness [with] other males," CMS Ex. 17, at 44, no apparent formal or systematic effort was made to communicate that information to the nursing, social services, housekeeping, and other staff after Resident 1 began exhibiting sexually inappropriate or suspicious behavior in September 2012. Declarations by some Countryside employees imply that Resident 1's "history as a registered sex offender" was "common knowledge," *see, e.g.*, P. Ex. 12, ¶ 5, but Countryside's Director of Nursing admitted during the survey that no staff training ("in-services") concerning Resident 1's behavioral issues was performed in the wake of the incidents with the nurse and CNA in September and December 2012. CMS Ex. 2, at 24-25. Surveyor Aromola further testified that Countryside did not fully disseminate information about the content of, or changes to, Resident 1's plan of care, and that the plan inadequately specified how the staff was expected to implement certain interventions, such as the instruction to "monitor for & document" Resident 1's behaviors. CMS Ex. 50, ¶¶ 16, 22-24, 29; CMS Ex. 17, at 44. That testimony likewise was un rebutted, and it was consistent with holdings in prior Board decisions that a care

plan “functions as a roadmap for all of the resident’s caregivers” and “must include sufficient guidance to ensure that the services provided promote the plan’s specified objectives.” *Deltona Health Care*, DAB No. 2511, at 18 (2013) (internal quotation marks omitted).

Dr. Burgess’s opinion that Countryside’s care planning was “adequate” was premised on its supposed implementation of a care plan that at least included “notification of staff of Resident 1’s past.” P. Ex. 2, ¶ 14. Given that Dr. Burgess’s opinions were based on factual premises that were unsupported by the evidence of record, the ALJ could reasonably decline to accord weight to those opinions.

One other element of Dr. Burgess’s testimony is worth mentioning. She took issue with CMS’s characterization of the September and December 2012 incidents with staff as involving “molestation” or “sexually predatory” conduct, asserting that these terms are “inappropriate” in light of Resident 1’s weak ability to “plot a sexual assault,” physically “subdue” victims, and other factors. P. Ex. 2, ¶¶ 9, 12-13 15-20. However, we do not review CMS’s characterization of those incidents; our analysis properly focuses on the ALJ’s findings. The ALJ did not describe the incidents with staff in September and December 2012 as involving sexual predation or “molestation” or use other terms that connote a forcible assault or an intention to injure. Furthermore, the issue here is not whether Resident 1 was likely to commit a forcible assault or other crime in the facility, but whether he was prone to engage in behavior that, regardless of his intent or purpose, subjected other residents to unwanted sexual touching. *Cf. Somerset Nursing & Rehab. Facility*, DAB No. 2353, at 18-19 (2010) (rejecting the suggestion that a resident had to be capable of acting “willfully,” or with intent to injure, in order to find that he had perpetrated, or was a threat to inflict, “abuse” on other residents).

For the reasons outlined above, we conclude substantial evidence supports the ALJ’s conclusion that Countryside was not in substantial compliance with section 483.13(b) beginning on December 8, 2012.

B. *Substantial evidence supports the ALJ’s holding that Countryside was not in substantial compliance with 42 C.F.R. §§ 483.20(d) and 483.20(k)(2) as of December 8, 2012.*

42 C.F.R. §§ 483.20(d) and 483.20(k)(2) specify requirements relating to the development, review, and revision of a resident’s comprehensive plan of care.⁹ The Board has held that “[i]mplicit in [section 483.20’s plan-of-care requirements] is a SNF’s

⁹ Section 483.20(d) states that a SNF “must maintain all resident assessments completed within the previous 15 months in the resident’s active record and use the results of the assessments to develop, review and revise the resident’s comprehensive plan of care.” Section 483.20(k)(2)(iii) requires that a comprehensive plan of care be “[p]eriodically reviewed and revised by a team of qualified persons”

“obligation to develop care plan revisions that meaningfully respond to changes in a resident’s particular needs” – which may, of course, include a need for supervision. *Sheridan Health Care Ctr.*, DAB No. 2178, at 38 (2008) (noting that surveyor guidance in the State Operations Manual (SOM) explains that a SNF must evaluate the results of interventions in a resident’s care plan and “revise the intervention as necessary”); *see also Meridian Nursing Ctr.*, DAB No. 2265, at 18 (2009) (a SNF must change its care plan when it becomes “apparent that . . . planned interventions [are] not working”), *aff’d*, *Fal-Meridian, Inc. v. U.S. Dep’t of Health & Human Servs.*, 604 F.3d 445 (7th Cir. 2010).

The ALJ concluded that Countryside was noncompliant with sections 483.20(d) and 483.20(k)(2) because it failed to revise Resident 1’s plan of care in late 2012 or early 2013 in response to “clear evidence” that “current interventions had failed to curb Resident 1’s inappropriate sexual behavior.” ALJ Decision at 16. That conclusion is supported by substantial evidence. There is no dispute that, in December 2012 – despite weeks of psychotherapy and the continuation of his medication regimen – Resident 1 attempted to engage in nonconsensual sexual touching of a male CNA. Neither Dr. Henderson nor Dr. Burgess denied that this was the type of “high risk behavior” that, according to Dr. Henderson’s initial assessment, evidenced a “risk of reoffending.” *See* CMS Ex. 17, at 11 (identifying the reduction of “high risk behaviors” as a short-term treatment goal for Resident 1). As we observed above, the December 2012 incident indicated not only that Resident 1’s psychosexual disorder was not fully controlled but that there was a possibility that persons other than Resident 4 might become the objects of his sexually inappropriate behavior. However, Countryside at that point did not seek out input from Dr. Henderson or the nurse practitioner in order to determine whether, or the extent to which, the incident portended misbehavior with its residents (besides Resident 4).¹⁰ Especially given that Countryside did not make or solicit an informed judgment about what risks Resident 1 presented to other residents or how to minimize them, prudence demanded that it revise Resident 1’s plan of care to include precautions that, at minimum, restricted or monitored Resident 1’s access to residents who may have been unable, due to physical or other limitations, to resist Resident 1’s advances.

Countryside submits that there was no need to revise the plan of care because the CNA involved in the December 2012 incident “counseled” Resident 1 “not to do it again,” and that “[a]t no point thereafter did Resident 1 attempt to re-offend with that staff member, or any other staff member or resident at Countryside until March 18, 2013.” RR at 23. This argument ignores the fact that existing interventions, supposedly in place for more

¹⁰ Dr. Henderson testified that she did not become aware of the December 2012 incident involving the CNA incident until the March 2013 survey, P. Ex. 22, ¶ 12, and Countryside does not contest the ALJ’s finding that the nurse to whom the incident was reported failed to pass on what she learned to the rest of the nursing staff.

than three months, had not fully achieved the care plan's stated objective of curbing Resident 1's sexually inappropriate behavior and that the plan did not reflect an intention to protect residents besides Resident 4.¹¹ CMS Ex. 17, at 44. That Resident 1 did not "attempt to re-offend" for weeks after the December 2012 incident is immaterial – and merely fortuitous. The issue presented under section 483.20 is whether Countryside should have responded promptly to the December 2012 incident (and ongoing concern about Resident 4's safety) with additional care planning in order to minimize the *risk* that Resident 1 might "re-offend" with a vulnerable resident.

Countryside contends that the ALJ did not "identify one other intervention that was required for Resident 1 that was not included on his care plan" or specify an intervention that would have prevented the incident that occurred on March 18, 2013. RR at 23-24. We disagree. One possible intervention, noted in Surveyor Aromola's declaration, would have been to relocate Resident 1 or Resident 2 so that they no longer shared a room. CMS Ex. 50, ¶ 36 (stating that Countryside "could have prevented Resident 1 from sharing a room with . . . residents who could not protect themselves from sexual assault"). The ALJ alluded to that intervention as well, stating that Countryside "ought not to have placed Resident 1 with a highly vulnerable resident." ALJ Decision at 14. A second intervention mentioned by the ALJ were "15 minute checks" of Resident 1. Countryside instituted that measure in September 2012, soon after Dr. Henderson's initial assessment. *See* P. Ex. 24, at 145-56. After ceasing the checks without explanation in early October 2012, Countryside inexplicably failed to reinstitute, or at a minimum reassess the need for, that precaution in November 2012 after Resident 1 was observed outside of Resident 4's room, or in December 2012 after the incident between Resident 1 and the CNA, or in January 2013 when staff expressed ongoing concern about Resident 4's safety. Although 15-minute checks of Resident 1 may not have prevented the March 18, 2013 incident, they would have narrowed Resident 1's opportunities for misbehavior and thus reduced the likelihood that he might succeed in committing an abusive act.

We therefore affirm the ALJ's conclusion that Countryside was not in substantial compliance with 42 C.F.R. § 483.20(d) and 483.20(k)(2). In light of our conclusion that Countryside failed to meet those requirements with respect Resident 1's plan of care, we need not address Countryside's objection to the ALJ's finding that Countryside should also have revised Resident 2's plan of care.

¹¹ As noted in the previous section, the nurse responsible for developing Resident 1's plan of care testified that the section of the plan that addressed Resident 1's sexually inappropriate behavior was "drafted solely in response to the discussions staff was having about Resident #1 and Resident #4 at the time." P. Ex. 7, ¶ 6. She did not say that the interventions were intended to protect any other resident.

- C. *Countryside alleged no ground on which to overturn the ALJ's conclusion that Countryside was not in substantial compliance with 42 C.F.R. § 483.75.*

42 C.F.R. § 483.75 states that a SNF “must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.” The Board has held that noncompliance with section 483.75 may be evidenced by violations of other participation requirements. *See Life Care Ctr. of Tullahoma*, DAB No. 2304, at 45 (2010), *aff'd*, *Life Care Ctr. Tullahoma v. Sec’y of U.S. Dep’t of Health & Human Servs.*, 453 F. App’x 610 (6th Cir. 2011); *Life Care Ctr. of Bardstown*, DAB No. 2233, at 28 (2009) (stating that the existence of other deficiencies “may constitute a prima facie case that a facility has not been administered efficiently or effectively as required by section 483.75”).

The ALJ held that evidence supporting his conclusion that Countryside had violated 42 C.F.R. §§ 483.13(b), 483.20(d), and 483.20(k)(2) “also supports my conclusion that Countryside failed to comply with” section 483.75. ALJ Decision at 18. In its appeal brief, Countryside states that it “incorporates” its arguments opposing the other noncompliance findings as “its defense” to the conclusion that it violated section 483.75. RR at 26. However, we have rejected those arguments on their merits, and Countryside does not assert alternative grounds to overturn the ALJ’s conclusion that it was noncompliant with section 483.75. We therefore affirm that conclusion without further discussion. *Brenham Nursing & Rehab. Ctr.*, DAB No. 2619, at 15-16 (2015) (summarily upholding a finding that the SNF was noncompliant with section 483.75 because the SNF’s argument for reversing that finding was founded on its objection to other noncompliance findings that the Board had already affirmed), *aff'd*, *Brenham Nursing & Rehab Ctr. v. U.S. Dep’t of Health & Human Servs.*, 637 F. App’x 820 (5th Cir. 2016).

- D. *Countryside does not challenge the ALJ's conclusion that it was not in substantial compliance with 42 C.F.R. § 483.25(h).*

The ALJ concluded that the evidence supporting his conclusion that Countryside was noncompliant with 42 C.F.R. §§ 483.13(b), 483.20(d), and 483.20(k)(2) also shows that Countryside was not in substantial compliance with 42 C.F.R. § 483.25(h). ALJ Decision at 18. Countryside takes no issue with that conclusion, and so we summarily affirm it.

- E. *CMS's determination that Countryside's noncompliance was at the immediate-jeopardy level as of December 8, 2012 was not clearly erroneous.*

“Immediate jeopardy” is defined as a “situation in which the [SNF’s] noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.” 42 C.F.R. § 488.301. CMS’s immediate-jeopardy determination must be upheld unless it is “clearly erroneous.” *Id.* § 498.60(c)(2). Under that review standard, the immediate-jeopardy determination – that is, the finding that the noncompliance caused or was likely to cause serious harm – is presumed to be correct, and the SNF has a “heavy burden” to overturn it. *Crawford Healthcare & Rehab.*, DAB No. 2738, at 14-15 (2016); *see also Libertywood Nursing Ctr.*, DAB No. 2433, at 18 (2011) (noting that under the clearly erroneous standard, “the harm or threatened harm caused by the noncompliance is presumed to be serious, and the facility has the burden to rebut the presumption with evidence and argument showing that the harm or threatened harm did not meet any reasonable definition of ‘serious’” (omitting some internal quotation marks)), *aff’d*, *Libertywood Nursing Ctr. v. Sebelius*, 512 F. App’x 285 (4th Cir. 2013).

In this case CMS determined that Countryside’s noncompliance had caused “actual harm” to Resident 2 and “placed other residents at high likelihood of serious harm.” CMS Ex. 50, ¶¶ 37-38. Countryside does not dispute that the noncompliance caused actual harm to Resident 2 or argue that the harm was not serious. RR at 26-27. Nor does it contend that the noncompliance found by the ALJ was not “likely to cause” serious harm to one or more residents. *Id.* Instead, Countryside submits that the immediate-jeopardy finding was unwarranted because the threat of harm posed by Resident 1 to any given resident on a given day was not immediate or imminent, as evidenced by the fact that there were few reported incidents of sexually inappropriate behavior by Resident 1 in the seven months prior to that incident that triggered the March 2013 survey and that Resident 1 “never assaulted or attempted to assault another resident” during that period. RR at 26 (asserting that “incongruity” existed between the ALJ’s finding of actual or likely harm and the “sustained history without occurrence of the harmful event that CMS contend[s] was likely every day for over six months”); Reply at 12 (“If the jeopardy was ‘immediate’ and anything similar to what the ALJ concluded about Resident 1’s risks, an assault of Resident #2 should have occurred long before the end of that six month period [in which Residents 1 and 2 were roommates], and an assault of another resident at risk should have occurred before the end of the three month period [during which the CMP was in effect]”).

This argument miscasts the issue presented by CMS’s immediate-jeopardy finding. The issue before us is not whether *Resident 1* was likely to harm a specific resident but whether Countryside’s *noncompliance* – that is, the failures of risk assessment, care planning, and supervision – was likely to cause serious harm given that Resident 1 was prone to engage in sexually inappropriate behavior. Moreover, the *imminence* of resident harm is not an element of the regulatory definition of immediate jeopardy. That definition, the Board has held, “sets [no] parameters as to the timing of potential harm”; it merely provides that a SNF’s noncompliance should be likely to cause serious harm if allowed to continue. *Agape Rehab. of Rock Hill* at 19; *see also Miss. Care Ctr. of Greenville*, DAB No. 2450, at 15-16 (2012) (discussing the holding in *Agape* and noting that the regulations do not define immediate jeopardy as a “crisis situation”), *aff’d*, *Miss. Care Ctr. of Greenville v. U.S. Dep’t of Health & Human Servs.*, 517 F. App’x 209 (5th Cir. 2013); *Pinehurst Healthcare & Rehab. Ctr.*, DAB No. 2246, at 14-15 (2009) (rejecting the assertion that it was “counterintuitive” that a SNF “could be in a state of immediate jeopardy for 99 days and yet have no further documented incidents or findings of any injury, harm, impairment, or death”). In any event, we find that the threat of harm posed by Resident 1 between December 2012 and March 2013 was imminent. It was imminent in the sense that Resident 2 or other vulnerable residents (besides Resident 4) could have become the object of Resident 1’s sexually inappropriate behavior at any time given that Resident 1’s access to them was neither restricted nor (apparently) monitored. We therefore sustain the ALJ’s conclusion that CMS’s immediate-jeopardy determination was not clearly erroneous.

F. *CMS’s determination that the immediate-jeopardy condition at Countryside was not abated until April 4, 2013 is not clearly erroneous.*

Countryside argued before the ALJ that it reduced the severity of its noncompliance below the immediate-jeopardy level earlier than April 4, 2013, the abatement date determined by CMS. *See* Pet.’s Oct. 13, 2015 Post-Hearing Br. at 22. Countryside asserts (RR at 27), and we agree, that the ALJ failed to address this issue. We do so here.

“[I]mmediate jeopardy is abated only when the facility has implemented necessary corrective measures so that there is no longer any likelihood of serious harm.” *Glenoaks Nursing Ctr.*, DAB No. 2522, at 19 (2013) (internal quotation marks omitted). CMS’s determination that a SNF’s ongoing noncompliance remains at the immediate-jeopardy level is subject to the clearly erroneous standard of review. *Id.* at 18.

Countryside asserts that, “immediately after” the March 18, 2013 incident, staff placed Resident 1 on “increased supervision[.]” RR at 27. Countryside also notes (accurately) that Resident 1 was discharged from its facility on March 20, 2013 and did not return. *Id.* In addition, Countryside alleges that it “performed background screens on all of its residents,” “determined that none of them were sex offenders,” and “initiated a new policy on March 22, 2013 that it would conduct background screens on all applicants [for residence] and not admit any applicant who was a sex offender.” *Id.* (citing P. Ex. 15, at 4). In light of these measures, says Countryside, residents were no longer subject to “any continuing risk of harm” from an “unsupervised sex offender” (that is, Resident 1) after March 18, 2013, and therefore it was “clear error for the ALJ to uphold [an immediate-jeopardy-level CMP] beyond March 18, 2013 but in no event past March 22, 2013.” *Id.*

This argument reveals no clear error by CMS. The Board has held that “incidents related to individual residents,” such as the March 18, 2013 incident involving Resident 1 and Resident 2, “are not themselves the deficiencies that must be corrected”; rather, “the deficiency is the underlying failure to meet a participation requirement evidenced by the incident.” *Glenoaks* at 19-20 (internal quotation marks omitted). Consequently, in order to abate the immediate jeopardy condition, Countryside needed to do more than neutralize the threat to resident safety posed by Resident 1’s presence in the facility. It also needed to take concrete steps toward correcting the regulatory violations that allowed the threat to exist in the first place. *Id.* at 20 (stating that “it is not sufficient for a facility to abate immediate jeopardy by addressing the deficiency with respect to the condition of one resident” and that it “needs to address and correct the conditions underlying the noncompliance that created the immediate jeopardy”); *Liberty Health & Rehab of Indianola, LLC*, DAB No. 2434, at 16 (2011) (stating that measures to abate immediate jeopardy “had to address more than just the residents involved in the incident or incidents that brought the noncompliance to a surveyor’s attention”).

Countryside does not explain how the measures taken in the immediate wake of the March 18, 2013 incident ensured that its noncompliance – that is, the shortcomings in risk assessment, care planning, and supervision – would no longer be likely to cause serious harm to residents. Countryside is also unclear or inaccurate about the timing of certain remedial actions. In particular, Countryside does not specify the date it completed background screens on its residents, nor does it point to documentary evidence confirming that the screens were completed prior to April 4, 2013. RR at 27. In addition, the record shows that Countryside initiated its admissions policy (denying admission to convicted sex offenders) on April 16, 2013, not March 22, 2013 as alleged. CMS Ex. 48, at 7. Finally, Countryside failed to say what corrective actions were specified in its own “abatement plan” to remove the immediate jeopardy – a plan submitted to the state

survey agency in early April 2013 – and whether those steps were completed prior to April 4, 2013.¹² *See* CMS Ex. 48, at 8-9; P. Ex. 23, ¶ 21. For all these reasons, we conclude that Countryside has not carried its burden to show that CMS’s determination regarding the duration of immediate jeopardy was clearly erroneous.

G. *Countryside does not challenge the ALJ’s conclusion that the CMP amounts are reasonable.*

In appealing a determination of noncompliance, a SNF may challenge the reasonableness of the amount of any CMP imposed. *Crawford Healthcare & Rehab.* at 2. In deciding whether a CMP amount is reasonable, the Board may consider only the factors specified in 42 C.F.R. § 488.438(f).¹³ 42 C.F.R. § 488.438(e)(3); *Crawford Healthcare & Rehab.* at 19. The daily or per-instance penalty amount selected by CMS is presumptively reasonable based on those regulatory factors, and the burden is on the SNF “to demonstrate, through argument and the submission of evidence addressing the regulatory factors, that a reduction is necessary to make the CMP amount reasonable.” *Crawford Healthcare & Rehab.* at 19 (internal quotation marks omitted).

Countryside takes no issue with the ALJ’s conclusion that the penalty amounts selected by CMS (\$6,850 per day for the immediate-jeopardy period, and \$100 per day for the period of noncompliance below the immediate-jeopardy level) were reasonable based on the regulatory factors. We therefore summarily affirm that conclusion. *Bivins Memorial Nursing Home*, DAB No. 2771, at 13 (2017) (affirming a CMP against a SNF that failed to present an argument based on the regulatory factors).

¹² When a state survey agency or CMS finds that an immediate-jeopardy condition exists, as AHCA did at the close its March 2013 survey (CMS Ex. 14, at 1), the SNF is expected to submit an “allegation of removal of the immediate jeopardy with sufficient information to show how the immediate jeopardy has been removed and the date of removal.” SOM § 7309.4; *see also id.* § 7308.1. The Board ordinarily holds that a SNF cannot be regarded as having returned to substantial compliance, or abated immediate jeopardy, until measures specified in an approved plan of correction, or plan to remove immediate jeopardy, have been implemented. *See, e.g., Meridian Nursing Ctr.* at 20-21 (affirming the determination of a multi-day immediate jeopardy period because, although certain corrective measures had been taken prior to the survey, the SNF had not taken all actions that its staff had determined to be necessary to abate the immediate jeopardy); *Brian Ctr. Health & Rehab./Goldsboro*, DAB No. 2336, at 11 (2010) (“[H]aving specified certain systemic corrective measures in its abatement plan, measures that go beyond the disciplining of any single employee, [the SNF] cannot be regarded as having abated the immediate jeopardy until the date those measures were implemented.”).

¹³ The regulatory factors are: (1) the SNF’s history of noncompliance; (2) the SNF’s financial condition – that is, its ability to pay the CMP; (3) the “seriousness” of the noncompliance; (4) the SNF’s degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety; and (5) the relationship of the one deficiency to other deficiencies resulting in noncompliance. 42 C.F.R. §§ 488.438(f), 488.404(a)-(c).

VI. Conclusion

For the reasons discussed, we affirm the ALJ's conclusions: (1) that Countryside was not in substantial compliance with 42 C.F.R. §§ 483.13(b), 483.20(d), 483.20(k)(2), 483.25(h), and 483.75 from December 8, 2012 through April 19, 2013; (2) that the noncompliance was at the immediate-jeopardy level from December 8, 2012 through April 3, 2013; and (3) that the CMP amounts imposed by CMS for the period of noncompliance were reasonable. We therefore sustain the CMPs at issue.

/s/

Susan S. Yim

/s/

Constance B. Tobias

*/s/*Leslie A. Sussan
Presiding Board Member