Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	
Holy Cross Village at Notre Dame, Inc., Petitioner,	DATE: December 21, 2009 Civil Remedies CR1951 App. Div. Docket No. A-09-102 Decision No. 2291
- v. -	
Centers for Medicare & Medicaid Services.	

REMAND OF ADMINISTRATIVE LAW JUDGE DECISION

Holy Cross Village of Notre Dame, Inc. (Holy Cross) appealed the May 14, 2009 decision of Administrative Law Judge (ALJ) Steven T. Kessel granting summary judgment for the Centers for Medicare & Medicaid Services (CMS). Holy Cross Village of Notre Dame, Inc., DAB CR1951 (2009) (ALJ Decision). The ALJ sustained the imposition of civil money penalties (CMPs) of $3,750 per day for July 30 and 31, 2008 and $100 per day from August 1 through August 28, 2008, based on his conclusion that Holy Cross failed to comply substantially with regulatory requirements at 42 C.F.R. §§ 483.13(b) (prevention of abuse) and 483.25(h)(2) (prevention of accidents) in caring for a resident who engaged in inappropriate sexual activity.

As discussed below, we conclude that the ALJ failed to view the evidence in the light most favorable to Holy Cross and thereby erred in determining that this matter could be resolved through summary judgment. We vacate the ALJ Decision and remand the case for further proceedings consistent with this decision.

Background

Holy Cross is a skilled nursing facility that participates in the Medicare program. Holy Cross was surveyed for compliance with Medicare participation requirements on August 6, 2008 by the state survey agency. The surveyors concluded that Holy Cross was not in substantial compliance with multiple Medicare participation requirements, including three at the immediate jeopardy level.[1]

CMS accepted the state survey agency's findings and imposed, among other remedies, the loss of nurse aide training and the CMPs listed above. Holy Cross requested an ALJ hearing. CMS then moved for summary judgment, which Holy Cross opposed. The ALJ received all of the parties' exhibits into the record (CMS Exs. 1 – 37; P. Exs. 1 – 11). ALJ Decision at 2.[2] The ALJ granted CMS's summary judgment motion.

[1] The term "immediate jeopardy" is defined at 42 C.F.R. § 488.301 to include noncompliance that has caused or is likely to cause serious injury, impairment, harm, or death to a resident or residents of a facility.

[2] As to the evidence submitted by the parties, the ALJ stated:

> I receive all of the parties' exhibits into the record and I cite to some of them in this decision for purposes of explanation. However, I make no evidentiary findings from the exhibits. I base my decision entirely on the undisputed material facts as are averred by the parties.

ALJ Decision at 2. As discussed at length in Illinois Knights Templar Home, DAB No. 2274, at 3-8 (2009), this approach is not consistent with Rule 56 of the Federal Rules of Civil Procedure (by which the ALJ informed the parties he would be guided) and is contrary to Board practice and summary judgment case law. Moreover, it is inconsistent with what the ALJ ultimately did. Citing and weighing the exhibits, he rejected Holy Cross' averments of fact about staff's care of the resident at issue.

Standard of Review

Whether summary judgment is appropriate is a legal issue that we address de novo. Lebanon Nursing and Rehabilitation Center, DAB No. 1918 (2004). In reviewing whether there is a genuine dispute of material fact, we view proffered evidence in the light most favorable to the non-moving party. Kingsville Nursing and Rehabilitation Center, DAB No. 2234 (2009); Madison Health Care, Inc., DAB No. 1927 (2004), and cases cited therein. The standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. Departmental Appeals Board, Guidelines--Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs, http://www.hhs.gov/dab/guidelines/prov.html.

Applicable law

"Substantial compliance" is defined as "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health and safety than the potential for causing minimal harm." 42 C.F.R. § 488.301.

Section 483.13(b) of 42 C.F.R. provides: "The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion."

Section 483.25(h)(2) of 42 C.F.R. provides:

> *Accidents.* The facility must ensure that –
>
> * * *
>
> (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

Analysis

We conclude that the ALJ erred in determining on summary judgment that Holy Cross was not in substantial compliance with 42 C.F.R. §§ 483.13(b) and 483.25(h)(2). Below, we review the standards for summary judgment, the relevant facts, and how the ALJ misapplied those standards to the facts in reviewing the deficiency citations under these sections.

1. Summary judgment standards

The Board recently laid out the process and standards for resolving a motion for summary judgment (MSJ) by CMS in a nursing facility case, in which, as here, the ALJ has informed the parties that he will be guided by Rule 56 of the Federal Rules of Civil Procedure (FRCP). We quote that explanation at length since we rely on summary judgment principles articulated therein:

> Summary judgment is appropriate when the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. See Celotex Corp. v. Catrett, 477 U.S. 317, 322-25 (1986). . . . The party moving for summary judgment bears the initial burden of demonstrating that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. Celotex, 477 U.S. at 323. If a moving party carries its initial burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial.'" Matsushita Elec. Industrial Co. v. Zenith Radio, 475 U.S. 574, 587 (1986) (quoting FRCP 56(e)). To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact -- a fact that, if proven, would affect the outcome of the case under governing law. Id. at 586, n.ll; Celotex, 477 U.S. at 322. In order to demonstrate a genuine issue, the opposing party must do more than show that there is "some metaphysical doubt as to the material facts. Where the record taken as a whole could not lead a rational trier of fact to find for the nonmoving party, there is no 'genuine issue for trial.'" Matsushita, 475 U.S. at 587. **In making this determination, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor.** See, e.g., U.S. v. Diebold, Inc., 369 U.S. 654, 655 (1962). . . .
>
> [I]f CMS in its summary judgment motion has asserted facts that would establish a prima facie case that the facility was not in substantial compliance, the first question is whether the facility has in effect conceded those facts. If not, the next question is whether CMS has come forward with evidence to support its case on any disputed fact. If so, the facility must aver facts and proffer evidence

> sufficient to show that there is a genuine dispute of material fact. **Ultimately, if the proffered evidence as a whole, viewed in the light most favorable to the facility, might permit a rational trier of fact to reach an outcome in favor of the facility, summary judgment on the issue of substantial compliance is not appropriate.**

Kingsville, DAB No. 2234, at 3-4 (citations omitted, emphasis added); see also Crestview Parke Care Center, DAB No. 1836 (2002), aff'd in part, Crestview Parke Care Ctr. v. Thompson, 373 F.3d 743 (6th Cir. 2004).

Moreover, as the Board has explained in prior decisions, an ALJ's role in deciding a summary judgment motion differs from the role of an ALJ resolving a case after a hearing (whether an in-person hearing or on the written record). For example, in Madison Health Care, Inc., DAB No. 1927, at 6 (2004), the Board stated that "the ALJ deciding a summary judgment motion does not 'make credibility determinations, weigh the evidence, or decide which inferences to draw from the facts,' as would be proper when sitting as a fact-finder after a hearing, but instead should 'construe the record in the light most favorable to the nonmovant and avoid the temptation to decide which party's version of the facts is more likely true.' Payne v. Pauley, 337 F.3d 767, 770 (7th Cir. 2003)." In that process, the ALJ should not be assessing credibility or evaluating the weight to be given conflicting evidence.

As discussed below, the ALJ failed to properly apply the standards for evaluating whether summary judgment was appropriate. We first summarize relevant facts and then discuss why we conclude the ALJ erred.

2. Relevant facts and evidence[3]

The deficiency citations at issue on appeal involve care provided to a resident identified as Resident # 7, who had lived at Holy Cross since 2006. CMS Ex. 8, at 22. Resident # 7 was an 85 year-old man whose medical conditions include Alzheimer's dementia with behavioral disturbance, congestive heart failure

[3] We make no finding of fact here but rather present the undisputed facts as found in the ALJ Decision and the record and identify evidence of disputes of material fact.

and coronary artery disease. CMS Ex. 7, at 14, 85; CMS Ex. 8, at 1, 61, 72.

Resident # 7 suffered from "sexual disinhibition," which his psychiatrist associated with his deteriorating mental capacities, and had a history of engaging in inappropriate sexual behavior at Holy Cross. CMS Ex. 8, at 97-99. As to non-residents, the record indicates that Resident # 7's behavior included sexually inappropriate remarks to staff, attempts to grab male staff and other non-resident males, and his fondling himself naked in his own room but within view of construction workers outside his window. CMS Ex. 8, at 14-17, 97, 118. As to behavior directed towards residents, it is undisputed that Resident # 7 engaged in publicly inappropriate sexual activity with a resident identified as Resident # 163. CMS did not contest Holy Cross' assertion (and supporting evidence) that the sexual activity between Resident # 7 and Resident # 163 was consensual. The ALJ accepted, for purposes of summary judgment, that this relationship was consensual and not abusive of Resident # 163 and that the two residents "were . . . observed by Petitioner's staff seeking each other out for sexual activity." ALJ Decision at 6.

Resident # 163 died on June 18, 2008. Holy Cross represented that, "concerned for the emotional and psychological effect [Resident # 163's death] could have on Resident # 7, . . . [Holy Cross] sought the guidance of Resident # 7's psychiatrist." P. Pre-hearing Br. and MSJ Response at 7 (P. MSJ Response), citing CMS Ex. 8, at 112. As a result of this consultation, Resident # 7 started taking Depo-Provera on July 16, 2008 (id.), which CMS described as "a form of chemical castration." CMS Pre-hearing Br. and MSJ at 13, n.2 (CMS MSJ). The Depo-Provera was intended "to reduce [Resident # 7's] inappropriate behaviors." P. Ex. 8, at ¶ 5. Neither CMS nor the ALJ points to any evidence in the record of further inappropriate behaviors by Resident # 7 after beginning Depo-Provera with the exception of an incident the nature of which is disputed as we discuss next.

Some time in the week prior to July 30, 2008, an incident occurred involving Resident # 7 and a resident identified as Resident # 11, who had been assessed as having expressive aphasia, severely impaired cognitive skills and extremely limited mobility. CMS Ex. 9, at 64-65. Both the nature of and facts involved in this incident are disputed. In moving for summary judgment, CMS asserted that Resident # 7 had sexually abused Resident # 11 by grabbing Resident # 11's crotch. CMS MSJ, at 11-14. Holy Cross did not deny that Resident # 7

reached out for Resident # 11, but asserted that Resident # 7 was prevented by staff from even touching Resident # 11 and disputed CMS's characterization of the action as necessarily sexual. P. MSJ Response at 12, 14, citing P. Exs. 6, 11. The ALJ decided it was irrelevant whether Resident # 7 had actually succeeded in touching Resident # 11 but accepted CMS's characterization of the incident as sexual. ALJ Decision at 4, 6.

Holy Cross asserted that it had implemented strategies to prevent Resident # 7 from inappropriately interacting sexually with other residents; such strategies included supervising Resident # 7, training staff, documenting inappropriate sexual behavior, and arranging psychiatric treatment, which had included medication culminating with Depo-Provera in mid-July. P. MSJ Response, at 6-8, 14-15; see also P. Exs. 6, 11. Holy Cross asserted that the fact that Resident # 7, whatever his intention, had not succeeded in touching Resident # 11 demonstrated that staff was adequately supervising Resident # 7 and preventing Resident # 7 from sexually abusing other residents, including Resident # 11. P. MSJ Response at 12, 14.

3. 42 C.F.R. § 483.13(b) (prevention of abuse)

Section 488.301 defines abuse as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." Section 483.13(b) provides: "The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion" and this "obligates the facility to take reasonable steps to prevent abusive acts, regardless of their source." Western Care Management Corp., d/b/a Rehab Specialties Inn, DAB No. 1921, at 12 (2004). As the ALJ recognized, section 483.13(b) protects residents, not staff or visitors, so the fact that Resident # 7 engaged in sexually inappropriate behavior towards nonresidents was not a violation of section 483.13(b). ALJ Decision at 7. Finally, CMS is not required to establish, and the ALJ is not required to find, that actual abuse occurred to show Holy Cross was not in substantial compliance with section 483.13(b). Western Care Management Corp., DAB No. 1921, at 15. It is sufficient for CMS to show that that the facility failed to protect residents from reasonably foreseeable risks of abuse. Id., citing Windsor Park Care Center, DAB No. 1902 (2003); Woodstock Care Center, DAB No. 1726, at 25-30 (2000) (citing 54 Fed. Reg. 5316, 5332 (February 2, 1989)), aff'd, Woodstock Care Ctr. v. Thompson, No. 01-3889 (6th Cir. 2003); and, cf. 59 Fed. Reg. 56,116, 56,130 (Nov. 10,

1994) (rejecting suggestion that a facility may be cited for "neglect" only when a resident is actually harmed, and noting that the "potential for negative outcomes" should be considered).

The ALJ granted summary judgment for CMS under section 483.13(b) on the ground that the facts he set forth as undisputed in section B.1 of his decision "strongly support" CMS's position that Holy Cross, "by failing to supervise Resident # 7 effectively, either allowed this resident to perpetrate sexual abuse against other residents or tolerated the likelihood that the resident would perpetrate abuse." ALJ Decision at 5.

The ALJ's determination that summary judgment was appropriate under this regulatory requirement is erroneous.

First, the ALJ misstated the standard for summary judgment, which is not whether the facts relied on by the ALJ "strongly support" CMS's position. As noted above, summary judgment is appropriate when the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. If the proffered evidence as a whole, viewed in the light most favorable to the non-moving party, might permit a rational trier of fact to reach an outcome in favor of the non-moving party, summary judgment is not appropriate.

Second, the ALJ failed to view the evidence in the light most favorable to Holy Cross and to recognize that a rational trier of fact might reach an outcome in favor of Holy Cross. Below we discuss examples of this failure.

In section B.1 of his decision, the ALJ set forth two pages of what he characterized as "undisputed facts" that were "the basis for my decision." ALJ Decision at 3. One of these allegedly undisputed facts was that, prior to the disputed incident with Resident # 11, Resident # 7 had directed sexual behavior towards residents other than Resident # 163. The ALJ wrote:

> In April and May 2008, the staff documented numerous incidents of inappropriate conduct by Resident # 7. These included several attempts by Resident # 7 to grope or fondle other male residents.

ALJ Decision at 3, citing CMS Ex. 8, at 14-17. In concluding that Holy Cross was not in substantial compliance with section 483.13(b), the ALJ repeatedly relied on this finding. See, e.g., ALJ Decision at 4 (on "numerous occasions" Resident # 7

"was observed making advances towards other residents"); at 5 (as of 2007 staff knew Resident # 7 "had manifested proclivities for engaging in inappropriate sexual conduct which included making advances towards and attempting to grope other residents"); at 6 (there were "many undisputed incidences of inappropriate conduct by Resident # 7 directed towards other residents, the staff, and even the public").

The evidence that the ALJ cited in support of his finding was nurses notes recording five incidents of sexualized behavior by Resident # 7 towards a "resident" in May and April of 2008. CMS Ex. 8, at 14-17. Holy Cross argued and presented evidence which, viewed in the light favorable to Holy Cross, tends to show that these notes described only consensual encounters between Resident # 7 and Resident # 163. While Resident # 7's nursing notes do not specifically identify Resident # 163 as the other "resident" involved in all of these incidents, Resident # 163's daily nursing notes that CMS set forth in its MSJ (at 9-10) and the ALJ cited elsewhere in the decision (ALJ Decision at 4) record identical or similar incidents occurring at the same times of day.[4] Thus, Holy Cross' contemporaneous documentation

[4] Nursing notes for April 2, 2008 at 10:00 a.m. for Resident # 7 state that Resident # 7 "went to library and was seen with another resident talking sexual with gestures" (CMS 8, at 14); for Resident # 163 the notes state that "resident approached another resident who was reading the newspaper, sexual talk and gestures heard and observed by staff" (CMS 10, at 13). Nursing notes for April 2, 2008 at 11:40 a.m. for Resident # 7 state that "Resident setting next to another resident trying to get into resident's pants during chapel" (CMS Ex. 8, at 14); for Resident # 163 the notes state that "Resident sitting next to another resident in chapel and attempting to get into resident's pants" (CMS Ex. 10, at 13). Nursing notes for April 9, 2008 at 7:00 p.m. for Resident # 7 state that "Resident in dining room after dinner, went straight over to another resident and allowed other male resident to fondle him and talk sexual talk to him" (CMS Ex. 8, at 16); for Resident # 163 the notes state that "resident in dining room fondling another male resident" (CMS Ex. 10, at 14). Nursing notes for May 3, 2008 at 1:00 p.m. for Resident # 7 state that "Resident trying to be sexually inappropriate with another resident reaching for his genitals" (CMS Ex. 8, at 17); for Resident # 163 the notes state that "Resident in dining room fondling another male resident" (CMS Ex. 10, at 14). Notes for May 10, 2008 at 10:00 a.m. for

(Continued . . .)

could reasonably be read to indicate that these incidents involved only Resident # 7 and Resident # 163. Further, Holy Cross offered multiple declarations from staff, including the Social Services Director, the Director of Nursing, the Administrator, and direct care staff, indicating that the only resident with whom Resident # 7 interacted sexually was Resident # 163. P. Exs. 6, 8, 9, and 10. In light of this evidence, it was error for the ALJ to construe, on summary judgment, Resident # 7's nursing notes as establishing that Resident # 7 had directed sexual behavior towards residents other than Resident # 163 prior to the disputed incident with Resident # 11.

Another example of the ALJ's failure to view the evidence in the light most favorable to Holy Cross involves the incident with Resident # 11, which the ALJ characterized as, at a minimum, an attempted sexual "grop[ing]" and attempted sexual abuse. ALJ Decision at 5. In his summary of "undisputed facts," the ALJ described this incident as Resident # 7's having "made sexual advances towards Resident # 11," as reported by a Certified Nursing Assistant (CNA), by "attempting to grab [Resident # 11's] crotch." ALJ Decision at 4. Holy Cross did not dispute that Resident # 11 was dependent and, therefore, vulnerable, but did dispute whether the incident involved any actual contact and whether the approach was sexual in nature. Holy Cross submitted a declaration from the CNA stating that (contrary to what was reported in the Statement of Deficiencies) she had not told the surveyor that she had seen such an incident but had said she had been told about an incident involving Resident # 7 and Resident # 11. P. Ex. 11, at ¶ 2. Moreover, Holy Cross submitted the declaration of an eyewitness to the incident; she stated that she saw Resident # 7 "reaching for" Resident # 11 but that staff stopped him before he even touched Resident # 11. P. Ex. 7, at ¶ 3. Viewing the evidence favorably to Holy Cross would permit a rational trier of fact to find that the event was not sexual abuse or attempted sexual abuse, nor grounds for concluding, as the ALJ did, that Resident # 11 had "become a target of Resident # 7's [sexual] aggression" (ALJ Decision at 6).

(Continued . . .)
Resident # 7 state that "Resident sexually inappropriate with another resident with talk and gestures, reported by dietary staff" (CMS Ex. 8, at 17); for Resident # 163 the notes state that "Resident sexually inappropriate in gestures and talk per dietary staff" (CMS Ex. 10, at 16).

Finally, the ALJ failed to view the evidence about Holy Cross' efforts to address Resident # 7's sexual disinhibition in the light most favorable to Holy Cross. In his statement of undisputed facts in section B.1, the ALJ wrote that Holy Cross' interventions were "limited," describing only its practice of "redirecting the resident" (ALJ Decision at 4, citing CMS Ex. 8, at 14-17) and having him seen by a psychiatrist, and, ultimately, having him take Depo Provera (id.). The ALJ either ignored or did not view favorably Holy Cross' other evidence tending to show that it employed multiple strategies to ensure that Resident # 7 did not sexually abuse another resident. This evidence included declarations by the Director of Nursing (DON) and Social Services Director stating the staff supervised and monitored Resident # 7 to ensure that unsolicited contact with other residents did not occur (P. Ex. 8, at ¶ 3; P. Ex. 6, at ¶ 7); information about a May 2008 training for all staff on behavior management and tracking (P. Ex. 7, at ¶ 8; P. Ex. 3); the DON's statement that, based on observation and consultation with Resident # 7's doctor, psychiatrist and psychologist, she "did not feel it was necessary to institute one-on-one supervision of Resident # 7 as he had never had physical contact with another resident without the consent of that resident" (P. Ex. 8, at ¶ 4); and statements of staff indicating that Resident # 7 was easily monitored because, though he could propel himself in his wheelchair, he could only move very slowly (P. Exs. 8, at ¶¶ 2-4; 9, at ¶ 5; 11 at ¶ 3).

Further, the ALJ concluded, for purposes of immediate jeopardy, that "the probability of serious harm or injury resulting from Resident # 7's unchecked sexual aggression was extremely high" (ALJ Decision at 10). Indeed, the ALJ's description of the threat posed by Resident # 7 was far more extreme than even CMS's description. For example, the ALJ used the terms "predator," "predatory behavior," and "predation" ten times in the decision in relation to Resident # 7 while CMS never characterized him that way in its MSJ.[5] ALJ Decision at 7, 8, 9. More importantly, the ALJ's characterization of Resident # 7 as a sexual predator posing an extremely high risk of harm to other residents was completely at odds with the declarations of the

[5] We take notice that Webster's Third International Dictionary (1976) defines "predator" as "one that preys, destroys, or devours."

Holy Cross Social Services Director, DON, Administrator, and direct care staff indicating that, in their experience and in the context of the facility's care, Resident # 7 did not pose an abuse threat to other residents. P. Exs. 6, 8, 9, and 10. For summary judgment purposes, the ALJ should have accepted the factual assertions in this testimony as true (though not, of course, any legal conclusions).

Additionally, while the ALJ found that Resident # 7 and Resident # 163's sexual relationship was consensual and did not find that it was abusive of each other (ALJ Decision at 6), the ALJ and CMS appear to have presumed that Resident # 7 and Resident # 163's public sexual activity was abusive to other residents.[6] Under the definition of "abuse" set forth in section 488.301, displays of consensual sexual behavior, even if inappropriate, do not necessarily result in sexual abuse of other residents. Indeed, given the nature of nursing home populations, a range of behaviors may occur in a nursing home that are socially inappropriate and make observers (including other residents) uncomfortable, but such behaviors do not necessarily constitute abuse. Here, the ALJ refers to no evidence that would indicate that Resident # 7 and Resident # 163's consensual conduct resulted in or risked causing "physical harm, pain or mental anguish," and therefore abuse, to other residents.

Finally, while the ALJ recognized that Resident # 7's "sexually aggressive" behavior towards staff was not a violation of section 483.13(b), he treated it as relevant because he concluded that the only "reasonable inference" he could draw from such conduct was that it "illustrat[ed] the resident's propensity for sexual aggression" towards both staff and residents. ALJ Decision at 7. Again, the ALJ did not view the evidence in the light most favorable to Holy Cross, drawing all

[6] For example, CMS's abuse discussion referred to "Resident # 7's public displays of sexualized behavior towards Resident # 163" (CMS Br. and MSJ at 11), and CMS faulted Holy Cross for not "set[ting] clear limits on that public sexualized behavior" after Resident # 163 died (id. at 13). See also CMS Ex. 34, at ¶¶ 13, 16, 18 (surveyor's declaration indicating she regarded public display as abuse). In discussing abuse, the ALJ characterized the episodes of inappropriate public conduct as "acting abusively" and "specific episodes of abusive behavior." ALJ Decision at 5; see also at 6.

reasonable inferences in its favor. He seemed to have defined all "inappropriate" sexual behavior by Resident # 7 as "aggressive," contrary to the evidence proffered by Holy Cross. Evidence in the record indicates that Resident # 7's "major concern" as reported to his psychiatrist was that his behavior was "sexually very inappropriate" (CMS Ex. 8, at 118) and that he was aware that his behavior "could lead to serious consequences" (P. Ex. 1, at 1). These facts, coupled with the absence of evidence of aggression towards residents prior to July of 2008 and the multiple declarations filed by Holy Cross staff denying such aggression, support the inference that Resident # 7 appreciated that sexual aggression towards other residents could result in more serious consequences than aggression towards staff and had been able to refrain from sexually engaging uninterested residents.

Therefore, viewing the evidence as developed thus far in the light most favorable to Holy Cross, we conclude that a rational trier of fact could find that Resident # 7 was not a sexual threat to other residents or, if he were, that Holy Cross had taken reasonable steps to manage his behavior so that it "pose[d] no greater risk to resident health and safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. Therefore, a dispute of material fact exists on this issue. It was error for the ALJ to conclude on summary judgment that Holy Cross was not in substantial compliance with section 483.13(b).

4. 42 C.F.R. § 483.25(h) (prevention of accidents)

Section 483.25(h)(2) provides that residents "must receive adequate supervision . . . to prevent accidents," which means that a facility must take "all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents." Briarwood Nursing Center, DAB No. 2115, at 11 (2007), citing Woodstock Care Center, DAB No. 1726, at 28 (facility must take "all reasonable precautions against residents' accidents").

The ALJ concluded that Holy Cross was not in substantial compliance with section 483.25(h)(1) because he found that CMS's position that "Petitioner's staff were well aware of Resident # 7's proclivities for sexual predation but failed to develop or implement effective measures that protected other residents from Resident # 7" was "supported by the undisputed facts of this case." ALJ Decision at 8.

The ALJ's determination that summary judgment was appropriate is erroneous.

First, as before, the ALJ misstated the test for summary judgment, which is not whether undisputed facts "support" CMS's position about the deficiency citation.

Second, in assessing the nature of the foreseeable risk of accident, the ALJ relied on facts that Holy Cross disputed, e.g., finding as undisputed that Resident # 7 had a history of sexual aggression towards other residents and had attempted to sexually abuse Resident # 11. Based on his view of these disputed facts, the ALJ characterized Resident # 7 as a "predator" who posed a high risk for sexual abuse of other residents, particularly Resident # 11, who had become, according to the ALJ, a "target" of Resident # 7's sexual aggression. ALJ Decision at 9. The ALJ's subsequent evaluation of the strategies that Holy Cross asserted it employed (including supervision, diversion, psychiatric consultation, and medication) was necessarily tainted by his failure to assess evidence about the foreseeable risk in the light most favorable to Holy Cross. This failure led him to conclude that Holy Cross' strategies were inadequate and that it should have engaged in "a focused effort to curb Resident # 7's actions or, failing that, to segregate the resident from those who were his intended or actual victims." ALJ Decision at 5. Elsewhere, the ALJ stated the risk of harm was so great that, to protect other residents, Holy Cross "could have "segregate[ed] Resident # 7 from the general resident population." Id. at 8. In concluding that actions such as segregation would have been reasonable, the ALJ inferred that the risks were at a level not compelled by the view of the evidence most favorable to Holy Cross and failed to consider countervailing concerns about infringing on Resident # 7's rights under 42 C.F.R. § 483.10.[7] That regulation ensures the rights of residents, among other things, to a "dignified existence, self-determination and communication and access to persons and services inside and outside the facility." In addition, facilities are prohibited from using "involuntary seclusion" or imposing restraints "for purposes of discipline or

[7] CMS did not assert that segregation would have been a reasonable intervention but stated that Holy Cross should have instituted one-on-one monitoring after the incident with Resident # 11. CMS MSJ at 15.

convenience." 42 C.F.R. § 483.13(a) and (c)(1)(i); see P. Request for Review at 10. On remand, the ALJ should evaluate the risks to the other residents and the measures taken by Holy Cross in light of the need to balance the goals of protecting all residents from abuse while preserving the rights of the resident suffering from sexual disinhibition and engaging in sexually inappropriate behavior.

Third, in evaluating the strategies Holy Cross represented that it did employ, the ALJ did not review the evidence in the light most favorable to Holy Cross. For example, Holy Cross represented that its staff collectively supervised Resident # 7 closely and this supervision was facilitated by the fact that Resident # 7 could only wheel himself about at a very slow pace. See P. Ex. 8, at ¶¶ 3, 14; P. Ex. 6, at ¶ 7. Specifically, a CNA, who represented that he had worked at Holy Cross since June of 2007 and with Resident # 7 "intensively" (P. Ex. 9, at ¶ 7), stated that it took Resident # 7 ten minutes to go the length of the hall, some 128 feet (id. at ¶ 5). The ALJ accepted that Resident # 7 "could not move rapidly" but found that "that fact in and of itself is no assurance that the resident could not engage in predatory behavior" because Resident # 7 "was not under supervision." ALJ Decision at 9. While the ALJ also faulted Holy Cross' evidence in support of its assertions of supervision (ALJ Decision at 9), viewing the evidence favorably a rational trier of fact could find that staff was watchful of Resident # 7 for inappropriate behaviors and that Resident # 7 would have had a difficult time eluding staff's supervision. Further, Holy Cross alleges that staff intervened before Resident # 7 could even touch Resident # 11 and that such quick intervention could be viewed as evidence of the close attention being paid to monitoring Resident # 7's behavior. P. Request for Review at 11, 20.

Therefore, again viewing the evidence as developed thus far in the light most favorable to Holy Cross, we conclude that a rational trier of fact could find that Holy Cross had taken all reasonable steps to supervise and manage Resident # 7's behavior so that it "pose[d] no greater risk to resident health and safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. Therefore, a dispute of material fact exists on this issue. It was error for the ALJ to conclude on summary judgment that Holy Cross was not in substantial compliance with section 483.25(h)(2).

Conclusion

For the reasons explained above, we remand this case to the ALJ for further proceedings consistent with this decision.

_____/s/_____
Judith A. Ballard

_____/s/_____
Constance B. Tobias

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