Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Golden Living Center - Trussville
(CCN: 01-5131),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-1175

Decision No. CR4916

Date: August 11, 2017

AMENDED DECISION

One of Petitioner's nurses left two of Petitioner's residents alone in the residents' room with a man whom the nurse did not recognize, even though the man was partially undressed and appeared to be intoxicated, the room smelled of alcohol, the nurse felt "uncomfortable," and one of the residents told the nurse that the man had been "messing with" the other resident. When the nurse returned two minutes later with her supervisor, the man was still there and one of the residents was naked from the waist down. When the supervisor questioned the man, he became belligerent, and she asked him to leave. The police arrested the man, who turned out to be the son of the partially naked resident, a short time later and removed him from the premises. Based on a partial extended survey that the Alabama Department of Public Health (state agency) conducted due to this incident, the Centers for Medicare & Medicaid Services (CMS) determined that Petitioner was not in substantial compliance with several Medicare program participation requirements related to protecting residents from abuse and the proper administration of a skilled nursing facility (SNF). CMS further determined that Petitioner's noncompliance posed immediate jeopardy to resident health and safety. CMS imposed a series of enforcement remedies on Petitioner, including a $5,000 per-day civil money penalty (CMP) for the period of time when residents were placed in immediate jeopardy and a

$100 per-day CMP for the period of time when Petitioner was not in substantial compliance, but residents were not placed in immediate jeopardy. In response, Petitioner requested a hearing before an administrative law judge (ALJ) to challenge the noncompliance findings, the finding that the noncompliance posed immediate jeopardy to resident health and safety, and the enforcement remedies imposed due to those findings. The parties each moved for summary judgment.

As explained below, I conclude the following after reviewing the facts in the light most favorable to Petitioner: summary judgment for CMS is appropriate; there is a basis for CMS's noncompliance findings and imposition of enforcement remedies because Petitioner did not take reasonable steps to protect its residents from a reasonably foreseeable risk of abuse; CMS's determination that Petitioner's noncompliance posed immediate jeopardy to resident health and safety is not clearly erroneous; and the CMPs imposed by CMS are reasonable. Therefore, I grant CMS's cross-motion for summary judgment, deny Petitioner's motion, and affirm CMS's initial determination.

I. Background and Procedural History

The Social Security Act (Act) sets forth requirements for the participation of a SNF in the Medicare program and authorizes the Secretary of Health and Human Services (the Secretary) to promulgate regulations implementing those statutory provisions. 42 U.S.C. § 1395i-3. The Secretary's regulations are found at 42 C.F.R. Parts 483 and 488. To participate in the Medicare program, a SNF must maintain substantial compliance with program participation requirements. To be in substantial compliance, a SNF's deficiencies may "pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301.[1] A deficiency is a violation of a participation requirement established by sections 1819(b), (c), and (d) of the Act, 42 U.S.C. § 1395i-3(b), (c), and (d), or the Secretary's regulations at 42 C.F.R. pt. 483, subpt. B. "Noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." 42 C.F.R. § 488.301. A facility may violate a statutory or regulatory requirement, but it is not subject to enforcement remedies if the violation does not pose a risk for more than minimal harm. 42 C.F.R. §§ 488.402(b), 488.301.

The Secretary contracts with state agencies to conduct periodic surveys to determine whether SNFs are in substantial compliance. 42 U.S.C. § 1395aa(a); 42 C.F.R. § 488.10. The Act also authorizes the Secretary to impose enforcement remedies against SNFs that are not in substantial compliance with the program participation requirements. 42 U.S.C. § 1395i-3(h)(2). The regulations specify the enforcement remedies that CMS may impose. 42 C.F.R. § 488.406. Among other enforcement remedies, CMS may impose a

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[1] All citations to the Code of Federal Regulations are to the version in effect at the time of the incident at the heart of this decision unless otherwise indicated.

per-day CMP for the number of days a SNF is not in substantial compliance or a per-instance CMP for each instance of the SNF's noncompliance. 42 C.F.R. § 488.430(a). A per-day CMP may range from either $50 to $3,000 per day for less serious noncompliance, or $3,050 to $10,000 per day for more serious noncompliance that poses immediate jeopardy to the health and safety of residents. 42 C.F.R. § 488.438(a)(1).[2] "Immediate jeopardy" exists when "the provider'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.

If CMS imposes a CMP based on a noncompliance determination, then the facility may request a hearing before an ALJ to challenge the noncompliance finding and enforcement remedy. 42 U.S.C. §§ 1320a-7a(c)(2); 1395i(h)(2)(B)(ii); 1395cc(h)(1); 42 C.F.R. §§ 488.408(g), 488.434(a)(2)(viii), 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *CarePlex of Silver Spring*, DAB No. 1683 (1999) (holding that ALJs hold *de novo* hearings based on issues permitted under the regulations and ALJ review is not a quasi-appellate review); *see also Claiborne-Hughes Health Ctr. v. Sebelius*, 609 F.3d 839, 843 (6th Cir. 2010) (The Departmental Appeals Board (DAB) "reviewed the finding under the *de novo* standard that the ALJ would have applied."). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); *see also* 42 C.F.R. §§ 488.330(e), 498.3. However, CMS's choice of remedies and the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2).

In regard to the burden of proof, CMS must make a *prima facie* case that the SNF failed to comply substantially with federal participation requirements and, if this occurs, the SNF must, in order to prevail, prove substantial compliance by a preponderance of the evidence. *Hillman Rehab. Ctr.*, DAB No. 1611 at 8 (1997); *see Batavia Nursing & Convalescent Inn*, DAB No. 1911 (2004); *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004); *Emerald Oaks*, DAB No. 1800 (2001); *Cross Creek Health Care Ctr.*, DAB No. 1665 (1998).

Petitioner is a SNF located in Alabama that participates in the Medicare program. From November 5-7, 2014, the state agency conducted an "Abbreviated and Partial Extended Survey" at the facility. CMS Exhibit (Ex.) 1 at 1; CMS Ex. 2 at 1. At the conclusion of

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[2] CMS recently increased the CMP amounts to account for inflation in compliance with the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015, 104 Pub. L. No. 114-74, 129 Stat. 584, 599. The new adjusted amounts apply to CMPs assessed after August 1, 2016, for deficiencies occurring on or after November 2, 2015. *See* 81 Fed. Reg. 61,538 (Sept. 6, 2016). As the deficiencies alleged in this case occurred prior to November 2, 2015, the increased CMP amounts do not apply in this case.

the survey, the surveyors completed a CMS-2567 Statement of Deficiencies specifying their findings and conclusions. CMS Ex. 1. The cited deficiencies are as follows:

- 42 C.F.R. § 483.13(b), (c)(1)(i) (Tag F223- Free From Abuse/involuntary Seclusion) at a J level of scope and severity.[3]
- 42 C.F.R. § 483.13(c) (Tag F226 - Abuse and Neglect Policies and Procedures) at a J level of scope and severity.
- 42 C.F.R. § 483.75 (Tag F490 - Effective Administration) at a J level of scope and severity.

CMS adopted those findings and conclusions, which included the determination that Petitioner's actions placed residents in immediate jeopardy from October 25, 2014 through November 6, 2014. CMS Ex. 2 at 1-2. CMS imposed a $5,000 per day CMP for the period of immediate jeopardy and a $100 per day CMP commencing November 7, 2014, which would continue until Petitioner achieved substantial compliance with SNF standards, as well as a prohibition on approval of a nurse aide training and competency evaluation program. CMS Ex. 1 at 2, 4. CMS also warned that it would impose a denial of payment for new admissions on December 17, 2014, if Petitioner did not return to compliance by that date, and a termination of Petitioner's provider agreement on April 9, 2014, if Petitioner still did not return to compliance by that date. CMS Ex. 1 at 2-3.

Based on a December 18, 2014 revisit survey, the state agency found that Petitioner had corrected the noncompliance cited following the November 7, 2014 survey as of December 9, 2014. Petitioner (P.) Ex. 2. However, the state agency further found that Petitioner remained out of compliance with Medicare participation requirements. P. Ex. 2 at 1. On January 15, 2015, CMS issued a change in remedies notice to Petitioner based

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[3] Scope and severity levels are used by CMS and state survey agencies when selecting remedies. The scope and severity level is designated by letters A through L, selected by CMS or the state agency from the scope and severity matrix published in the State Operations Manual, chap. 7, § 7400.5 (Sep. 10, 2010). A scope and severity level of A, B, or C indicates a deficiency that presents no actual harm but has the potential for minimal harm, which is an insufficient basis for imposing an enforcement remedy. Facilities with deficiencies of a level no greater than C remain in substantial compliance. 42 C.F.R. § 488.301. A scope and severity level of D, E, or F indicates a deficiency that presents no actual harm, but has the potential for more than minimal harm that does not amount to immediate jeopardy. A scope and severity level of G, H, or I indicates a deficiency that involves actual harm that does not amount to immediate jeopardy. Scope and severity levels J, K, and L are deficiencies that constitute immediate jeopardy to resident health or safety. The matrix, which is based on 42 C.F.R. § 488.408, specifies which remedies are required and optional at each level based upon the frequency of the deficiency.

in part on these findings. P. Ex. 3. In that notice, CMS informed Petitioner that the $100 per-day CMP accrued from November 7, 2014 through December 1, 2014, after which a $250 per-day CMP would accrue beginning December 2, 2014. P. Ex. 3 at 2. Petitioner timely requested a hearing to challenge CMS's noncompliance findings stemming from the survey completed on November 7, 2014, and the imposition of remedies based on those findings.[4] Following receipt of Petitioner's hearing request, the ALJ originally assigned to this case issued an Acknowledgment and Prehearing Order (prehearing order) that established a prehearing exchange schedule for the parties. In that order, the ALJ directed the parties to file briefs, proposed exhibits, and written direct testimony for all witnesses they wanted to present in this case. The ALJ also set forth guidelines for the parties to file a motion for summary disposition.

In compliance with the prehearing order, CMS filed an exchange, including a prehearing brief (CMS Br.), a list of proposed exhibits and witnesses, and 21 proposed exhibits (CMS Exs. 1-21). In its brief, CMS gave notice that it was citing Petitioner for an additional instance of noncompliance with 42 C.F.R. § 483.13(c)(3) for Petitioner's alleged failure to thoroughly investigate the incident involving two residents (identified for purposes of this case as Resident 1 and Resident 2) and Resident 1's son. CMS Br. at 8, 10-12; *see also* 42 C.F.R. § 498.56(a). Petitioner then filed its own exchange, including a prehearing brief (P. Br.), in which Petitioner objected to CMS Ex. 8; a list of proposed exhibits and witnesses; and 18 proposed exhibits (P. Exs. 1-18). Several months later, Petitioner filed a motion for summary judgment (P. MSJ). In response, CMS filed a cross-motion for summary judgment and opposition to Petitioner's motion (CMS Cross-MSJ). Petitioner subsequently filed a reply to CMS's cross-motion (P. Reply). Finally, CMS filed a reply to Petitioner's reply (CMS Reply).

On March 31, 2016, the Civil Remedies Division notified the parties that the ALJ presiding over this case transferred to a different division within the Department of Health and Human Services and I would replace that ALJ. *See* 42 C.F.R. § 498.44(b).

II. Evidentiary Ruling

CMS did not object to Petitioner's proposed exhibits, and Petitioner did not object to CMS Exs. 1-7 and 9-21; I therefore admit them all into the record. Although Petitioner does not cite any authority for its objection to CMS Ex. 8, its argument suggests two bases for the objection. First, Petitioner objects to a lack of authentication of the exhibit, evoking Federal Rule of Evidence (FRE) 901(a), which requires a party seeking to admit an item of evidence to authenticate that item with "evidence sufficient to support a

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[4] Petitioner states on page 7 of its prehearing brief that it has not appealed the $250 per-day CMP and the findings of noncompliance on which it is based; that CMP and those findings are thus not at issue in this case.

finding that the item is what the proponent claims it is." Second, Petitioner argues that "there is no way to tell from the proposed exhibit whether the proffered exhibits are complete," evoking FRE 106, which provides that "[i]f a party introduces all or a part of a writing or recorded statement, an adverse party may require the introduction, at that time, of any other part — or any other writing or recorded statement — that in fairness ought to be considered at the same time." While either (or both) of these rules might preclude admission of CMS Ex. 8 in a judicial proceeding, in this administrative proceeding I am not bound by the Federal Rules of Evidence when ruling on the admissibility of evidence. 42 C.F.R. § 498.61. Thus, while FRE 106 and 901(a) provide guidance on the appropriate weight to assign to evidence (like CMS Ex. 8) that may be incomplete or that may lack authentication, they do not constrain my ability to admit such evidence into the record. I therefore overrule Petitioner's objection to CMS Ex. 8 and admit it into the record. However, I note that although I admit CMS Ex. 8 into the record, I do not rely on it in my analysis below.

III. Issues

1. Whether summary judgment is appropriate;

2. Whether Petitioner substantially complied with the participation requirements at 42 C.F.R. §§ 483.13(b), (c)(1)(i) (Tag F223) and 483.75 (Tag F490);[5]

3. If Petitioner was not in substantial compliance, whether CMS's determination that Petitioner's noncompliance posed immediate jeopardy to resident health and safety is clearly erroneous; and

4. If Petitioner was not in substantial compliance, whether the CMP imposed is reasonable.

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[5] As already noted above, CMS alleges that Petitioner also allegedly failed to comply substantially with 42 C.F.R. § 483.13(c), 483.13(c)(1)(i), and 483.13(c)(3). I need not address these allegations of noncompliance because the noncompliance allegations I do address support both the imposition of enforcement remedies, including a CMP, and the reasonableness of the CMPs imposed by CMS. *See Claiborne-Hughes Health*, 609 F.3d at 847; *Carrington Place of Muscatine*, DAB No. 2321 at 20-21 (2010).

IV. Facts[6]

1. Petitioner had a written anti-abuse policy contained within its Human Resources Management Policies and Procedures Manual. CMS Ex. 16.

2. Petitioner's general anti-abuse policy was "to take appropriate steps to prevent the occurrence of abuse . . . ." CMS Ex. 16 at 1.

3. Petitioner also had a policy for dealing with intoxicated visitors at its facility. P. Ex. 13 at 4-5; P. Ex. 15 at 4.

4. Petitioner's intoxicated-visitor policy, as explained by Stacey Merritt Hord, the Vice President of Quality for Petitioner's parent company, "is that if a staff member suspects that a visitor is intoxicated or impaired, the staff person (or staff persons, if warranted) should escort the person out, or, if needed, call 911." P. Ex. 13 at 4.

5. According to Ms. Hord, the concern motivating this policy "is not necessarily that the intoxicated person is a threat to other residents, but is based upon the common knowledge . . . that intoxicated persons can be loud, disruptive, or argumentative, and could frighten residents and staff or even interfere with care." P. Ex. 13 at 4-5.

6. According to Petitioner's Director of Nursing (DON), Janie Dawson, Petitioner's nurses were trained "not to confront or argue with visitors who might be impaired, or who are being loud or aggressive, but to get a supervisor . . . ." P. Ex. 18 at 2.

7. Petitioner's expert witness, Annette O'Brien, R.N., also notes that individuals who are "impaired/mentally-disturbed . . . can become very unpredictable and unmanageable." P. Ex. 17 at 13; *accord* CMS Ex. 21.

8. Resident 1 was an 83-year-old woman admitted to Petitioner on October 14, 2014. CMS Ex. 12 at 1, 5.

9. Resident 2 was a 76-year-old woman admitted to Petitioner on October 23, 2014. CMS Ex. 14 at 1.

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[6] The following facts are either not disputed by the parties or, where there is a dispute, I accept Petitioner's version of the facts to the extent it is supported by evidence in the record.

10. On October 25, 2014, Resident 1's son visited Resident 1 at the facility. P. Ex. 16 at 1; P. Ex. 9 at 1.

11. "Some time in the mid-afternoon" on October 25, 2014, LPN Verwanda Evans went to the room shared by Residents 1 and 2 "in order to do a skin assessment on Resident #2." P. Ex. 15 at 1.

12. At the time, Nurse Evans "had not provided services to either Resident [1 or Resident 2] before, did not know either of them at all, and d[id] not recall hearing any reports of any unusual visitors or behaviors relating to either of them." P. Ex. 15 at 1-2.

13. Upon arriving at the room, Nurse Evans found the door closed, so she knocked on the door before entering. P. Ex. 15 at 2.

14. Hearing no response, Nurse Evans "opened the door a crack and announced [her]self," which elicited an invitation from a "male voice" to enter the room. P. Ex. 15 at 2.

15. When she walked into the room, Nurse Evans found that it "was dark, the lights off, and the blinds pulled, and the privacy curtain between the bed[s] was pulled out." Resident 2 "was in the far bed, nearer the window," and Nurse Evans saw "a wheelchair between the beds, and a man standing near the end of the closer bed, who sat down in the wheelchair as [she] entered the room." P. Ex. 15 at 2.[7]

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[7] Nurse Evans claims in her sworn testimony, which was "prepared and typed by [Petitioner's] attorney's office based on [her] interview with counsel," that when she first entered the room on October 25, 2014, she did not smell alcohol. P. Ex. 15 at 1-2. Petitioner also asserts in its motion for summary judgment that "[t]here is no evidence to support th[e] assertion" that Nurse Evans "did smell alcohol when she first entered the room . . . ." P. MSJ at 16 n.13. Nurse Evans's claim and Petitioner's assertion are directly contradicted by several other pieces of evidence in the record. For example, a nursing note written by Nurse Evans at 5:30 p.m. on October 25, 2014, states that when Nurse Evans walked into the room initially, the "[r]oom smell[ed] like alcohol . . . ." P. Ex. 9 at 1. Hospital records for Resident 1, dated October 25, 2014, include a note that Resident 1's son was "[n]oted to be intoxicated" by Nurse Evans when she first entered the room. CMS Ex. 11 at 5. Petitioner's incident report, dated October 26, 2014, confirms that "there was a smell of alcohol in the room" when Nurse Evans first entered. CMS Ex. 3 at 3. Finally, Nurse Evans's statement to police, dated October 25, 2014, also says that the "[r]oom smell[ed] like alcohol" the first time she entered. CMS Ex. 8 at 8.

This contradiction casts significant doubt on the credibility of Nurse Evans's testimony regarding the events at the heart of this case. However, I cannot assess witness

16. As far as Nurse Evans knew, she "had not seen the man before." P. Ex. 15 at 2.

17. Nurse Evans told the man that she was there to check on Resident 2, turned the light on, and walked to Resident 2's bed. At that point, she "noticed that the man's right shoe and sock were off." P. Ex. 15 at 2.

18. Immediately after Nurse Evans reached Resident 2, Resident 2 "said, '[H]e's been messing with her' in a soft, matter of fact, calm voice." Nurse Evans "asked [her] to repeat what she said, and she repeated the same words in the same calm voice." Resident 2 said nothing more despite Nurse Evans asking her what she meant. P. Ex. 15 at 2.

19. Seeing that "nothing looked out of the ordinary" and believing Resident 2 might be confused, Nurse Evans "left the room . . . and went to the nearby nursing station to check Resident #2's chart to determine her cognitive status." P. Ex. 15 at 3.

20. After checking Resident 2's chart, which revealed that she was "moderately impaired" and thus "could have been confused," Nurse Evans "returned to the room . . . ." P. Ex. 15 at 3.

21. Upon returning, Nurse Evans "saw the man again standing at the end of the bed, appearing to hold his pants up," and when she walked in "he again sat down in the wheelchair next to the bed." His belt and shoe were on the floor and there was an "odor of alcohol" in the room. In addition, Resident 1 was "awake, sitting up, and calm." P. Ex. 15 at 3.

22. After observing all this, Nurse Evans became "uncomfortable," suspecting "the man might have been drinking," and "began to wonder what was going on"; she

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credibility when deciding a summary judgment motion; rather, I must "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." *Holy Cross Vill. at Notre Dame, Inc.*, DAB No. 2291 at 5 (2009) (internal citation and quotation marks omitted). In her testimony, Nurse Evans presents a version of the events that occurred on October 25, 2014, that is more favorable to Petitioner than the version described in the documents produced on or shortly after October 25, 2014 (including the documents produced by Nurse Evans herself). Therefore, for purposes of this decision on summary judgment, I accept the version of events presented by Nurse Evans in her testimony.

thought "something about the situation looked odd" and thought that "if the man had been drinking, [she] might need help from another nurse."[8] P. Ex. 15 at 3-4.

23. Nurse Evans then left the room a second time to find the nurse supervisor on duty, Terry Wyatt, R.N. P. Ex. 15 at 4.[9]

24. Nurse Evans took at least one minute to find Nurse Wyatt at the nursing station "on the other wing of the building," whereupon she asked Nurse Wyatt to come with her, explaining that she smelled alcohol in Resident 1's room and needed Nurse Wyatt's "assessment of the situation." P. Ex. 15 at 4.

25. Nurse Evans returned to Resident 1's room with Nurse Wyatt "two or three minutes" after leaving. P. Ex. 15 at 4.

26. When the two returned, Nurse Wyatt entered first and discovered Resident 1 lying in her bed with her "sheet pulled away" and "her genital area exposed." P. Ex. 15 at 4; *see also* P. Ex. 9 at 1; CMS Ex. 11 at 5, 7.

27. After covering up Resident 1, Nurse Wyatt asked the man what was going on; he "became somewhat belligerent" in response to this inquiry and "asked whether [Nurse Wyatt] was accusing him of being a pedophile." P. Ex. 15 at 4.

28. Nurse Wyatt then told the man that he would have to leave because he was "partially undressed" and escorted him from the room. P. Ex. 9 at 1; P. Ex. 15 at 4-5.

29. At some point, one of Petitioner's staff members called 911, and the man was arrested and removed from the facility premises. P. Ex. 9 at 1; CMS Ex. 3 at 1-2, 4.

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[8] Before leaving, Nurse Evans testified that she might have told the man to step into the hallway because she smelled alcohol, but is not certain that she did this. P. Ex. 15 at 4.

[9] According to DON Dawson, Nurse Evans called her to tell her that the man in Resident 1's room "appeared to be drunk." DON Dawson testifies that she "told Nurse Evans to get her supervisor, and to call the police to help remove the visitor from the building." DON Dawson further testifies that shortly after this call, Nurse Wyatt (the supervisor) called, and DON Dawson "told her the same thing" she had told Nurse Evans. P. Ex. 18 at 1-2. DON Dawson's testimony appears to contradict Nurse Evans's account of events and suggests that Nurse Evans may have taken longer than "two or three minutes" to return to Resident 1's room, contrary to Nurse Evans's testimony. P. Ex. 15 at 4. Because I am resolving this case against Petitioner on summary judgment, I take as true the version of events most favorable to Petitioner—in this instance, the version of events reported by Nurse Evans in her testimony at P. Ex. 15.

30. Resident 1 was assessed and later transported to the hospital for an alleged sexual assault. The hospital performed a rape kit on Resident 1.[10] CMS Ex. 11 at 6-7; P. Ex. 9 at 1.

31. Nurse Evans later learned that the man she found in the room with Residents 1 and 2 was Resident 1's son. P. Ex. 9 at 1.

32. It appears that Resident 1's son was initially charged with two sexual offenses—sexual abuse by force and first degree rape—but Alabama court records submitted by Petitioner indicate those charges were "WAIVED TO GJ," which appears to stand for grand jury. P. Ex. 12.[11]

V. Conclusions of Law and Analysis

My conclusions of law are set forth in italics and bold font followed by detailed factual and legal analyses.

A. Summary judgment is appropriate.

Summary judgment is appropriate in cases where 42 C.F.R. Part 498 applies if there is no genuine dispute of any material fact and the moving party is entitled to judgment as a matter of law. *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743, 750 (6th Cir. 2004); CRDP § 19(a). A "genuine" dispute exists if "the evidence is such that a reasonable [trier of fact] could return a verdict for the nonmoving party," *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986), and a "material" fact is one "that, if proven, would affect the outcome of the case under governing law." *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 3 (2010).

To obtain summary judgment, the moving party must show that there is no genuine dispute of material fact requiring an evidentiary hearing and that it is entitled to judgment as a matter of law. *Mission Hosp. Reg'l Med. Ctr.*, DAB No. 2459 at 5 (2012). If the moving party meets this initial burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial . . . .'" *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986). "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." *Senior Rehab.*, DAB No. 2300 at 3.

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[10] The results of that rape kit are not in the record.

[11] Nothing in the record suggests that Resident 1's son had been indicted by the time the parties fully briefed their respective motions for summary judgment.

In evaluating a motion for summary judgment, an ALJ does not address credibility or evaluate the weight of conflicting evidence. *Holy Cross*, DAB No. 2291 at 5. Rather, in examining the evidence to determine the appropriateness of summary judgment, an ALJ must draw all reasonable inferences in the light most favorable to the non-moving party. *See Brightview Care Ctr.*, DAB No. 2132 at 10 (2007) (upholding summary judgment where inferences and views of non-moving party are not reasonable). "[A]t the summary judgment stage the judge's function is not . . . to weigh the evidence and determine the truth of the matter but to determine whether there is a genuine issue for trial." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 255 (1986). However, drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions. *Cedar Lake Nursing Home*, DAB No. 2344 at 7 (2010).

As explained below, even when viewed in the light most favorable to Petitioner, the evidence establishes the following: (1) Petitioner violated 42 C.F.R. § 483.13(b), (c)(1)(i) (and, by extension, § 483.75) by failing to take reasonable steps to protect Residents 1 and 2 from the reasonably foreseeable risk of abuse posed by Resident 1's son; (2) Petitioner's noncompliance posed a risk for more than minimal harm to Residents 1 and 2; (3) CMS's determination that Petitioner's noncompliance posed immediate jeopardy to resident health and safety is not clearly erroneous; and (4) the CMPs imposed by CMS are reasonable. Petitioner makes what amount to several legal arguments why the evidence shows either that the risk of abuse posed by Resident 1's son was unforeseeable or, if the risk of abuse was foreseeable, it took all reasonable steps to protect Residents 1 and 2 from abuse, which, in Petitioner's view, entitle Petitioner to summary judgment.[12] However, I find Petitioner's legal arguments unavailing.

B. The undisputed fact that a member of Petitioner's staff left Residents 1 and 2 alone with a man she did not know for at least two minutes even after she (1) smelled alcohol and suspected the man had been drinking; (2) was told by Resident 2 that the man had been "messing with" Resident 1; (3) witnessed the man in a state of partial undress; and (4) felt uncomfortable enough to seek out her supervisor and even to possibly tell the man to leave the room support a conclusion that Petitioner was not in substantial compliance with 42 C.F.R. §§ 483.13(b), (c)(1)(i) (Tag F223) and 483.75 (Tag F490).

1. Petitioner violated 42 C.F.R. § 483.13(b), (c)(1)(i) (Tag F223).

A resident of a long-term care facility "has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion." 42 C.F.R. § 483.13(b). To protect that right, a facility cannot use any form of abuse, corporal

[12] I have considered all of Petitioner's arguments in preparing this decision; however, I only address those that are relevant to my analysis below.

punishment, or involuntary seclusion when caring for a resident. *Id.* § 483.13(c)(1)(i). "Abuse" is defined as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish." 42 C.F.R. § 488.301. "Protecting and promoting a resident's right to be free from abuse necessarily obligates the facility to take reasonable steps to prevent abusive acts, regardless of their source." *Pinehurst Healthcare & Rehab. Ctr.*, DAB No. 2246 at 6 (2009) (quoting *Western Care Mgmt. Corp., d/b/a Rehab Specialties Inn*, DAB No. 1921 at 12 (2004)) (internal quotation marks omitted). Actual abuse need not occur for a facility to violate 42 C.F.R. § 483.13(b) and (c)(1)(i). *See Holy Cross* DAB No. 2291 at 7 (citation omitted). "It is sufficient for CMS to show that that [sic] the facility failed to protect residents from reasonably foreseeable risks of abuse." *Id.* (citing *Western Care Mgmt.*, DAB No. 1921 at 15). In order to demonstrate that Petitioner violated 42 C.F.R. § 483.13(b), (c)(1)(i), CMS must show that (1) there was a reasonably foreseeable risk of abuse and that (2) Petitioner failed to take reasonable steps to prevent abuse from occurring. Even when viewing the evidence in the light most favorable to Petitioner, CMS has made a sufficient showing as to both of these requirements.

First, Nurse Evans's account of events demonstrates there was a reasonably foreseeable risk of abuse. When she arrived at the room shared by Residents 1 and 2, the door was closed, and when she first walked into the room, it was dark, with the lights off and the blinds pulled. P. Ex. 15 at 2. In addition, there was a man she had never seen before in the room with two elderly residents she did not know at all. CMS Ex. 12 at 1, 5; CMS Ex. 14 at 1; P. Ex. 15 at 1-2.[13] When she entered the room, the man went from standing at the end of Resident 1's bed to sitting in the wheelchair, and she noticed that his right shoe and sock were off. As soon as she reached Resident 2, Resident 2 told her twice softly and matter-of-factly, "[H]e's been messing with [Resident 1]." Seeing nothing unusual at that point, Nurse Evans left the room to check Resident 2's chart to see if she might be confused and found that her chart indicated she was "moderately impaired," which might indicate she was indeed confused. P. Ex. 15 at 2-3.

While the above-mentioned facts, standing alone, might not give rise to a reasonably foreseeable risk of abuse, the same cannot be said about what Nurse Evans found upon returning to the room. As she walked in, she saw the man again standing at the end of Resident 1's bed, but this time he looked like he was holding his pants up. Further, his belt and shoe were on the floor, and there was an "odor of alcohol" in the room. Nurse Evans began to suspect at that point that "the man might have been drinking" and thought

[13] The fact that the man turned out to be Resident 1's son is irrelevant under these circumstances because Nurse Evans did not know who he was and made no apparent effort to find out. As Petitioner observes in its motion for summary judgment, its staff members' "judgments and acts must be evaluated by what they *did* see and hear on and before October 25[, 2014]." P. MSJ at 22 (emphasis in original).

that "something about the situation looked odd." She also thought that "if the man had been drinking, [she] might need help from another nurse." P. Ex. 15 at 3-4.

The presence of an unknown, partially undressed, intoxicated man in a room with two elderly nursing home residents, one of whom told Nurse Evans he had been "messing with" the other one, certainly points to a risk of abuse. Petitioner's policy for dealing with intoxicated guests—escorting the guest out or even calling 911—and the reasoning behind that policy—intoxicated guests could be disruptive, frighten residents, or even interfere with resident care—shows that Petitioner foresaw that intoxicated guests could pose a risk of abuse to its residents.[14] P. Ex. 13 at 4-5. Petitioner's expert witness testified that impaired individuals "can become very unpredictable and unmanageable." P. Ex. 17 at 13. Nurse Evans rightfully became uncomfortable with the situation and reasonably considered seeking help to deal with the unknown, apparently intoxicated man in the room. Further, although she claims that she "did not suspect that the man was actually doing anything inappropriate" and that the thought he might be molesting one of the residents "never crossed her mind at the time," P. Ex. 15 at 3-4, she does not deny that he posed at least a risk of abuse to Residents 1 and 2. That she may have ordered the man to leave the room on her way out to search for her supervisor, and that she sought out her supervisor to deal with the situation, strongly suggest that she was aware of the risk the man posed.

Notwithstanding Nurse Evans's account of events, Petitioner argues that a risk of abuse was not foreseeable in this case because (1) in general, sexual assault against nursing home residents by their family members is extremely rare, and (2) in this particular case, Petitioner's staff had no reason to suspect Resident 1's son would sexually assault Resident 1. *See* P. Br. at 2-5, 9-10, 21-23; P. MSJ at 5-8, 21-23; P. Reply at 21. These legal arguments are not persuasive or even particularly relevant in light of Nurse Evans's account of events. Even accepting as true for purposes of summary judgment that sexual assault against nursing home residents by their family members is rare, this fact is not material here because sexual assault is not the only, or even the most obvious, risk of

[14] Ms. Hord, in describing this policy, attempts to disclaim that the policy was motivated by concern that an intoxicated guest might pose a threat to Petitioner's residents. P. Ex. 13 at 4. Even accepting this as true, however, the concerns she identifies that I have highlighted (i.e., that intoxicated guests could be disruptive, frighten residents, or interfere with resident care) all fall within the definition of abuse contained in interpretive guidance issued by CMS related to the regulation at 42 C.F.R. § 483.13. CMS's State Operations Manual (SOM), app. PP (CMS Pub. 100-07 (rev. 107; eff. April 4, 2014)), contains an interpretive guideline explaining that "abuse" includes, among other things, "the deprivation by an individual . . . of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being." The same guidance also includes as an example of verbal abuse, "saying things to frighten a resident."

abuse posed by Resident 1's son.[15] Moreover, even if Petitioner's staff had no reason to suspect Resident 1's son might be abusing Resident 1 before Nurse Evans entered the room, Nurse Evans certainly had reason to suspect such abuse might occur based on her testimonial account of the incident. Indeed, Nurse Evans did not even know the man in Resident 1's room was Resident 1's son; thus, even the risk of sexual abuse was within the range of possible risks of abuse that she should have foreseen when she left him alone with Residents 1 and 2.

In light of these facts, I conclude that CMS has shown that there was a reasonably foreseeable risk of abuse.

Nurse Evans's account of events also demonstrates that Petitioner did not take reasonable steps to prevent abuse from occurring. Having encountered a reasonably foreseeable risk of abuse, Nurse Evans's instinct to seek help from one of her fellow nurses was not inherently faulty. However, her decision to leave the room, thereby leaving Residents 1 and 2 alone with a partially undressed man she did not know, but suspected was intoxicated, for at least two minutes was manifestly unreasonable. At a minimum, Nurse Evans should have stayed in the room and called for assistance. I therefore further conclude that CMS has shown that Petitioner failed to take reasonable steps to prevent abuse from occurring.

Petitioner recognizes the importance of Nurse Evans's response to the situation she found in the room shared by Residents 1 and 2, admitting that the "key question" in this case "appears to be whether Nurse Verwanda Evans adequately protected Resident #1 (and her roommate) against abuse when she left the son and his mother alone while she went to fetch her supervisor after she saw (and heard) something that did not look quite right." P. Br. at 23; *see also* P. MSJ at 24 ("[I]t seems reasonable to question whether [Nurse Evans] adequately protected Resident #1 (and her roommate) against abuse when she left the son and his mother alone while she went to fetch her supervisor after she saw (and heard) something that did not look quite right."). Petitioner argues, however, that Nurse Evans "did protect the [r]esidents by leaving the lights on and the door wide open while she sought out her supervisor." P. Br. at 23; P. MSJ at 24. In effect, Petitioner would have me conclude that Nurse Evans leaving the lights on and the door open were reasonable steps that satisfied its duty under 42 C.F.R. § 483.13(b), (c)(1)(i) to protect Residents 1 and 2 from the foreseeable risk of abuse posed by Resident 1's intoxicated, partially undressed son.

Although I accept as true for purposes of this decision the apparently undisputed facts that Nurse Evans left the lights on and the door open when she left the room to find her

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[15] Nurse Evans did not know anything about the man she left unattended with Residents 1 and 2. As it turns out, Resident 1's son pled guilty in 2012 to public intoxication and disorderly conduct, and in September 2014, to theft of property. P. Ex. 12 at 5.

supervisor, I am not required to accept Petitioner's legal conclusion that these actions were sufficient to discharge Petitioner's duty under 42 C.F.R. § 483.13(b), (c)(1)(i) to protect Residents 1 and 2. *See Cedar Lake*, DAB No. 2344 at 7. Resident 1's son could easily have turned off the lights or closed the door, or both, in the time Nurse Evans took to find her supervisor and return. Moreover, even with the lights on and the door open, Resident 1's son could have (and indeed may have) acted abusively towards Residents 1 or 2 while left alone with them.[16] I therefore conclude that Nurse Evans did not act reasonably when she left Resident 1's son alone with Residents 1 and 2 even though she left the lights on and the door open when she left.

In addition to the preceding arguments, Petitioner makes a more general argument that its duty to protect residents from abuse under 42 C.F.R. § 483.13(b), (c)(1)(i) must be construed in light of 42 C.F.R. § 483.10(j)(1)(vii), which provides that "[t]he resident has the right and the facility must provide immediate access to any resident by the following: . . . [s]ubject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident." In essence, Petitioner argues that in this case, since it was one of the resident's immediate family members whose visitation posed a risk of abuse to the residents, its choices for dealing with the risk of abuse were constrained by § 483.10(j)(1)(vii). The problem with this argument is threefold. First, in this case, Petitioner *did* give Resident 1's son access to Resident 1. Resident 1's son was already visiting with Resident 1 when Nurse Evans first noticed something was amiss and left to find her supervisor. Second, and more importantly, once Resident 1's son began to pose a risk of abuse to Petitioner's residents that was reasonably foreseeable to Petitioner, Petitioner's duty to protect the residents' right to be free from abuse trumped Resident 1's right to visit with her son. Finally, as stated above, Nurse Evans did not know that the intoxicated man was Resident 1's son and her testimony related to the October 25 incident manifests no concern over the man's right to visit Resident 1.[17] Therefore, section 483.10(j)(1)(vii) presented no barrier to her.

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[16] Although not crucial to my decision, I further question the efficacy of such minimal protective steps as turning the lights on and leaving the door open given that Resident 1's son was intoxicated and thus very likely suffered from impaired judgment.

[17] Nurse Wyatt, who escorted Resident 1's son from Resident 1's room, does not appear to have known that the intoxicated man was Resident 1's son. Nurse Evans testified to the following interaction between Nurse Wyatt and Resident 1's son: "Nurse Wyatt told [Resident 1's son] that he would have to leave, that it was not appropriate for him to be partially undressed in a room with a woman to whom he was not related." P. Ex. 15 at 4. It is possible that Nurse Wyatt did know he was Resident 1's son because she also told him "that we could discuss his visitation rights another day." P. Ex. 15 at 4. Therefore, even if Nurse Wyatt knew that Resident 1's son was Resident 1's relative with "visitation rights," it did not stop her from removing Resident 1's son from Resident 1's room.

In light of the foregoing, I conclude that Petitioner violated 42 C.F.R. § 483.13(b), (c)(1)(i).

2. Petitioner violated 42 C.F.R. § 483.75 (Tag F490).

The regulation dealing with administration of SNFs provides that "[a] facility 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." 42 C.F.R. § 483.75. The regulation also includes specific requirements to comply with federal, state, and local laws and professional standards and requirements in other areas as well, including: licenses; training; registry verification; in-service education; staff qualifications; and provisions for laboratory, radiology, and other diagnostic services; and clinical records. 42 C.F.R. § 483.75(a)-(p). The language of § 483.75 is such that any failure of management that adversely affects a resident constitutes a violation. *See, e.g.*, *Stone Cty. Nursing & Rehab. Ctr.*, DAB No. 2276 at 15 (2009) ("[A] determination that a SNF failed to comply substantially with section 483.75 may be derived from findings that the SNF was not in substantial compliance with other participation requirements." (citing *Life Care Ctr. at Bardstown*, DAB No. 2233 at 28 (2009) and *Britthaven, Inc., d/b/a Britthaven of Smithfield*, DAB No. 2018 at 22 (2006))).

As stated in one case:

> The administrative deficiency [at 42 C.F.R. § 483.75] is a derivative deficiency based on findings of other deficiencies . . . where a facility has been shown to be so out of compliance with program requirements that its residents have been placed in immediate jeopardy, the facility was not administered in a manner that used its resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of each resident.

Asbury Ctr. at Johnson City, DAB No. 1815 at 11 (2002); *see also Odd Fellow & Rebekah Health Care Facility*, DAB No. 1839 (2002).

CMS essentially argues that Petitioner's noncompliance with § 483.75 is derivative of Petitioner's other immediate jeopardy level noncompliance arising from the incident involving Residents 1 and 2 and Resident 1's son. CMS Cross-MSJ at 22-23. Any failure of management that adversely affects a resident constitutes a violation of § 483.75. I have already found that Petitioner violated Medicare participation requirements at 42 C.F.R. § 483.13(b), (c)(1)(i), and, as I conclude later in the decision, CMS's determination that Petitioner's noncompliance posed immediate jeopardy to resident health and safety is not clearly erroneous. The same undisputed facts that

support that noncompliance finding also support my conclusion that Petitioner violated the administration requirement at 42 C.F.R. § 483.75. In addition, Nurse Evans's unreasonable response to the situation she found in Resident 1's room reflects a failure of Petitioner's management to ensure direct care staff was trained to respond appropriately to such a situation, particularly one involving an intoxicated visitor.

3. Petitioner's violations of 42 C.F.R. §§ 483.13(b), (c)(1)(i) (Tag F223) and 483.75 (Tag F490) had the potential to cause more than minimal harm to Petitioner's residents; therefore, Petitioner was not in substantial compliance with those regulatory requirements.

As already noted, a SNF's regulatory violations must have the potential to cause more than minimal harm to its residents to justify the imposition of enforcement remedies. *See* 42 U.S.C. § 1395i-3(h)(2); 42 C.F.R. §§ 488.301, 488.402(b). Consequently, to conclude that Petitioner was not in substantial compliance with 42 C.F.R. §§ 483.13(b), (c)(1)(i) and 483.75, I must conclude not only that Petitioner violated them, as I already have above, but also that Petitioner's violations had the potential to cause more than minimal harm to Petitioner's residents.

Petitioner attempts to minimize the significance of Nurse Evans leaving Residents 1 and 2 alone with Resident 1's son, characterizing it as "a few moments" and questioning what risk of harm she exposed the residents to when she left. P. MSJ at 18. This amounts to an argument that even if Petitioner violated 42 C.F.R. § 483.13(b), (c)(1)(i) by virtue of Nurse Evans's actions, it was still in substantial compliance with those regulations (and, by extension, § 483.75) because any violation had the potential to cause no more than minimal harm (or even no harm at all). In this vein, Petitioner also argues that Nurse Evans protected Residents 1 and 2 by leaving the lights on and the door open as she left the room. P. MSJ at 24.

These arguments, however, are not supported by the facts in this case. Before this incident, Petitioner had recognized some of the risks associated with intoxicated guests—namely, that such guests can be disruptive, frighten residents, or interfere with resident care—and developed policies to deal with those risks. P. Ex. 13 at 4-5. With regard to the actual incident, by her own account, Nurse Evans left for at least two minutes and possibly three (not "a few moments"), and when she returned with her supervisor, her supervisor found Resident 1 naked from the waist down lying in bed—which was not the case when Nurse Evans left minutes before. This particular risk (i.e., a risk of sexual abuse in the form of nonconsensual exposure of a resident's genitals to public view) is one of a variety of possible risks of harm to which Residents 1 and 2 were exposed by Nurse Evans when she left them alone with a man she did not know who was partially

undressed and appeared (to her) to be intoxicated, even for just two minutes and even with the lights on and the door open.[18]

Nurse Evans also opened Resident 2 to harm. After all, Resident 2 reported to Nurse Evans that Resident 1's son was "messing with" Resident 1. P. Ex. 15 at 2. Given the close proximity of Resident 1's son, he could well have heard Resident 2's remarks, especially since Nurse Evans unwisely made her repeat the warning and then continued to question her about it within earshot of Resident 1's son. Perhaps this is why Resident 2 refused to answer any more questions. Regardless, had Resident 1's son known of Resident 2's comments, she could have been subjected to harm. After all, when Nurse Wyatt questioned Resident 1's son about his conduct, he "became somewhat belligerent." P. Ex. 15 at 4.

Moreover, Residents 1 and 2 were not the only residents put at risk when Nurse Evans left; Resident 1's son easily could have left the room through the (now conveniently open) door in that two-minute window and roamed the facility still intoxicated and partially undressed.[19] These facts are sufficient to establish that Petitioner's violation of 42 C.F.R. § 483.13(b), (c)(1)(i)—and, by extension, § 483.75—posed a risk for more than minimal harm to Petitioner's residents.

C. CMS's determination that Petitioner's noncompliance posed immediate jeopardy to resident health and safety is not clearly erroneous.

Immediate jeopardy exists if a facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. 42 C.F.R. § 488.301. The regulation does not require that a resident *actually* be harmed. *Lakeport Skilled Nursing Ctr.*, DAB No. 2435 at 8 (2012). I must uphold CMS's determination as to the level of a facility's substantial noncompliance (which includes an immediate jeopardy finding)

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[18] Without weighing the evidence, I cannot say on this record whether Resident 1's son exposed Resident 1's genitals at all, much less that he did so without her consent. That he did abuse his mother in this specific way or not is beside the point, however. The point is that the *possibility* that he did so illustrates vividly how leaving him alone in the room with Residents 1 and 2 for even two minutes with the lights on and the door open could have posed a risk of more than minimal harm.

[19] That the man turned out to be Resident 1's son and happened to stay in the room with Residents 1 and 2 is perhaps a fortunate circumstance for Petitioner to the extent it limited whatever harm he might have inflicted on Petitioner's residents before his arrest. However, these facts are irrelevant to the analysis of the potential for harm he posed to Petitioner's residents because at the time of this incident, Nurse Evans had no idea that he was Resident 1's son or that he would stay in the room when she left.

unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The "clearly erroneous" standard imposes on facilities a heavy burden to overcome a finding of immediate jeopardy, and the DAB has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *See, e.g.*, *Barbourville Nursing Home*, DAB No. 1962 at 11 (2005) (quoting *Florence Park Care Ctr.*, DAB No. 1931 at 27-28 (2004)), *aff'd*, *Barbourville Nursing Home v. U.S. Dep't of Health & Human Servs.*, 174 F. App'x 932 (6th Cir. 2006). "In applying [the clearly erroneous] standard, . . . a reviewing court must ask whether, 'on the entire evidence,' it is 'left with the definite and firm conviction that a mistake has been committed.'" *Easley v. Cromartie*, 532 U.S. 234, 242 (2001). Therefore, in order to grant summary judgment to CMS on the immediate jeopardy issue, I must conclude that even when viewing the facts and evidence in the light most favorable to Petitioner, I do not have a "definite and firm conviction" that CMS's immediate jeopardy determination was a mistake.

In this case, Petitioner makes little effort to carry its heavy burden of overcoming the finding that its noncompliance with 42 C.F.R. §§ 483.13(b), (c)(1)(i) and 483.75 posed immediate jeopardy to resident health or safety. Petitioner only asserts, without elaboration, "that there is no factual or legal basis for CMS' findings of . . . 'immediate jeopardy' . . . ." P. Br. at 8.

I am unpersuaded by Petitioner's conclusory assertion. Nurse Evans left Residents 1 and 2 alone with Resident 1's son for at least two whole minutes, even though she (1) did not recognize him, (2) suspected he was intoxicated, (3) witnessed him in a partially undressed state, and (4) was told by Resident 2 that he had been "messing with" Resident 1. Nurse Evans did observe the first two times she entered the room that Resident 1 was calm and awake, and she determined that Resident 2 was moderately cognitively impaired and likely could not see what was going on because the privacy curtain was up. Nevertheless, even Nurse Evans was "uncomfortable" under the circumstances and thought it appropriate to seek help and possibly order Resident 1's son out of the room as she left. Someone even thought it appropriate to call 911. P. Ex. 18 at 2. Moreover, in just two minutes of her absence, someone pulled away Resident 1's sheet and likely removed her diaper to leave her genital area exposed. P. Ex. 15 at 4-5. Finally, Resident 1's son became belligerent when questioned and ultimately was arrested and removed from the premises by police. P. Ex. 15 at 2-4. In light of these circumstances, I cannot say that even when viewing the evidence in the light most favorable to Petitioner I am "left with the definite and firm conviction" that CMS made a mistake in determining that Petitioner's noncompliance was at least likely to cause serious harm to Petitioner's residents.[20] To the contrary, one could reasonably conclude from the evidence, even

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[20] Petitioner does raise material disputes of fact regarding whether its noncompliance actually caused harm to any of its residents. Therefore, I cannot conclude on summary

when viewed in Petitioner's favor, that Nurse Evans's actions gave rise to an immediate jeopardy situation, at least with respect to Residents 1 and 2, if not to all the residents who might have been harmed by Resident 1's son when he was left alone for two minutes while intoxicated and partially undressed. *See Barbourville*, DAB No. 1962 at 11. Therefore, I conclude that CMS's immediate jeopardy determination is not clearly erroneous.

D. The imposed CMPs are reasonable.

In determining whether the per-day CMP amounts imposed against Petitioner are reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f). 42 C.F.R. § 488.438(e)(3). These factors include: (1) the facility's history of compliance; (2) the facility's financial condition; (3) the factors specified at 42 C.F.R. § 488.404; and (4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort, or safety. The absence of culpability is not a mitigating factor. The factors at 42 C.F.R. § 488.404 include: (1) the scope and severity of the deficiency; (2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and (3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies. Unless a facility contends that a particular regulatory factor does not support the CMP amount, the ALJ must sustain it. *Coquina Ctr. v. CMS*, DAB No. 1860 at 32 (2002). My review of the reasonableness of a CMP amount is *de novo* and based upon the evidence in the record before me. I am not bound to defer to the CMS determination of the reasonable amount of a CMP to impose, but my authority is limited by regulation as already explained. I am to determine whether the amount of any CMP imposed is within reasonable bounds considering the purpose of the Act and regulations. *Emerald Oaks*, DAB No. 1800 at 10 (2001); *CarePlex of Silver Spring*, DAB No. 1683 at 14-16 (1999); *Capitol Hill Cmty. Rehab. & Specialty Care Ctr.*, DAB No. 1629 (1997).

In this case, CMS imposed a $5,000 per day CMP for the period of Petitioner's immediate jeopardy noncompliance (October 25, 2014 through November 6, 2014) and a $100 per day CMP for the period of Petitioner's non-immediate jeopardy noncompliance at issue in this case (November 7, 2014 through December 1, 2014), a total CMP of $67,500. CMS Ex. 2 at 1-2; P. Ex. 3 at 2. The immediate jeopardy level CMP is in the bottom third of the range permitted for such CMPs, and the non-immediate jeopardy level CMP is the second-lowest amount permitted for such CMPs.

Although Petitioner states that it "specifically challenges the amount and duration of the CMP," Petitioner does not argue that any particular regulatory factor does not support the CMP amount. Nor does Petitioner argue that the duration of the CMPs is unreasonable

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judgment that Petitioner's noncompliance actually caused serious injury, harm, or impairment to one or more residents.

by, for example, showing that it abated immediate jeopardy earlier than November 6, 2014, or showing that it returned to substantial compliance earlier than December 1, 2014. For that reason alone, I could conclude the CMPs are reasonable in amount and duration. *See Coquina Ctr.*, DAB No. 1860 at 32. In any event, as already discussed in detail above, Petitioner's noncompliance placed its residents in immediate jeopardy and involved failures by Petitioner's direct care staff and management. Petitioner's deficiencies were therefore serious, and Petitioner was culpable at least for neglecting, if not disregarding, its residents' care, comfort, and safety. Therefore, I conclude that a CMP in the bottom third of the immediate jeopardy range for Petitioner's immediate jeopardy noncompliance is reasonable. I also conclude that a CMP of $100 per day for Petitioner's continued non-immediate jeopardy noncompliance is reasonable as Petitioner remained out of compliance with at least two participation requirements even after it abated the immediate jeopardy conditions in its facility. CMS Ex. 1; P. Ex. 2. In addition, I conclude that Petitioner has not raised a genuine issue of material fact related to the duration of the CMPs because Petitioner did not present evidence that it abated immediate jeopardy before November 6, 2014, or returned to substantial compliance before December 1, 2014.[21] I therefore further conclude that the CMPs are reasonable in duration as well.

E. Other issues raised by Petitioner are without merit.

In its prehearing brief, Petitioner challenges the DAB's "policy that imposes the 'burden of proof' on petitioners as a violation of the Administrative Procedure Act . . . ." P. Br. at 25. The allocation of the burden of proof is irrelevant in this case because the evidence, even when viewed in Petitioner's favor, affirmatively establishes Petitioner's noncompliance with 42 C.F.R. §§ 483.13(b),(c)(1)(i) and 483.75. Petitioner also argues that the Medicare Act is violated and Petitioner is deprived of due process if CMS is not required to submit evidence to prove it considered the regulatory criteria established by 42 C.F.R. §§ 488.404 and 488.438(f) in determining enforcement remedies. P. Br. at 25. I reviewed the evidence related to the regulatory factors *de novo* and perceive no prejudice to Petitioner because I did not require CMS to submit evidence related to its consideration of the regulatory factors.

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[21] Indeed, Petitioner submitted as an exhibit a post-certification revisit report from the state agency that states that Petitioner did not correct its deficiencies related to 42 C.F.R. §§ 483.13(b), (c)(1)(i) and 483.75 until December 9, 2014. P. Ex. 2 at 2. Petitioner does not dispute this correction completion date.

VI. Conclusion

I grant CMS's cross-motion for summary judgment, deny Petitioner's motion for summary judgment, affirm CMS's initial determination as explained herein, and order Petitioner to pay the per-day CMPs, totaling $67,500.00, to CMS.

/s/
Scott Anderson
Administrative Law Judge