Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Kenwood Manor
(CCN: 37-5459),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-914

Decision No. CR4401

Date: November 9, 2015

DECISION

Petitioner, Kenwood Manor, is a long-term care facility located in Enid, Oklahoma, that participates in the Medicare program. Over a period of many months, facility staff documented that one of its residents – a registered sex offender who suffered from a variety of mental disorders – repeatedly touched, rubbed, slapped, or otherwise inflicted, upon other residents and staff, uninvited and unwelcome physical contact. He also yelled at them. Contrary to federal requirements and its own policies, the facility neither investigated the incidents nor took meaningful steps to assess the victims and to protect its most vulnerable residents from further abuse. The Centers for Medicare & Medicaid Services (CMS) determined that (among other deficiencies) the facility was not in substantial compliance with Medicare requirements governing abuse. CMS has imposed civil money penalties (CMPs) of $3,050 per day for 251 days of immediate jeopardy ($765,550) and $50 per day for 46 days of substantial noncompliance that did not pose immediate jeopardy ($2,300). Petitioner appeals, and CMS has moved for summary judgment.

As discussed below, the undisputed evidence establishes that, from June 18, 2012, through April 10, 2013, the facility was not in substantial compliance with Medicare

program requirements. From June 18 through October 25, 2012; October 30, 2012 through February 23, 2013; and March 1 through 4, 2013, its deficiencies posed immediate jeopardy to resident health and safety. The penalties imposed are reasonable.

Background

The Social Security Act (Act) sets forth requirements for skilled nursing facilities to participate in the Medicare program and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act § 1819. The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may "pose no greater risk to resident health and safety than the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to survey skilled nursing facilities in order to determine whether they are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. Each facility must be surveyed annually, with no more than fifteen months elapsing between surveys, and must be surveyed more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a), 488.308. The state agency must also investigate all complaints. Act § 1819(g)(4).

In this case, surveyors from the Oklahoma State Department of Health (state agency) completed a survey on March 8, 2013. Based on their findings, CMS determined that the facility was not in substantial compliance with an astonishing number of program requirements, specifically:

- 42 C.F.R. § 483.10(a)(1) and (2) (Tag F151 – resident rights: exercise of rights) at scope and severity level D (isolated instance of substantial noncompliance that caused no actual harm with the potential for more than minimal harm);

- 42 C.F.R. § 483.10(b)(11) (Tag F157 – resident rights: notice of rights and services) at scope and severity level G (isolated instance of substantial noncompliance that caused actual harm that was not immediate jeopardy);

- 42 C.F.R. § 483.10(c)(1) (Tag F158 – resident rights: protection of resident funds) at scope and severity level E (pattern of noncompliance that caused no actual harm with the potential for more than minimal harm);

- 42 C.F.R. § 483.10(c)(2)-(5) (Tag F159 – resident rights: management and deposit of personal funds) at scope and severity level E;

- 42 C.F.R. §§ 483.10(e) and 483.75(*l*)(4) (Tag F164 – resident rights: privacy/confidentiality and administration: clinical records) at scope and severity level D;

- 42 C.F.R. § 483.10(g)(1) (Tag F167 – resident rights: examination of survey results) at scope and severity level D;

- **42 C.F.R. § 483.13(b) and (c)(1)(i) (Tag F223 – abuse and staff treatment of residents), at scope and severity level K (pattern of noncompliance that posed immediate jeopardy to resident health and safety)**;[1]

- **42 C.F.R. § 483.13(c)(1)(ii)-(iii) and (c)(2)-(4) (Tag F225 – staff treatment of residents: investigate and report allegations of abuse) at scope and severity level K**;

- **42 C.F.R. § 483.13(c) (Tag F226 – policies to prohibit abuse and neglect) at scope and severity level K**;

- 42 C.F.R. § 483.15(a) (Tag F241 – quality of life: dignity) at scope and severity level E;

- 42 C.F.R. § 483.15(f)(1) (Tag F248 – quality of life: activities) at scope and severity level E;

- 42 C.F.R. § 483.15(h)(2) (Tag F253 – quality of life: housekeeping and maintenance services) at scope and severity level E;

- 42 C.F.R. § 483.20(b)(1) (Tag F272 – resident assessment: comprehensive assessments/assessment instrument) at scope and severity level E;

- 42 C.F.R. § 483.20(b)(2)(ii) (Tag F274 – resident assessment: comprehensive assessments/when required) at scope and severity level D;

- 42 C.F.R. § 483.20(g) – (j) (Tag F278 – resident assessment: accuracy/coordination/certification) at scope and severity level D;

- 42 C.F.R. § 483.20(d) and (k)(2) (Tag F279 – resident assessment: use and comprehensive care plans) at scope and severity level E;

[1] As I discuss below, Petitioner has not appealed most of the deficiencies cited. This list highlights, in bold, those that are the subject of this appeal.

- 42 C.F.R. §§ 483.20(k)(2) and 483.10(d)(3) (Tag F280 – resident assessment: comprehensive care plans; and resident rights: free choice) at scope and severity level E;[2]

- 42 C.F.R. § 483.20(k)(3)(ii) (Tag F282 – resident assessment: comprehensive care plans/services provided) at scope and severity level E;

- 42 C.F.R. § 483.25 (Tag F309 – quality of care) at scope and severity level G;

- 42 C.F.R. § 483.25(a)(3) (Tag F312 – quality of care: activities of daily living) at scope and severity level E;

- 42 C.F.R. § 483.25(h) (Tag F323 – quality of care: accident prevention) at scope and severity level E;

- 42 C.F.R. § 483.25(*l*) (Tag F329 – quality of care: unnecessary drugs) at scope and severity level D;

- 42 C.F.R. § 483.30(a) (Tag F353 – nursing services: sufficient staff) at scope and severity level E;

- 42 C.F.R. § 483.30(b) (Tag F354 – nursing services: registered nurses) at scope and severity level E;

- 42 C.F.R. § 483.35(d)(1)-(2) (Tag F364 – dietary services: food) at scope and severity level E;

- 42 C.F.R. § 483.35(i) (Tag F371 – dietary services: sanitary conditions) at scope and severity level E;

- 42 C.F.R. § 483.40(a) (Tag F385 – physician services: physician supervision) at scope and severity level E;

- 42 C.F.R. § 483.70(d)(1)(iv)-(v) (Tag F460 – physical environment: resident rooms) at scope and severity level E;

- 42 C.F.R. § 483.70(h) (Tag F465 – physical environment: other environmental conditions) at scope and severity level E;

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[2] Although the survey report form correctly describes the regulatory requirements, it misnumbers the subparagraphs. P. Ex. 8 at 152-3.

- **42 C.F.R. § 483.75 (Tag F490 – administration) at scope and severity level K**; and

- **42 C.F.R. § 483.75 (o)(1) (Tag F520 – administration: quality assessment and assurance) at scope and severity level F (widespread noncompliance that caused no actual harm with the potential for more than minimal harm)**.

P. Ex. 2 at 1-2; *see* P. Ex. 8. CMS also determined that the facility was not in substantial compliance with 42 C.F.R. § 483.70(a) – physical environment: life safety from fire – because surveyors found six violations of the National Fire Protection Association's Life Safety Code. P. Ex. 2 at 2.

Surveyors revisited the facility on April 17, 2013. Based on their findings, CMS determined that the facility returned to substantial compliance on April 11, 2013. P. Exs. 4 at 1, 5 at 1.

CMS has imposed against the facility CMPs of $3,050 per day for 251 days of immediate jeopardy (June 18 through October 25, 2012; October 30, 2012, through February 23, 2013; and March 1 through 4, 2013) and $50 per day for 46 days of substantial noncompliance that was not immediate jeopardy (October 26 through 29, 2012; February 24 through 28, 2013; and March 5 through April 10, 2013), for a total CMP of $ 768,850 ($765,550 + $2,300 = $768,850). P. Exs. 5, 7.[3]

The appeal. Petitioner timely requested review, challenging the deficiencies cited at the immediate jeopardy level – 42 C.F.R. §§ 483.13(b), 483.13(c), and 483.75 – and the deficiencies cited under 42 C.F.R. § 483.75(o)(1) (Tag F520). Petitioner claims that it limits its appeal to these deficiencies because CMS did not provide adequate notice of the deficiencies on which it based the CMP, and Petitioner "assumes" that the penalty was based solely on the deficiencies cited at the immediate jeopardy level.[4] P. Pre-hrg. Br. at 1-2.

CMS, however, submits signed FAX sheets showing that it sent a comprehensive notice letter to the facility on April 1, 2013, and the (then) facility administrator returned to the agency an acknowledgment of receipt dated April 2, 2013. CMS Ex. 1 at 1-2. The April 1 letter lists each and every deficiency upon which the penalty is based. CMS Ex. 1 at 3-4; P. Ex. 2 at 1-2. CMS has thus established that it sent the facility notice of all the

[3] The more serious deficiencies involved the abusive behavior of one resident. In an unusual move, CMS apparently gave the facility a break and removed the immediate jeopardy determination for those days that this resident was away from the facility.

[4] This does not explain why Petitioner challenges the Tag F520 deficiencies, which were cited at a lower level of scope and severity.

deficiencies upon which it based the CMPs. CMS Ex. 1 at 1, 2; CMS Pre-hrg. Br. at 14. Moreover, inasmuch as the state agency provided the facility with a copy of its statement of deficiencies, the facility was well aware of all of the deficiencies cited. P. Exs. 1, 8.

And even if CMS had not previously advised the facility of all those deficiencies, it did so during these proceedings. In its pre-hearing brief, CMS asserted that, because the facility did not appeal the 32 findings of substantial noncompliance that were not immediate jeopardy, those findings are final. CMS Pre-hrg. Br. at 23-24 (citing 42 C.F.R. § 498.20(b)); *see also* CMS MSJ at 3. Petitioner could have responded to CMS's argument, but did not. *See* Acknowledgment and Initial Pre-hearing Order at 2, ¶ 3 (June 21, 2013).

In any event, as I discuss below, CMS has imposed the minimum per day penalties. So long as I affirm even one of the deficiencies cited, I must also affirm the $50 per day penalty. 42 C.F.R. §§ 488.408(d)(1)(iii), 488.438(a)(1)(ii). Here, because I find that the facility was not in substantial with the abuse citations, I need not consider whether Petitioner waived challenging the deficiencies that it did not specifically appeal.

CMS now moves for summary judgment, which Petitioner opposes. The parties filed pre-hearing briefs (CMS Pre-hrg. Br.; P. Pre-hrg. Br.). CMS subsequently filed a motion for summary judgment (CMS MSJ) and Petitioner filed a response (P. Response). Petitioner has submitted 52 exhibits (P. Exs. 1-52). CMS has submitted 50 exhibits (CMS Exs. 1-50).

Issues

As a threshold matter, I consider whether summary judgment is appropriate.

On the merits, the issues are:

1. Was the facility in substantial compliance with the Medicare requirements governing abuse and staff treatment of residents, 42 C.F.R. § 483.13(b) and (c), and those governing administration, 42 C.F.R. § 483.75;

2. If the facility was not in substantial compliance with 42 C.F.R. §§ 483.13(b) and (c) and 483.75, did those deficiencies pose immediate jeopardy to resident health and safety.

With respect to the amount of the CMPs, CMS has imposed the minimum amounts. 42 C.F.R. §§ 488.408(d), 488.408(e)(1)(iii), 488.438(a)(1)(i), 488.438(a)(1)(ii). So long as I find that the facility was not in substantial compliance and that the facility's

substantial noncompliance posed immediate jeopardy, I must affirm those amounts. The facility may not appeal CMS's determination to impose a CMP. 42 C.F.R. § 488.408(g)(2).

Discussion

Summary judgment. Summary judgment is appropriate if a case presents no genuine issue of material fact, and the moving party is entitled to judgment as a matter of law. *Bartley Healthcare Nursing & Rehab.*, DAB No. 2539 at 3 (2013) (citing *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986)); *Ill. Knights Templar Home*, DAB No. 2274 at 3-4 (2009), and cases cited therein.

The moving party may show the absence of a genuine factual dispute by presenting evidence so one-sided that it must prevail as a matter of law, or by showing that the non-moving party has presented no evidence "sufficient to establish the existence of an element essential to [that party's] case, and on which [that party] will bear the burden of proof at trial." *Livingston Care Ctr. v. Dep't of Health & Human Servs.*, 388 F.3d 168, 173 (6th Cir. 2004) (quoting *Celotex Corp. v. Catrett*, 477 U.S. at 323-24). To avoid summary judgment, the non-moving party must then act affirmatively by tendering evidence of specific facts showing that a dispute exists. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 n.11 (1986); *see also Vandalia Park*, DAB No. 1939 (2004); *Lebanon Nursing & Rehab. Ctr.*, DAB No. 1918 (2004). The non-moving party may not simply rely on denials, but must furnish evidence of a dispute concerning a material fact. *Ill. Knights Templar*, DAB No. 2274 at 4; *Livingston Care Ctr.*, DAB No. 1871 at 5 (2003).

In examining the evidence for purposes of determining the appropriateness of summary judgment, I must draw all reasonable inferences in the light most favorable to the non-moving party. *Brightview Care Ctr.*, DAB No. 2132 at 2, 9 (2007); *Livingston Care Ctr.*, 388 F.3d at 172; *Guardian Health Care Ctr.*, DAB No. 1943 at 8 (2004); *but see Brightview*, DAB No. 2132 at 10 (entry of summary judgment upheld where inferences and views of non-moving party are not reasonable). 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. *Cf. Guardian Health Care Ctr.*, DAB No. 1943 at 11 ("A dispute over the conclusion to be drawn from applying relevant legal criteria to undisputed facts does not preclude summary judgment if the record is sufficiently developed and there is only one reasonable conclusion that can be drawn from those facts.").

1. ***CMS is entitled to summary judgment because the undisputed evidence establishes that facility staff allowed one of its residents to abuse other residents. Administration and staff did not follow the facility's policies and procedures for preventing abuse; they did not immediately report or thoroughly investigate instances of abuse, potential abuse, or unexplained injury; and they made inadequate efforts to prevent potential abuse while an investigation was pending. The facility was therefore not in substantial compliance with 42 C.F.R. §§ 483.13(b) and (c) and 483.75.***[5]

Program requirements. "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. 42 C.F.R. § 488.301.

Facility residents have the right to be free from verbal, sexual, physical, and mental abuse. 42 C.F.R. § 483.13(b) (Tag F223). To this end, a facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. 42 C.F.R. § 483.13(c). It must ensure that all alleged violations are reported immediately to the facility administrator and appropriate state officials. The facility must have evidence that all alleged violations are thoroughly investigated, and it must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator (or designated representative) and to the appropriate state officials within five working days of the incident. If the violation is verified, the facility must take appropriate action. 42 C.F.R. § 483.13(c)(2), (3), and (4) (Tags F225, F226).

The facility must also be governed 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 (Tag F490).

Facility policies. The facility had three sets of written policies and procedures for preventing abuse: those governing staff abuse of residents (CMS Ex. 18); those specifically addressing resident-to-resident abuse (CMS Ex. 17); and general abuse prevention policies, which include both (CMS Ex. 16). All three sets reflect program requirements and provide that "[r]esidents must not be subject to abuse by anyone." CMS Ex. 17 at 1; *see* CMS Ex. 16 at 1; CMS Ex. 18 at 1.

The policies reflect the regulatory definition of abuse, 42 C.F.R. § 488.301 (CMS Ex. 17 at 1), and add that abuse includes "any act or omission" that may cause physical, psychological, or emotional harm or injury to a resident or any act that willfully deprives a resident of his rights. Examples include actions such as striking or kicking a resident,

[5] My findings of fact and conclusions of law are set forth, in bold and italics, as captions in the discussion section of this decision.

improper restraint, or other actions "which can be seen as causing physical pain. . . ." CMS Ex. 16 at 1. Acts such as teasing, humiliating, degrading, or intentionally ignoring a resident may also constitute abuse. Non-actions resulting in injury are "viewed in the same manner." CMS Ex. 16 at 1.

According to the general policy, *any* employee who witnesses or has knowledge of an act of abuse to a resident must *immediately* report the matter to the licensed nurse in charge, the director of nursing (DON), and the facility administrator/abuse coordinator. CMS Ex. 16 at 2-3. All reported events, including "inappropriate or abusive behaviors," must be investigated by the DON or her designee. The information gleaned will be forwarded to the facility administrator, who serves as the abuse coordinator. If the administrator is not able, the DON will act as abuse coordinator and will conduct the necessary investigation. CMS Ex. 16 at 3-4. The abuse coordinator must investigate *all* reports of suspected abuse. CMS Ex. 16 at 4.

Once reported, the prescribed forms must be completed and delivered to the abuse coordinator for an investigation. CMS Ex. 16 at 3.

When an incident is reported, the suspect must be segregated from the resident/victim. CMS Ex. 16 at 4. The licensed nurse in charge or the DON must perform and document a thorough nursing assessment and notify the resident/victim's attending physician and responsible party. An incident report must be filed "as soon as possible." CMS Ex. 16 at 4.

The investigator must take written statements from the victim, the suspect, and all possible witnesses. He/she must secure all physical evidence and prepare a detailed report. CMS Ex. 16 at 4. The DON, department manager, abuse coordinator, and one other administrative staff member must review the completed report. The abuse coordinator must refer "any [and] all incidents and reports of resident abuse to the appropriate state agencies." CMS Ex. 16 at 5.

In addition to these general rules, the resident-to-resident abuse policy includes a step-by-step protocol to be followed when abuse is reported:

1. Remove the residents from danger immediately;

2. Move the resident causing the danger to another room or unit, pending investigation;

3. Closely monitor and document the behavior and condition of the residents involved to evaluate any injury and to prevent recurrence of the incident;

4. The policy emphasizes that staff "**MUST**" notify the attending physician and responsible party for all residents involved in the incident;

5. The administrator, DON, or their designee "**MUST**" initiate "**A DOCUMENTED**" investigation within twenty-four hours of the facility's learning of the alleged incident. The investigation includes talking to all those directly or indirectly involved, including family, residents, visitors, and volunteers. The investigator must obtain written statements as necessary;

6. The nurse in charge must complete an incident/accident report;

7. The administrator "**MUST**" notify designated corporate officials of the alleged or actual incident and the ongoing investigation;

8. The administrator, DON, or their designee must notify the adult protective services agency of any alleged abuse per state specific protocols;

9. The administrator, DON, or their designee must notify the State Department of Health of the facility's knowledge of resident-to-resident altercations in which a resident is injured "to the extent that physical intervention and/or transfer or discharge to a hospital is required";

10. The administrator, DON, or their designee must notify local law enforcement of any instance of resident abuse, mistreatment, neglect, or misappropriation of personal property that is a criminal act and in accordance with the Elder Justice Act;

11. The administrator must notify specific corporate officers "immediately" and provide a copy of the investigative report if there is potential for a lawsuit;

12. The facility must develop and document measures to prevent recurrence and include those measures in the resident's plan of care;

13. The facility may consider other measures, including medication changes, psychiatric consultation, and supervision.

CMS Ex. 17 (emphases in original).

The facility also had policies that addressed the facility's response to finding injuries of unknown origin. CMS Ex. 24. The policy defines "injuries of unknown origin" to include bruises that have no known cause. CMS Ex. 24 at 1. When the injury is discovered, staff must immediately notify the facility administrator and the DON. They "**MUST**" also notify the resident's responsible party and the physician. The

administrator, DON, or their designee must begin a "documented investigation of the cause of the injury." The investigation must include interviews with the resident, all staff involved (directly or indirectly), and family, visitors, or volunteers who might have had contact with the resident and could help with the investigation. The investigator should obtain written statements "as necessary." Staff *must* report *all* injuries of unknown origin to the appropriate state agencies. If the investigator finds no reasonable cause to suspect that a staff member or other individual inflicted the injury or that neglect occurred, he/she must thoroughly document, using the investigative report form to show that there is no cause to believe that abuse or neglect by staff caused the injury. The facility must also use its performance improvement process to identify problems and corrective action. It must develop and implement measures, via the performance improvement process, to prevent injuries of unknown origin. CMS Ex. 24 at 1. The policy concludes by recognizing that staff education "is vital" for preventing injuries and mandates that the facility implement such education any time preventable injuries occur. CMS Ex. 24 at 2.

Resident 11's (R11's) aggressive behavior and the facility's response. R11 was a 69-year-old man suffering from Parkinson's Disease, anxiety, and depression. P. Ex. 20 at 1. He had intellectual disability with an IQ composite of 58. P. Ex. 20 at 3. He was also treated for significant problems with impulse control and for inappropriate sexual behavior. P. Ex. 20 at 1-2. He took several psychotropic medications, including Depakote for impulse control and Estradiol (estrogen) to attempt to control his "inappropriate sexual behavior." P. Ex. 20 at 1.

R11 was an imposing figure, standing 6 ft. 2 in. tall and weighing 245 pounds. CMS Ex. 48.

He had a significant criminal record. In December 1989, he was convicted of assault with a deadly weapon. CMS Ex. 3 at 3. In January 2003, he was convicted of lewd molestation because he sexually abused a six-year-old boy. CMS Ex. 2; P. Ex. 25 at 9-10. The court sentenced R11 to 10 years in prison, but suspended that prison term. In lieu of prison (and due to his medical issues), he was admitted to the facility.[6] P Ex. 25 at 11.

According to his March 11, 2012 assessment, R11 exhibited "verbal behavioral symptoms" toward others, such as threatening, screaming, and cussing. CMS Ex. 12 at 10.

His care plan, dated March 30, 2012, reiterates that R11 could "demonstrate verbally abusive behaviors." In response, staff were to document, in a behavior log, R11's observed behavior and staff's attempted interventions; they were to intervene when he became agitated, before his agitation escalated, guiding him away from the source of his

[6] The unsavory details of R11's crimes are set forth in CMS Exs. 2 and 4.

distress and calmly engaging him in conversation. If he responded aggressively, they were to walk away. Staff were also instructed to analyze and document the key times, places, circumstances, triggers, and the measures taken that successfully de-escalated the behavior. Subsequent handwritten notes indicate that, on June 23, 2012, and September 23, 2012, R11 continued to be counselled for his abusive behavior. P. Ex. 10 at 12; *but see* CMS Ex. 8 at 11.[7] The care plan identifies that R11 had a "mood problem" and also took anti-anxiety medications, noting that as a "paradoxical side effect," R11 could exhibit "[m]ania, [h]ostility and rage, [a]ggressive or impulsive behavior, [h]allucinations." P. Ex. 10 at 8, 15.

The care plan does not identify as a problem sexually inappropriate behavior and does not include interventions to address such behavior.

The record includes behavior logs from June 2012 through April 2013. They document repeated instances of R11's "anger/pouting" and "yelling at others." P. Ex. 12. More specifically, the nursing notes and treatment reports document repeated instances of R11's aggressive and "sexually inappropriate behaviors" (which he generally inflicted on the facility's most defenseless residents):

- A nursing note dated June 18, 2012, indicates that staff observed R11 "rubbing [a] female resident's legs." Staff told him that he could not do that without the resident's consent, and he "verbalized understanding." P. Ex. 9 at 4. The victim is not identified, and she was not interviewed or assessed. The incident was not reported to the victim's family, nor to any physician, nor to the facility administrator. The facility did not investigate or add the behavior to R11's care plan.

- Another note, dated July 13, 2012, documents R11's "inappropriately touching other residents." Staff told him to keep his hands off others and, according to the note, he folded his arms and began to pout. P. Ex. 9 at 4. The affected residents were not identified, interviewed, or assessed. Staff did not report or investigate. No changes were made to R11's care plan.

- On July 30, 2012, R11 was falling asleep at the breakfast table. When a nurse aide offered to take him back to his room for a nap, he "became hateful [and] began yelling." P. Ex. 9 at 5.

[7] Inexplicably, the record contains two similar, but not identical versions of R11's care plan. Both identify the verbally abusive behaviors and include similar instructions to staff. But CMS's version includes a different set of handwritten notes. A note dated June 12 says that staff is able to redirect or remove R11 when a behavior occurs and that he sees a counselor. A note dated January 11, 2013 says "continue [with] current recommendation." CMS Ex. 8 at 11.

- On August 17, 2012, R11 was evaluated by a psychiatric nurse practitioner at Millennium Medical Services. Her report indicates that facility staff had reported R11's "inappropriate sexual behavior toward a male peer," and a history of "inappropriate touching of female peers that are not his girlfriend." R11 claimed that he was "comforting" the other resident by stroking his inner thigh. The nurse practitioner prescribed Depakote for "impulsive behavior." P. Ex. 20 at 8.

- A nurse's note, dated August 21, 2012, indicates that R11 was "hateful to other residents [at] the breakfast table." Staff provided one-on-one supervision, redirected him, and notified the facility administration of his behavior. P. Ex. 9 at 9.

- On September 14, 2012, the nurse practitioner from Millennium Medical Services noted the recent Depakote prescription to address R11's impulse control (or lack of it) and to treat his "inappropriate sexual behavior toward male and female peers." Despite noting that R11 was "doing better," the nurse practitioner continued to document R11's "poor impulse control." P. Ex. 20 at 9.

- On September 25, 2012, staff observed R11 in the dining room "kissing another resident." When told the behavior was inappropriate, he became hateful[,] demanding[,] yelling at staff." According to the note, staff redirected and provided one-to-one supervision but with no result. P. Ex. 9 at 16.

- An October 2, 2012 note says that R11 was observed "lifting another resident." According to the note, he had been told "multiple times" that such behavior was inappropriate. Staff informed the administration. P. Ex. 9 at 17.

- On October 19, 2012, facility staff notified Dr. Garrett Shelton's office (R11's physician) that R11 "continues to exhibit inappropriate sexual behavior [with] staff [and] guests." The physician ordered more Depakote "to assist with mood stabilization." P. Ex. 9 at 17.

- On October 24, 2012, two nurses and a nurse aide entered the dining room and observed R11 "rubbing another resident's thigh." They told him to keep his hands to himself. He told them that he didn't know why he touched other residents, knowing that it was inappropriate. They asked him what would happen *if* "*he did it to someone who was mentally alert*," and he conceded that he would "probably get hit." P. Ex. 9 at 19 (emphasis added). Staff reported the incident to the administrator, director of nursing (DON), and Dr. Shelton. P. Ex. 9 at 19, *see* P. Ex. 13 at 2; P. Ex. 20 at 6; CMS Ex. 6 at 6.

- The following day, facility staff sent R11 to a psychiatric facility, where he was briefly admitted. P. Ex. 9 at 19. On October 26, 2012, he underwent a psychiatric evaluation, performed by Dr. Michael Feldman. Dr. Feldman reported that R11 had "been showing increasing sexual inappropriateness, touching both men and women and *targeting residents that are either paraplegic or blind*." P. Ex. 20 at 6 (emphasis added). R11 was also verbally aggressive toward staff. CMS Ex. 5 at 1; P. Ex. 20 at 6. He was diagnosed with an impulse control disorder and anxiety disorder. CMS Ex. 5 at 2; P. Ex. 20 at 7. Among his other medications, he was prescribed Estradiol, a female hormone, to treat his "inappropriate sexual behavior." CMS Ex. 6 at 3.

On October 30, R11 returned to the facility. P. Ex. 9 at 19.

- On November 1, 2012, staff observed R11 in the day area with his "girlfriend sitting on his lap." He had removed his estrogen patch. Staff told him that the behavior was inappropriate and informed the administration and the director of nursing. P. Ex. 9 at 20.

- The following day, November 2, R11 was up in the common area "rubbing his genitals inside [his] pants." Staff redirected and he stopped the behavior. P. Ex. 9 at 20. Staff did not report the behavior.[8]

- A psychiatric progress note, dated November 16, indicates that R11 was still behaving inappropriately, "most recently today" (although I see no note or report of such behaviors that day). His Depakote was increased. P. Ex. 20 at 11.

[8] Petitioner accuses CMS of "distorting the facts" because it characterizes this behavior as "masturbation." P. Response at 7. I do not consider this a distortion but a reasonable inference to be drawn from the documentary evidence. But it is not the only reasonable inference, and, for summary judgment purposes, I must draw all reasonable inferences in the light most favorable to the nonmoving party. I therefore do not characterize the behavior as public masturbation. But I also reject Petitioner's suggestion that R11's genitals itched because he had prostatitis, which, based on the evidence is not a reasonable inference. P. Response at 8. First, nowhere in the record is there any suggestion that R11 suffered itching related to prostatitis, for which he would (or should) have been examined and treated. Second, the staff member observing his behavior did not suggest that his genitals were irritated and itching and thus in need of treatment. She described his conduct as "inappropriate" and stopped the behavior. The uncontroverted evidence thus establishes that he was publically rubbing his genitals. Whatever his motivation, such conduct may certainly cause an observer psychological or emotional harm and thus falls within the facility's definition of abuse. CMS Ex. 16 at 1.

- Social Service notes summarizing the months of September, October, and November 2012 refer to R11's inappropriately touching other residents, specifically *those who* "*cannot tell him to stop*," and touching a resident on the thigh. P. Ex. 13 at 2 (emphasis added). The notes confirm that the facility response was to tell him to keep a distance between himself and others. When he removed his hormone patch, they told him not to. P. Ex. 13 at 2.

- On December 22, 2012, staff reported that R11 "flicked water at another resident." The nurse spoke to him, told him that it was inappropriate, and removed him from the area. P. Ex. 9 at 22.

- On January 2, 2013, staff observed him rubbing the arms of another resident and told him to keep his hands to himself. He became angry and started "pouting." P. Ex. 9 at 24.

- A nurse's note, dated February 10, 2013, indicates that R11 was in the common area when he started yelling at one of the nurse aides. The nurse aide reported that R11 and another resident had been making fun of and "getting aggressive with" a non-verbal resident. Staff told him to go to his room and return when he was calm. P. Ex. 9 at 29.[9]

- On February 17, 2013, he was again yelling at another resident. Staff redirected him and he stopped. Later that same day, a nurse aide reported that R11 "hit another resident in the butt and tried to hit him in the face." A visitor confirmed that R11 had slapped the resident on the butt and, when the resident tried to walk away, R11 "raised his fist to him." The nurse reported the incident to the DON and to the facility administrator. R11 was "redirected to his room." P. Ex. 9 at 30. The following day, the DON and the facility administrator questioned the residents about the incident. According to the nurse's note, the residents claimed that the incident was "all done in fun." The DON and administrator reminded R11 that he was not allowed to touch the other residents and should refrain from putting himself in situations where hitting might arise. P. Ex. 9 at 30.

- On February 23, 2013, staff again observed R11 grabbing a staff member and hitting her "on the butt." According to the note, he had been doing this to the same staff member throughout the week. The nurse consulted R11's physician and sent him to the local hospital's emergency room, which then transferred R11 to the psychiatric facility. P. Ex. 9 at 31; P. Ex. 20 at 4.

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[9] As discussed below, on this day, staff reported that R11's roommate had suffered bruising of unknown origin.

- On March 1, 2013, R11 underwent another psychiatric evaluation, again performed by Dr. Feldman. Dr. Feldman noted that R1 exhibited "increased aggressive behaviors directed toward both nursing staff as well as another male resident within the nursing home." Among his disturbing behaviors, he was "stalking" the other male resident, tried to pour hot liquid on the resident, pointed his finger as if shooting at the resident, and attempted to strike the resident. CMS Ex. 6 at 1; P. Ex. 20 at 4. R11 told the psychiatrist that he patted the male resident on the backside but denied that he did so in an aggressive manner. He promised to keep his hands to himself. CMS Ex. 6 at 2.

On March 1, 2013, R11 returned to the facility. P. Ex. 9 at 31.

- On March 2, 2013, staff observed R11 "placing his hands on another resident's legs below the table." P. Ex. 9 at 32. Staff redirected R11 and the behavior stopped. But half an hour later, R11 was arguing with another resident. Staff again redirected. P. Ex. 9 at 32. Again, the resident he touched was not identified, interviewed, or assessed, and staff failed to report the incident to R11's physician, the victim's family or physician, or the facility administrator. No one investigated.

- On March 3, 2013, a nurse aide reported that R11 had been going to her hall, where he was not allowed. P. Ex. 9 at 32.

The surveyors arrived at the facility on March 4. At 9:15 p.m. that day, staff contacted the physician covering for Dr. Shelton and reported that R11 was "possibly placing other residents at risk for abuse." They put R11 in a private room with one-on-one supervision. The physician told staff: "You need to find him a new [doctor]." P. Ex. 9 at 33; P. Ex. 8 at 36.[10] R11 remained closely supervised until March 6, when staff asked Dr. Washburn about transfer to the emergency room for evaluation and possible psychiatric placement. But the doctor said that the facility was providing a sufficient level of supervision. P. Ex. 9 at 33. In fact, even though the one-on-on level of supervision continued, subsequent events cast significant doubt on its adequacy.

- On March 8, 2013, R11 and a female resident were sitting near each other touching each other's arms. Staff redirected and told them to keep their hands to themselves. P. Ex. 9 at 34.

- On March 13, 2013, R11 kissed or attempted to kiss the nurse aide who was supervising him. Staff reported the incident to the facility administrator, who

[10] No one has explained what the doctor meant by this or why he said it, although it appears that R11 soon had a new primary care physician, Dr. Washburn. *See* P. Ex. 9 at 35-48.

reported it to the facility's regional office. The following day, the staff member resigned because of the incident. P. Ex. 9 at 36. Her disturbing report reads as follows:

> [R11] went to get up to go to the bathroom and almost fell. I told him not to [fall] and he said how about falling for you. I told him as long as he [doesn't] hit the floor[.] It would hurt. He then put his arms around me and walked to the bathroom. At the door he leaned in and kissed me on the cheek. I told him he can't do that[;] he said it would be alright. I told him we both would be in trouble[.] He said not if anyone didn't catch us. I told him they always catch [us].

P. Ex. 9 at 37.[11]

Resident 29's (R29's) injuries and the facility's response. As noted above, when R11 acted out, staff sometimes sent the angry resident to his room until he calmed down. During most of this period, his room was at the back of the facility, at the end of the hall, near an exit door. CMS Ex. 14 at 2; CMS Ex. 28; CMS Ex. 45 at 3 (Roth Decl.). R11 was not alone in that room; he had a roommate – R29.

R29's diagnoses included seizures, atrial fibrillation, dysphagia, and Alzheimer's disease. He had "no discernable consciousness" and was totally dependent on staff for all of his activities of daily living. P. Ex. 8 at 49-50; P. Ex. 19 at 2, 8; CMS Ex. 45 at 3 (Roth Decl.). R29 was completely defenseless.

On February 10, 2013, a nurse aide reported "discoloration of the skin on [R29's] side." One of the nurses also reported that R29's gums had been bleeding excessively. The nurse contacted his physician, suggesting a blood test to measure how quickly his blood was clotting (INR). The physician said that he had a current test and another was scheduled soon. P. Ex. 22 at 1.[12]

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[11] I recognize that this report raises as many questions about the nurse aide's response and training as it does R11's behaviors. But that hardly strengthens Petitioner's case.

[12] Those tests appear to indicate relatively normal prothrombin times. P. Ex. 19 at 12, 13. In his written declaration, R29's physician suggests that anticoagulant therapy could cause bruising, but does not discuss the prothrombin times or point to any evidence that it actually did so in this instance (except for the fact that the therapy can contribute to bruising). P. Ex. 51 at 2-3 (Washburn Decl. ¶ 12). Of course, had the physician believed that R29's anticoagulant therapy caused the bruising, serious questions would arise regarding his refusal to order additional testing or to alter the therapy.

A note dated February 11 describes a bruise on R29's left side as "dark purple, slightly warm, with slight dependent edema." P. Ex. 22 at 2.

On February 12, a nurse aide reported bruising on R29's left back. P. Ex. 22 at 1.

A nurse's note dated February 25, 2013, describes a "grape fruit-sized purple and green bruise to top of [left] ribcage" with "no previous documentation noted."[13] P. Ex. 22 at 3. The nurse prepared an incident report, put the report in the administrator's box, left a phone message for the resident's physician, and reported the bruise to the incoming nurse. P. Ex. 22 at 3; *see* P. Ex. 19 at 4, 6-7. Curiously, a weekly skin integrity check, dated February 26, does not mention the bruise. P. Ex. 19 at 15; *see* P. Ex. 22 at 4. The bruise was very large. When the surveyors saw it on March 7, they assessed it as approximately eight inches long and six inches wide. Staff told them that it had been even larger. P. Ex. 8 at 76.

The record includes no nurses' notes for R29 from February 28 through March 3.

On the day the surveyors arrived (March 4), staff contacted R29's physician and reported that the resident "was possibly at risk of abuse" from his roommate and, for his own safety, he was moved to another room, closer to the nurses' station. P. Ex. 22 at 6.

Facility staff also finally sent the state agency an incident report describing R29's "injury of unknown source." According to the report, the DON began investigating the injury on March 3, three weeks after the first bruise was reported. She determined that staff had caused the injury when they used the wrong size sling during transfers involving a full body lift. CMS Ex. 26 at 2.

For purposes of summary judgment, I accept this as true, but find it not material. Moreover, this hardly establishes the facility's substantial compliance with program requirements. Using the wrong transfer device, resulting in significant injury, constitutes a serious deficiency that, in this case, caused actual harm. Each resident must receive adequate assistance devices to prevent accidents. 42 C.F.R. § 483.25(h).

On March 4, facility staff finally notified R29's sister of the injury and told her that her brother had been transferred to another room. P. Ex. 22 at 6.

Substantial noncompliance. Petitioner does not challenge any of these facts, all of which come directly from the facility's own documents. *See generally* P. Response. Indeed, Petitioner's witnesses concede that the facility "was deficient for not promptly reporting and investigating [R29's] discoloration." P. Ex. 28 at 6 (Nay Decl. ¶ 19); P. Ex. 51 at 3

[13] I cannot tell whether this bruise above the left ribcage is the same as the one(s) that were described as on R29's back and/or side.

(Washburn Decl. ¶ 14) (conceding that the facility's failure to investigate and report the injury timely "may be a deficient practice").

But Petitioner and its witnesses dismiss the possibility that sending R11 back to his room exposed R29 to potential abuse. I accept, for purposes of summary judgment, that R29's injuries were caused by staff improperly using the wrong size sling. But facility staff could not have known the cause of the injuries until they launched an investigation. In the meantime, they did not even entertain the possibility that R29's roommate – who had impulse control issues and, on the day the bruises first appeared, had been sent into the room until he "calmed down" – could have been implicated. P. Ex. 9 at 29 (documenting that staff sent R29 to his room after they discovered him teasing and "getting aggressive with a non-verbal resident"). Obviously, these circumstances do not establish that R11 caused R29's injuries. But they should have alerted staff that R11 could have been responsible, and, until that possibility was eliminated, staff were obligated to keep R29 safe. Exposing a frail and defenseless resident to an angry and aggressive resident with impulse control problems puts the defenseless resident at significant risk.

Staff ignored virtually every policy instruction in place for responding to injuries of unknown origin. They did not immediately report the bruise to the administrator and DON. Although an unexplained bruise was first noted on February 10, no evidence establishes that staff notified the administrator until February 25, when the nurse put an incident report into the administrator's box. P. Ex. 22 at 3. Staff did not notify R29's sister until March 4. P. Ex. 22 at 6. The DON began her investigation on March 3. P. Ex. 26 at 2. Staff did not report to the appropriate state agency. Without regard to any dangers posed by R11, the facility's response – or lack of response to the bruising – is sufficient to establish substantial noncompliance with 42 C.F.R. §§ 483.13(b) and (c).

With respect to the other allegations of abuse, Petitioner relies on the opinions of its expert witnesses to argue that no evidence "supports the allegation" that R11 was abusive, caused any injury to residents or staff, or engaged in sexually inappropriate behavior. P. Response at 3; P. Ex. 27 at 2-3 (Crecelius Decl. ¶¶ 7, 9, 10, 11); P. Ex. 28 at 3-4 (Nay Decl. ¶¶ 11, 12, 14); P. Ex. 29 at 6 (Ziv Decl. ¶ III). These witnesses have no personal knowledge of the underlying facts, but claim to rely on their review of the record in this case. P. Ex. 27 at 2 (Crecelius Decl. ¶ 7); P. Ex. 28 at 1 (Nay Decl. ¶ 1); P. Ex. 29 at 1-2 (Ziv Decl. ¶ 1A). But their conclusions are not only unsupported, they fly in the face of the unchallenged facts. To accept these unsupported conclusions, I would have to ignore R11's medical records and conclude that the nurses who wrote the notes cited above and the psychiatrists and staff who assessed and treated R11 mischaracterized his condition and his behaviors. He was, after all, admitted to a psychiatric facility "due to increased aggressive behaviors and inappropriate sexual behaviors." P. Ex. 20 at 1. Moreover, if R11 did not engage in sexually abusive behaviors, how does the facility justify his medication, particularly the Estradiol? *See* 42 C.F.R. § 483.25(*l*)(1)(iv) (requiring adequate indications for a drug's use).

Further, the problem with Petitioner's claim that R11's conduct caused no injury to any of the residents he touched, teased, yelled at, or otherwise menaced is that, contrary to the requirements of the regulations and the facility's own policies, staff repeatedly failed to assess R11's victims, a serious omission for which it cannot now benefit. Failing to assess the welfare of a vulnerable resident victimized by abusive behavior has the potential for causing more than minimal harm and, by itself, justifies a finding of substantial noncompliance with 42 C.F.R. § 483.13(b) and (c). CMS need not establish actual harm. 42 C.F.R. § 488.301.

Each of Petitioner's experts simply reviews the record and opines on the ultimate – legal – conclusion. Petitioner admits as much, declaring that "CMS and Petitioner have stated diametrically opposing positions on the central issue – whether [R11] caused or was likely to cause serious harm that constituted immediate jeopardy." P. Response at 4. But an expert opinion on the ultimate legal issue does not create a material fact in dispute that would preclude summary judgment, particularly where, as here, that opinion is premised on statements that no rational trier of fact would accept. *Bartley Healthcare Nursing & Rehab.*, DAB No. 2539 at 8.

Petitioner's witnesses make additional statements that are unsupported and irrelevant.[14] Witnesses Nay and Crecelius claim that, in nine years, R11 was never involved in or charged with sexually inappropriate behaviors or physical altercations. P. Ex. 28 at 3 (Nay Decl. ¶ 11); *see* P. Ex. 27 at 2 (Crecelius Decl. ¶ 8). First, whatever occurred prior to this survey cycle is irrelevant. Even if it were relevant, none of Petitioner's expert witnesses claim any independent knowledge of what went on at the facility at any time, much less during the nine years preceding the dates of substantial noncompliance. They cite no support for the claim, and, based on the record before me, we simply don't know what went on prior to March 2012, except that, by March 2012, R11 had been "threatening, screaming, and cussing" at people. CMS Ex. 12 at 10. Based on his psychiatric records, we also know that his behaviors were escalating; his psychiatrist reported "increasing sexual inappropriateness" and "increased aggressive behavior." CMS Ex. 5 at 1; CMS Ex. 6 at 3; P. Ex. 20 at 1, 6.

The witnesses also accuse CMS of "extrapolating from . . . one event with a six-year-old boy in 2004. . . ." P. Ex. 28 at 3 (Nay Decl. ¶ 11). Again, this claim is not only wrong but irrelevant. It reflects a fundamental misunderstanding of the nature of these *de novo* proceedings. I am not concerned with the means by which CMS reached its

[14] Although the witnesses signed their declarations weeks after CMS determined the final penalty amount, they were apparently not aware that CMS imposed the minimum CMPs. *See* P. Ex. 7. They claim that the CMP is almost double the actual amount. P. Ex. 27 at 2 (Crecelius Decl. ¶¶ 5, 6); P. Ex. 28 at 3 (Nay Decl. ¶ 8). Nor did Witness Nay know that CMS sent the facility a notice letter that detailed the deficiencies upon which it based the CMPs. P. Ex. 2; CMS Ex. 1 at 1, 2; P. Ex. 28 at 3 (Nay Decl. ¶ 8).

determination; rather I take a "fresh look" at the legal and factual bases for the deficiency findings underlying the remedies to determine whether those findings and remedies accord with the Act and regulations. *Britthaven of Chapel Hill*, DAB No. 2284 at 6 (2009), and cases cited therein.

Thus, my finding of noncompliance here is not arrived at by "extrapolating from" R11's child abuse conviction, his assault conviction, or any other event that pre-dates the relevant time period. Indeed, my focus is on the *facility's* actions (or inaction), not R11's history. The facility was not in substantial compliance because its own records establish that, during the relevant time period, facility staff did not keep their residents safe from abuse, and they failed to assess, investigate, or report repeated allegations and evidence of abuse.

Further, although the undisputed facts show that R11 engaged in sexually inappropriate behaviors, even that finding is not material to the outcome of this case. Whether R11 was motivated by a desire for sexual gratification or some other reason does not change the reality that facility residents – including its most vulnerable residents – were touched, yelled at, teased, menaced, and not adequately protected by facility staff. The potential for harm to the victims of such conduct – not the underlying reasons for it – drives the finding of substantial noncompliance.

Willful intent. Without pointing to any evidence, Petitioner suggests that a factual dispute regarding whether R11 possessed the requisite "willful" intent required for abuse precludes entry of summary judgment. P. Response at 15. First, to preclude summary judgment, Petitioner may not rely on denials, but must come forward with admissible evidence of a dispute, which it has not done. And the argument fails for other reasons. R11 was unquestionably a difficult resident who had trouble controlling his impulses. But no evidence establishes that he was unable to control himself or could not have learned to control himself. Indeed, the facility's interventions – limited as they might have been – were premised on the presumption that he *could* control his behaviors.

Moreover, without regard to the state of R11's impulse control, so long as his actions are "deliberate" rather than accidental or inadvertent, they are considered "willful" within the meaning of the regulation. *Merrimack Cnty. Nursing Home*, DAB No. 2424 at 5 (2011); *cf. Singing River Rehab. & Nursing Ctr.*, DAB No. 2232 (2009) at 13 (suggesting that, so long as a mentally ill resident did not act "by accident," his conduct was abusive).

Finally, the regulations and facility policies require the facility to report and investigate thoroughly *all alleged* violations. Even if I agreed that these incidents were not abuse (which I do not), they were significant enough to trigger the facility's obligation to investigate and report. 42 C.F.R. § 483.13(c).

The facility was required to keep its residents free from abuse. 42 C.F.R. § 483.13(b). Section 483.13(c)(1)(i) puts the onus on it to protect its residents by developing and implementing policies that prevent resident-to-resident abuse. *See, e.g.*, *Martha & Mary Lutheran Servs.*, DAB No. 2147 at 12-13 (2008) (finding substantial noncompliance with section 483.13(c) where facility staff failed to implement facility policies and procedures to prevent resident-to-resident abuse). Because the facility here did not keep its residents free from abuse and did not implement its own policies for preventing abuse, it was not in substantial compliance with sections 483.13(b) and 483.13(c).

Administration. A finding of substantial noncompliance in the facility's administration may derive from findings of substantial noncompliance in other areas.

> [W]here 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); *Stone Cnty. Nursing & Rehab. Ctr.*, DAB No. 2276 at 15-16 (2009); *Odd Fellow & Rebekah Health Care Facility*, DAB No. 1839 at 7 (2002). As discussed below, I find that the facility's deficiencies posed immediate jeopardy to resident health and safety, which, by itself, justifies the finding that the facility was not in substantial compliance with 42 C.F.R. § 483.75.

Moreover, as the above discussion establishes, the failures here were directly attributable to administrative, as well as staff, failures. The facility's administration, as well as its staff, disregarded facility policies in failing to investigate thoroughly and report allegations of resident abuse. It also fell short in protecting residents from a potential abuser. The facility was therefore not administered in a manner that used its resources effectively to attain or maintain the highest practicable physical, mental, and psychosocial well-being of its residents and was not in substantial compliance with 42 C.F.R. § 483.75.

2. CMS's determination that the facility's substantial noncompliance with 42 C.F.R. §§ 483.13(b) and (c) and 483.75 posed immediate jeopardy to resident health and safety is not clearly erroneous.

Immediate jeopardy. 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. CMS's determination as to the level of a facility's noncompliance (which would include an immediate jeopardy finding) must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board has observed repeatedly that the "clearly

erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy, and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1931 at 27-28 (2004) (citing *Koester Pavilion*, DAB No. 1750 (2000)); *Daughters of Miriam Ctr.*, DAB No. 2067 at 7, 9 (2007).

The undisputed facts establish that R11 verbally and sexually abused facility residents, particularly those who were least able to defend themselves. Multiple facility employees – including the employee specifically charged with implementing the facility's abuse policies – repeatedly disregarded those policies in critical respects: reporting, protecting the residents, and investigating. Most alarming was their almost-complete disregard of the welfare of R11's victims. Although staff stepped in to stop the immediate abuse (including sending R11 back to his room), in virtually every case, they failed to assess the victim; they failed to investigate the incident; they never reported to the victim's responsible party or the victim's physician; they never reported to the appropriate state agency; and they only sporadically reported the incidents to the facility administrator, R11's responsible party, or R11's physician.

The undisputed facts also establish that facility staff failed to take any measures to protect R29 after discovering a large bruise on his body. Staff made no immediate attempt to investigate and determine the exact cause of the bruising and did not consider that R29 roomed with a potentially aggressive resident who had problems controlling his impulses.

Such disregard for the policies in place to protect residents from abuse puts those residents at risk, and the situation is likely to cause serious harm. CMS's determination that the deficiencies posed immediate jeopardy to resident health and safety is therefore not clearly erroneous.

Conclusion

The uncontroverted evidence establishes that, from June 18, 2012 through April 10, 2013, the facility was not in substantial compliance with Medicare participation requirements, and, from June 18 through October 25, 2012; October 30, 2012 through February 23, 2013; and March 1 through 4, 2013, those deficiencies posed immediate jeopardy to resident health and safety.

Because CMS has imposed the minimum penalty amounts – $3,050 per day for the period of immediate jeopardy and $50 per day for the period of substantial noncompliance – I must affirm those amounts.

I therefore grant CMS's motion for summary judgment.

/s/
Carolyn Cozad Hughes
Administrative Law Judge