**Department of Health and Human Services**

**DEPARTMENTAL APPEALS BOARD**

**Civil Remedies Division**

Countryside Rehabilitation and Health Center
(CCN: 10-5587),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-918

Decision No. CR4861

Date: June 8, 2017

# DECISION

Countryside Rehabilitation and Health Center (Countryside or Petitioner) challenges the Centers for Medicare & Medicaid Services' (CMS) determination that it was not in substantial compliance with Medicare program participation requirements, which placed residents in immediate jeopardy of harm. Countryside also challenges CMS's imposition of an $803,050 civil money penalty (CMP). For the reasons discussed below, I affirm CMS's determination and conclude that the CMP amount is reasonable.

## I. Background

The Social Security Act (Act) sets forth requirements for a Skilled Nursing Facility (SNF)'s participation 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. "Noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." 42 C.F.R. § 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 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). Relevant to the current case, 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). "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 administrative law judge (ALJ) to challenge the noncompliance finding and enforcement remedy. 42 U.S.C. §§ 1320a-7a(c)(2), 1395i(h)(2)(B)(ii)); 42 C.F.R. §§ 488.408(g), 488.434(a)(2)(viii), 498.3(b)(13).

Countryside is a SNF located in Palm Harbor, Florida, that participates in the Medicare program. Resident 1 had diagnoses including psychosexual disorder, depressive disorder, intellectual disability NOS (unspecified intellectual disabilities), and late effect Cerebrovascular Disorder. CMS Ex. 17 at 2. Resident 1 was admitted to Countryside on December 9, 2011, from a hospital, at which time he was noted to have a police monitoring ankle bracelet in place, alerting Countryside to his possible criminal history. CMS Ex. 2 at 7; CMS Ex. 17 at 4, 103.

On March 29, 2013, the Agency for Health Care Administration for the state of Florida completed an unannounced complaint survey at Countryside's facility. During an interview with Resident 2 conducted on March 26, 2013, the resident told surveyors that Resident 1, his roommate, touched his inner thigh and genitalia in an inappropriate manner several days before. He stated that he had reported the incident to the certified nursing assistant (CNA) caring for him and that he could not defend himself from the assault. Resident 2 had diagnoses including quadriplegia and contractures. Resident 1 was a known convicted sexual offender who had previously exhibited predatory behaviors toward Resident 4, a 25 year old vulnerable, dependent resident, as well as

facility staff members. The CNA indicated to surveyors that she did not have any training or in-services regarding Resident 1's medical condition – she had just "heard things from other staff members." CMS Ex. 1 at 2-3; CMS Ex. 2 at 4-5.

Surveyors also interviewed Countryside's Administrator, Sandra Ryczek, who indicated she was aware of the latest incident on March 18, 2013, when Resident 1 had inappropriately touched his roommate, Resident 2. She stated she had instructed the nurse to place Resident 1 on 1:1 monitoring and then authorized Resident 1 to be moved to Resident 3's room on the morning of March 19, 2013. When the Administrator was asked at that time why the resident was moved to a room with another resident, she stated that they had no private rooms available. CMS Ex. 1 at 4; CMS Ex. 2 at 6.

Surveyors reviewed Countryside's nursing notes and saw that Resident 1 was placed on 1:1 monitoring for inappropriate behavior on March 18, 2013, at 11:00 p.m. The last nursing note for Resident 1, dated March 19, 2013, at 2:00 p.m., stated Resident 1 remained on 1:1 monitoring. The surveyors concluded there was no additional documentation in the nursing notes of continuous 1:1 monitoring of Resident 1. CMS Ex. 1 at 4. Law enforcement removed Resident 1 from the facility on March 20, 2013. CMS Ex. 1 at 4-5; CMS Ex. 2 at 6.

A state surveyor interviewed Resident 1's former probation officer on March 26, 2013, who stated the resident had been admitted to the facility while on probation for "Unlawful Sexual Activity with Certain Minors 16/17 years old." CMS Ex. 1 at 6; CMS Ex. 14 at 5. The officer made recurring probation visits to Countryside until the resident came off probation on May 31, 2012, and the officer personally removed the ankle monitoring bracelet from Resident 1. CMS Ex. 1 at 6; CMS Ex. 2 at 7-8.

On March 27, 2013, surveyors interviewed the local law enforcement officer who performed the investigation of the alleged incident with Residents 1 and 2. The officer had arrested Resident 1 at the facility on March 20, 2013, after Resident 1 admitted to him that he touched Resident 2 inappropriately. In addition, the officer felt the resident was competent to understand the charges due to the resident's 13/15 "BIMS" (Brief Interview Mental Status) score. CMS Ex. 1 at 5; CMS Ex. 2 at 6-7.

At the conclusion of the survey, the surveyors completed a CMS-2567 Statement of Deficiencies (SOD) specifying their findings and conclusions. CMS Ex. 1. CMS adopted those findings and conclusions, which included the determination that Petitioner's actions placed residents in immediate jeopardy commencing on September 4, 2012. CMS Ex. 5 at 1. CMS imposed a $6,850 per day CMP commencing on September 4, 2012, which would continue until Petitioner achieved substantial compliance with SNF standards. CMS Ex. 5 at 2. CMS also warned that it would impose a denial of payment

for new admissions on April 18, 2013, if Petitioner did not return to compliance by that date, and a termination of Petitioner's provider agreement on April 21, 2013, if immediate jeopardy was not abated by that date. CMS Ex. 5 at 2-3.

Based on an April 19, 2013 revisit survey, CMS determined that Petitioner still failed to be in substantial compliance with SNF standards, but that immediate jeopardy ceased on April 4, 2013, and, as a result, CMS imposed the $6,850 per day CMP from September 4, 2012 through April 3, 2013. CMS Ex. 6 at 1-2. However, due to the continued existence of substantial noncompliance, CMS also imposed a $100 per day CMP commencing April 4, 2013, and the denial of payment for new admissions commencing April 18, 2013. CMS Ex. 6 at 2.

Based on a May 15, 2013 second revisit survey, CMS determined that Petitioner returned to substantial compliance on April 19, 2013, which resulted in CMS lifting the denial of payment for new admissions and ceasing the $100 per day CMP as of April 20, 2013. CMS Ex. 7. Therefore, CMS imposed a CMP of $6,850 per day for 212 days of immediate jeopardy (September 4, 2012, through April 3, 2013), and $100 per day for 16 days of substantial noncompliance that was not immediate jeopardy (April 4, 2012, through April 19, 2013). CMS Ex. 8 at 3.

A May 20, 2013 Informal Dispute Resolution proceeding resulted in some modifications to the deficiencies cited in the SOD. A modified SOD was issued. CMS Ex. 2. The cited deficiencies, which are the deficiencies relevant for this case, now consist of:

- 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.[1]

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[1] 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.

- 42 C.F.R. § 483.13(c)(1)(ii)-(iii), (c)(2)-(4) (Tag F225 – Investigate and Report Abuse and Neglect) at a J level of scope and severity.
- 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. § 483.20(d), 483.20(k)(2) (Tag F280 – Right to Participate in Planning Care-Revised Care Plan) at a J level of scope and severity.
- 42 C.F.R. § 483.20(k)(3)(ii) (Tag F282 – Services Performed by Qualified Professionals Per Care Plan) 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 Ex. 2.

Countryside timely requested a hearing before an ALJ to dispute CMS's imposition of enforcement remedies. The case was assigned to me, and I issued an Acknowledgment and Prehearing Order in which I directed the parties to file written direct testimony for all witnesses they wanted to present. CMS filed a prehearing brief (CMS Br.) and 51 proposed exhibits (CMS Exs. 1-51), including written direct testimony for two witnesses. Countryside filed a prehearing brief (P. Br.) and 32 proposed exhibits (P. Exs. 1-32), including written direct testimony for 20 witnesses. Countryside requested to cross-examine CMS's witnesses. CMS did not request to cross-examine any of Countryside's witnesses.

Prior to the hearing in this case, CMS gave notice that it was adding another deficiency:

- 42 C.F.R. § 483.25(h) (Tag F323 – Supervision and Accidents).

CMS Br. at 2, 19-20. Further, CMS stipulated to the reduction in the duration of immediate jeopardy to 117 days (commencing December 8, 2012, and ending on April 3, 2013), and 16 days of substantial noncompliance that was not immediate jeopardy (April 4, 2013, through April 19, 2013), for a total CMP of $803,050. January 2, 2015 Stipulation Regarding the Duration of the Civil Money Penalty at 1; P. Posthearing Br. at 2. CMS and Petitioner's counsel agreed that this was the new time-frame subject to review in this case. Hearing Transcript (Tr.) at 11-13.

On July 28, 2015, I held a video hearing during which I heard testimony on cross-examination from CMS's witnesses, state surveyors Pamela Aromola and Susan Morton, and ruled on objections to certain exhibits submitted by the parties.[2] Petitioner had objected to CMS Exhibits 1 through 3, 10, 11, 13 through 22, 24 through 32, 35 to 46 and

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[2] Although the cover sheet to the hearing transcript indicates that I held this hearing on July 28, 2014, I stated the correct year as 2015 on the record at the beginning of the hearing. Tr. at 1, 4.

48 to 51, and CMS filed responses to those objections. I ruled that CMS exhibits 30 and 32 were not relevant to this proceeding, and therefore did not admit them into the record. I admitted CMS exhibits 1 through 29, 31, and 33 to 51. Tr. at 15. CMS had objected to P. Exs. 25 and 26, because they involved depositions of state surveyors, which were taken from proceedings held under different rules. I did not admit P. Ex. 25 because Ms. Aromola was available at the hearing to testify. I did not admit P. Ex. 26 because Petitioner could have sought a subpoena for that surveyor to testify at the hearing, but did not. I admitted P. Exs. 1 through 24 and 27 through 32. Tr. at 14-19. After the hearing, CMS and Countryside filed post-hearing briefs (CMS Br. and P. Br.) and reply briefs (CMS Reply and P. Reply)

## II. Issues

The issues presented are:

1. Whether Petitioner failed to be in substantial compliance with the Medicare participation requirements.[3]

2. If so, whether CMS's determination of noncompliance at the immediate jeopardy level is clearly erroneous; and

3. Whether the CMP amount that CMS imposed is reasonable.

## III. Jurisdiction

I have jurisdiction to hear and decide this case. 42 U.S.C. §§ 1320a-7a(c)(2), 1395i(h)(2)(B)(ii)); 42 C.F.R. §§ 488.408(g), 488.434(a)(2)(viii), 498.3(b)(13).

## IV. Findings of Fact

1. Resident 1 was arrested in 2007 for sexual battery of a minor, was convicted of that offense, was incarcerated for six months in 2008, and was on probation following his incarceration until May 2012. CMS Ex. 10; CMS Ex. 20 at 2; CMS Ex. 21 at 1; P. Ex. 4; P. Ex. 24 at 92, 100.

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[3] In this decision, I have not discussed all of the deficiencies CMS alleges because the deficiencies I uphold below are sufficient to justify both a finding of noncompliance and the imposition of the remedies proposed by CMS. *See Claiborne-Hughes Health Ctr.*, 609 F.3d 839, 847 (6th Cir. 2010); *Carrington Place of Muscatine*, DAB No. 2321 at 20-21 (2010).

2. Countryside admitted Resident 1 from a hospital on December 9, 2011, when he was 67 years old, after Resident 1 suffered an intraventricular hemorrhage. CMS Ex. 17 at 1, 41; P. Ex. 5.

3. Resident 1 had a police monitoring ankle bracelet when he was admitted to Countryside. CMS Ex. 17 at 72, 90, 103; P. Ex. 9 at 1.

4. On admission to Countryside, Resident 1 had diagnoses including psychosexual disorder, depressive disorder, intellectual disability NOS (non-specified), late effect cerebrovascular disorder, difficulty walking, and paralysis. CMS Ex. 17 at 1-2; P. Ex. 5 at 16.

5. In January 2012, Resident 1 had improved bilateral upper extremity strength of 3+/5 and was able to safely perform activities of daily living (ADL) transfers with minimum assistance. CMS Ex. 17 at 63.

6. In January 2012, Resident 1 was taking Lexapro (anti-depressant) and Premarin (estrogen). CMS Ex. 17 at 90; P. Ex. 6 at 4-11.

7. On or about September 4, 2012, a "Behavioral Health Consultation" for Resident 1 took place because Resident 1 had been recently "talking nonsensically" and he had "grabbed male staff's penis." P. Ex. 24 at 98-99. The evaluator, a nurse practitioner, concluded that Resident 1's behaviors were generally controlled and that the inappropriate sexual behavior was an "isolated event." P. Ex. 24 at 99. The evaluator recommended redirection rather than medication changes. P. Ex. 24 at 99.

8. A September 6, 2012 initial assessment of Resident 1, authored by Lynn Henderson, Psy.D., indicates Resident 1 was "referred for psychotherapy for inappropriate behavior that consisted of grabbing a male nurse's penis on two occasions and 'lurking'[4] around a young incapacitated male's room [Resident

[4] Ms. Morton, the second surveyor on the scene, testified that she assisted Ms. Aromola with the survey, and that the use of the word "lurking" in the SOD to describe Resident 1's behavior was based on Dr. Henderson's psychological reports. Tr. at 211. Ms. Morton assisted Ms. Aromola to interview of Dr. Henderson; however; Ms. Morton did not interview any residents. Tr. at 224-225, 229.

4] in context of being a registered sex offender."[5] CMS Ex. 17 at 6; P. Ex. 24 at 100, 135. Dr. Henderson indicated that Resident 1 was receiving a hormonal agent to reduce libido, and assessed Resident 1 to have the following strengths: adequate judgment; being verbal; and intact memory. CMS Ex. 17 at 7; P. Ex. 24 at 101. Resident 1 was alert and oriented times three, had good concentration, was logical and coherent, but only had "poor" judgment and insight. CMS Ex. 17 at 8; P. Ex. 24 at 102. Resident 1 had a primary diagnosis of "Other Specified Psychosexual Disorders, Frotteurism" and a secondary diagnosis of "Depression, NOS." CMS Ex. 17 at 9; P. Ex. 24 at 103.

9. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV) provides the following diagnostic criteria for Frotteurism: "A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving touching and rubbing against a non-consenting person. B. The person has acted on these urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty." CMS Ex. 14 at 35; CMS Ex. 34 at 2.

10. Countryside staff checked Resident 1 every 15 minutes on September 6 through 10, 16, 17, 20, 21, 24, 25, 2012, and on October 4, 2012. P. Ex. 24 at 145-156; CMS Ex. 17 at 82-85.

11. Dr. Henderson met with Resident 1 and completed weekly psychology progress notes from September 10, 2012, through February 28, 2013, all of which indicated Resident 1 had diagnoses of "Frotteurism, Depression NOS" and was "at risk of re-offending." P. Ex. 24 at 106-116, 118-120, 122-128.

12. On September 10, 2012, Dr. Henderson noted that Resident 1 continued to be attracted to a young incapacitated patient [Resident 4]. P. Ex. 24 at 106.

13. On September 10, 2012, Countryside changed Resident 1's room "per Resident request" and Resident 2 became Resident 1's roommate. P. Ex. 15 at 3; CMS Ex. 17 at 70.

14. A September 16, 2012 care plan indicates Resident 1 had behaviors including, "sexually inappropriate [at times] comments about wanting to have sex with other male residents." CMS Ex. 17 at 102. The care plan was directed at Resident 1's interest in Resident 4. P. Ex. 7. The Resident's goal was to not demonstrate the

[5] In September 2012, Resident 4 was a 23-year-old male who had been admitted to Petitioner's facility in July 2011 with the following diagnoses based on a motor vehicle accident: muscle weakness, traumatic brain hemorrhage, dysphagia, convulsion, esophageal reflux, hypertension, and traumatic brain injury. CMS Ex. 19 at 1, 15.

behavior identified in the care plan more than 3 times per week. CMS Ex. 17 at 102. Interventions included: administer Premarin as ordered; encourage Resident 1 to verbalize feelings in appropriate setting; social services 1:1 when necessary; psychiatric services when necessary for supportive counseling; 15 minute checks on Resident 1; monitor/document behaviors; and redirection when Resident 1 is social/sexually inappropriate. CMS Ex. 17 at 102.

15. On September 20, 2012, Dr. Henderson reminded Resident 1 to stay away from Resident 4, and Resident 1 agreed with Dr. Henderson that going near Resident 4 puts Resident 1 at risk for re-offending. CMS Ex. 17 at 12; P. Ex. 24 at 107.

16. On September 24, 2012 and October 4, 2012, Resident 1 indicated to Dr. Henderson that he would not reoffend because he did not want to go back to prison. CMS Ex. 17 at 13, 15; P. Ex. 24 at 108, 110.

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

18. Countryside's November 14, 2012 care plan for Resident 1 indicated "past Hx of sexual inappropriateness . . . other males Hx frotterism [sic]." CMS Ex. 17 at 44. The care plan's goal for Resident 1 was to stop demonstrating inappropriate sexual behaviors, and the interventions to accomplish this were: provide positive feedback when resident is appropriate; provide psychological counseling as needed; administer medications (Premarin) as ordered; encourage Resident 1 to attend group activities; redirect Resident 1 from inappropriate behaviors; and monitor and document behaviors. CMS Ex. 17 at 44. Resident 1's care plan was not revised after November 14, 2012. CMS Ex. 16 at 20; CMS Ex. 17.

19. In December 2012, Resident 1 attempted to inappropriately touch a male CNA while the CNA provided personal care to Resident 1. The CNA was able to move out of the way of Resident 1's attempt to touch him, but Resident 1 made the CNA feel uncomfortable. The CNA reminded Resident 1 not to touch anyone inappropriately and reported the incident to a Licensed Practical Nurse (LPN); however, the LPN did not further report or document this incident. CMS Ex. 16 at 6; P. Ex. 15 at 3.

20. On January 10, 2013, Dr. Henderson noted that Countryside staff continued to have concerns that Resident 1 would re-offend with Resident 4. Dr. Henderson continued to emphasize stopping and redirection techniques. CMS Ex. 17 at 24; P. Ex. 24 at 120.

21. On February 28, 2013, Dr. Henderson transferred Resident 1 to the care of another psychologist, and indicated Resident 1's status at that time of transfer was stable and that he was compliant with treatment. P. Ex. 24 at 129.

22. By March 2013, Resident 1 had been roommates with Resident 2 for over six months. P. Ex. 15 at 3.

23. Resident 2 was a 56-year-old male in March 2013 with diagnoses including quadriplegia, abdominal pain, convulsions, anxiety, depressive disorder, hypertension, psychosis, and contractures. CMS Ex. 18 at 1. Resident 2 could report the correct year, could recall three words after cueing, and showed no evidence of an acute change in mental status. CMS Ex. 18 at 12. Resident 2's care plan did not include interventions to prevent unwanted sexual advances from Resident 1. CMS Ex. 18.

24. Late on March 18, 2013, Resident 1 inappropriately touched Resident 2. Commencing at 10:30 p.m. on March 18, 2013, Countryside staff started to check Resident 1 every 15 minutes, but at 11:00 p.m. Countryside placed Resident 1 on "one-on-one" monitoring.

25. On March 19, 2013, Countryside's Administrator and Social Services Director spoke to Resident 2 and Resident 2 stated: "roommate had come over & first touched his leg & then his penis. Resident [2] said he told roommate [Resident 1] to get away. He st'd roommate [Resident 1] hesitated & then left." On March 19, 2013, Countryside moved Resident 1 to a different room.

26. Resident 1 remained on 1:1 monitoring until he was arrested by police on the charge of lewd and lascivious battery, and taken into custody at 2:15 p.m. on March 20, 2013. Resident 1 admitted to the police that he inappropriately touched Resident 2. CMS Ex. 10; CMS Ex. 11; CMS Ex. 14 at 4; CMS Ex. 17 at 88-89; CMS Ex. 18 at 4; CMS Ex. 20 at 4.

27. On March 25, 2013, Resident 2 filed a complaint that Resident 1 fondled him against his will. CMS Ex. 12.

## V. Conclusions of Law and Analysis

My conclusions of law are in italics and bold followed by my analysis.

1. ***Countryside was not in substantial compliance with 42 C.F.R. § 483.13(b) from December 8, 2012, through April 3, 2013, because Countryside failed to ensure Resident 2 was free from sexual abuse.***

Residents of a SNF have "the right to be free from . . . sexual . . . abuse." 42 C.F.R. § 483.13(b). Relevant to this case, the word "abuse" is defined to mean: "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." 42 C.F.R. § 488.301. The requirement that an SNF has under 42 C.F.R. § 483.13(b) to "[p]rotect[] and promot[e] 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," which may include other residents. *Western Care Management Corp*, DAB No. 1921, at 12 (2004).

The weight of the evidence in this case is that Countryside failed to take necessary precautions to prevent one of its residents from engaging in sexually abusive conduct toward at least one other resident resulting in a violation of 42 C.F.R.§ 483.13(b).

***A. Countryside's arguments that Resident 1 did not or could not sexually abuse Resident 2 are unconvincing.***

Countryside calls into doubt whether Resident 2 was sexually abused by Resident 1, indicating Resident 2 "had psychoses and exhibited manipulative behaviors at Countryside." P. Prehearing Br. at 15. Dr. Henderson testified in support of Countryside that she believed that Resident 2 made up the story of abuse due to his psychoses. P. Ex. 22 at 5. Countryside also relies on the fact that the State Attorney did not prosecute Resident 1 as strong support for its position that Resident 1 did not abuse Resident 2. P. Prehearing Br. at 16.

The record indicates Resident 2 was a 56-year-old male in March of 2013 with diagnoses including abdominal pain, convulsions, anxiety, depressive disorder, hypertension, psychosis, and quadriplegia. CMS Ex. 18 at 1. Although Resident 2 was diagnosed with psychoses, Resident 2's psychological and medical records do not indicate Resident 2 was capable of imagining or lying about something as serious as sexual abuse. CMS Ex. 18; CMS Ex. 15 at 2. Countryside has not put forward evidence that Resident 2 even knew that Resident 1 was a sex offender in order to come up with his story of sexual abuse. Without such information, it seems unlikely that Resident 2 would happen to fabricate a story of male-on-male sexual abuse concerning his roommate. In addition, I find Dr. Henderson's opinion that Resident 2 created a false story of sexual abuse to be suspect. She, as the treating psychologist for Residents 1 and 2, should have advised Countryside against rooming a sexual abuser, with a current diagnosis for Frotteurism and a history, by the end of 2012, of having touched or attempted to touch two male Countryside staff and another incapacitated male resident in a sexual way, with another resident who was unable to move or defend himself.

Although Countryside theorizes that Resident 2 falsely accused Resident 1 of sexual abuse, the record is clear that Resident 1 confessed his sexual misconduct to police. CMS Ex. 10 ("After his arrest, [Resident 1] admitted molesting [Resident 2] to Sherriff's

Office investigators, according to the [arrest] affidavit."); CMS Ex. 11; CMS Ex. 14 at 4 ("Deputy stated that he did feel that [Resident 1] was competent and admitted to him that he touched [Resident 2] inappropriately."). Countryside does not submit evidence to dispute that Resident 1 admitted his sexual misconduct, but rather relies on the fact that Resident 1 was not prosecuted to dispute Resident 2's claim of abuse. However, the decision of the State Attorney's office not to prosecute Resident 1 is not necessarily an indication that Resident 1 was innocent, and Countryside provided no evidence as to why there was no prosecution. It is not difficult to see why prosecutors might not opt to send an individual in his late 60's to prison, especially one who has numerous physical ailments.

Countryside also disputes that Resident 1 was "physically unable to subdue anyone" and asserts that "the most Resident #1 could do to another person would be to reach out and touch that person." P. Prehearing Br. at 6; P. Ex. 2 at 3. As indicated above, Resident 1 was known to have Frotteurism, a condition that involves the desire to touch and rub against a non-consenting person, and acted upon those desires. CMS Ex. 17 at 9; CMS Ex. 34 at 2. Although the precise definition of sexual assault varies depending upon jurisdiction, sexual assault is commonly defined as:

> . . . **any type of sexual contact** or behavior that occurs without the explicit consent of the recipient. Falling under the definition of sexual assault are sexual activities as forced sexual intercourse, forcible sodomy, child molestation, incest, **fondling**, and attempted rape.

*Sexual Assault*, The United States Department of Justice (January 31, 2017), https://www.justice.gov/ovw/sexual-assault (emphasis added).

Therefore, conduct that is typical for individuals with Frotteurism can easily fall within the definition of sexual assault, as both involve the non-consensual sexual touching of another. In addition, there is no indication any advanced capacity to "plot" a sexual assault is necessary. P. Ex. 2 at 3. There is no indication that physically subduing the victim is necessary in order for sexual assault to occur.

By Countryside's own admission, Resident 1 was capable of reaching out and touching other residents. P. Prehearing Br. at 6; P. Ex. 2 at 3. Resident 1 was capable of self-propelling himself in a wheelchair all over the facility, including multiple times to Resident 4's room. CMS Ex. 17 at 10-14, 18, 48, 49, 106, 109, P. Ex. 2 at 3; *see also* CMS Ex. 16 at 14. Therefore, the evidence shows Resident 1 was physically capable of sexually touching another resident and mentally disposed to engage in such touching. Due to Resident 1's physical limitations, Resident 2 was exactly the type of victim Resident 1 would have sought since Resident 2 could neither run nor resist. The record

shows this to be true because Resident 1 first showed an attraction to Resident 4, another bed-bound resident who was incapable of defending himself.

Countryside asserts that Resident 2 was capable of voicing his displeasure upon being non-consensually touched, and that "Resident 1 was generally passive and would withdraw from any confrontation." P. Prehearing Br. at 14; P. Ex. 2 at 5. This argument again fails to take into account the definition and nature of sexual assault. The fact that Resident 2 was theoretically capable of calling for help *while being sexually assaulted* does not serve as a means of preventing that assault from occurring. Further, Resident 2's statement to Countryside staff shows that he succeeded in making Resident 1 withdraw through a verbal confrontation; however, Resident 1 still touched Resident 2 inappropriately before withdrawing. CMS Ex. 18 at 4. Simply because staff was not near enough to hear Resident 2 verbally ward Resident 1 off does not mean it did not happen.

### ***B. It was reasonably foreseeable that Resident 1 would re-offend as a sexual abuser, and Countryside's actions to prevent Resident 1's re-offense were insufficient to ensure Resident 2's right to be free from sexual abuse.***

Resident 1 was admitted to Countryside from a hospital on December 9, 2011. CMS Ex. 17 at 1, 41; P. Ex. 5. Resident 1 had a police monitoring ankle bracelet in place at the time, was known to be a convicted sex offender on probation, and received regular visits from his probation officer until May 31, 2012. CMS Ex. 17 at 72, 90, 103. In September 2012, Resident 1 was specifically "referred for psychotherapy for inappropriate behavior that consisted of grabbing a male nurse's penis on two occasions and 'lurking' around a young incapacitated male's room [Resident 4] in context of being a registered sex offender." CMS Ex. 17 at 6; P. Ex. 24 at 100. In addition to a psychological evaluation, Countryside responded by moving Resident 1 to another room farther away from Resident 4 and, for a time, conducting checks on Resident 1 every 15 minutes.

Resident 1 repeatedly demonstrated that he was capable of transporting himself in his wheelchair independently throughout the facility. CMS Ex. 16 at 14; CMS Ex. 17 at 63. In fact, by November 2012, Countryside staff twice observed Resident 1 to go near Resident 4's room, despite his room change and Dr. Henderson's repeated warnings not to do so, as well as Resident 1's own assessment that going near Resident 4 might cause him to reoffend. CMS Ex. 17 at 12, 18; P. Ex. 24 at 107, 113.

Although it appears that Resident 1 was finally dissuaded from attempting inappropriate contact with Resident 4, in December 2012, Resident 1 began to act on his impulses by attempting to inappropriately touch a male CNA while the CNA provided personal care to Resident 1. CMS Ex. 16 at 6; P. Ex. 15 at 3. Further, on January 10, 2013, Dr. Henderson noted that Countryside staff continued to have concerns that Resident 1 would

re-offend with Resident 4, again showing that Resident 1 was a potential threat for committing sexual abuse. CMS Ex. 17 at 24; P. Ex. 24 at 120.

Countryside seemed only concerned with Resident 1's potential for abusing Resident 4, even though Resident 1 had targeted male staff in September and December 2012. CMS Ex. 15 at 2. Although Countryside's expert witness, a clinical specialist in psychiatric nursing, testified that placing Resident 1 in the same room as Resident 2 did not create a risk of sexual assault on Resident 2 (P. Ex. 2 at 5), Dr. Henderson admitted to surveyors that assigning Resident 1 a quadriplegic roommate (Resident 2), "may have been poor judgment." CMS Ex. 15 at 2. Despite this, Dr. Henderson later testified that Resident 1's sexual assaults/attempted assaults on male Countryside staff members and interest in Resident 4 were not predictors of the sexual abuse he committed on Resident 2. P. Ex. 22 at 5.

As stated above, I do not credit Dr. Henderson's views completely in these proceedings. Rather, the record shows Countryside had ample evidence to be concerned that Resident 2 might be abused by Resident 1. Resident 1's conduct from September through December 2012 made it very clear that Resident 1's conduct did not involve isolated incidents, but rather recurring efforts to touch the genitals of male staff and Resident 4. As early as September, Dr. Henderson diagnosed Resident 1 with a psychological condition that meant Resident 1 had a predilection to offend this way. And the backdrop to all of this was Resident 1's criminal conviction for a sexual crime. Finally, as noted above, Resident 2 was immobile just as Resident 4 was immobile, making him a viable target for Resident 1, who had his own physical limitations.

Despite Resident 1's behavior, Resident 2's care plan did not include mention of interventions to prevent a scenario where Resident 1 attempts to re-offend with Resident 2, manifesting how Countryside never considered the potential for Resident 1 to abuse Resident 2. CMS Ex. 15 at 2; CMS Ex. 18. The record does include 15 minute check records from September 6, 2012, through October 4, 2012. P. Ex. 24 at 145-156. However, the 15 minute checks ceased about six months before Resident 1 abused Resident 2. The record, therefore, indicates Countryside failed to consistently carry out even the few interventions that they identified as necessary in Resident 1's care plan.

Based on the record in this case, I do not agree that Countryside's staff acted reasonably to prevent the abuse of Resident 2 and possible abuse of Resident 4. Countryside ought not to have placed Resident 1 with a highly vulnerable resident. Therefore, I conclude Countryside did not take appropriate action to ensure that Resident 2 was free of sexual abuse and was not in substantial compliance with 42 C.F.R. § 483.13(b) from December 8, 2012, through April 3, 2013.

***2. Countryside was not in substantial compliance with 42 C.F.R. §§ 483.20(d) and 483.20(k)(2) from December 8, 2012, through April 3, 2013, because Countryside failed to appropriately update Resident 1's care plan to prevent re-offense and failed to update Resident 2's care plan to prevent victimization by Resident 1.***

A facility must periodically conduct a comprehensive, accurate, standardized, and reproducible assessment of each resident's functional capacity, and it must use the results of those assessments "to develop, review, and revise the resident's comprehensive plan of care." 42 C.F.R. § 483.20(d). The care plan must be developed within seven days after the facility completes the comprehensive assessment, and must be prepared by an interdisciplinary team. A team of qualified persons must review and revise the plan after each assessment. 42 C.F.R. § 483.20(k)(2).

A September 6, 2012 psychologist initial assessment indicates Resident 1 was referred for psychotherapy for inappropriate behavior that consisted of grabbing a male nurse's penis on two occasions and "lurking" around a young incapacitated male's (Resident 4) room in the context of being a registered sex offender. CMS Ex. 17 at 6; P. Ex. 24 at 100. The assessment indicates Resident 1 was receiving a hormonal agent to reduce libido, and had strengths including adequate judgment, verbal, with memory intact. CMS Ex. 17 at 7. After the September 2012 incident in which Resident 1 "grabbed male staff's penis," the resident received a new care plan. P. Ex. 24 at 98-99. The September 16, 2012 care plan indicates Resident 1 had behaviors including, "sexually inappropriate at times, comments about wanting to have sex with other male residents." CMS Ex. 16 at 15. The care plan calls for staff to monitor and document behaviors, and to redirect when the resident was being socially/sexually inappropriate. CMS Ex. 17 at 102.

A March 28, 2013 interview with Regina Malloy, MDS Coordinator and LPN, indicates she was aware of the definition of Frotteurism, but that the disorder was listed under the broader "F code" for psychosexual disorder code on the facility's care plans. CMS Ex. 15 at 1. Resident 1's care plan was revised on November 14, 2012. CMS Ex. 17 at 44. The care plan includes similar directives to use redirection and encourage Resident 1 to attend activities to control his behaviors. CMS Ex. 17 at 44. Resident 1's care plan was reviewed but not revised after November 14, 2012. CMS Ex. 15 at 1; CMS Ex. 16 at 20; CMS Ex. 17.

Interventions included Premarin as ordered, encourage to verbalize feelings in appropriate setting, social services 1:1 when necessary, psychiatric care when necessary for supportive counseling, 15 minute checks, monitor/document behaviors, and redirection. CMS Ex. 16 at 15; CMS Ex. 17 at 102. The 15 minute checks portion has a notation of "D/C," presumably meaning "discontinued," however no initials or date are included with the notation. CMS Ex. 16 at 15; CMS Ex. 17 at 102. The record includes 15 minute check records, presumably for Resident 1, from September 6, 2012, through

October 4, 2012, prompted by Resident 1 being found by Resident 4's room. However there are no records of 15 minute checks after that date. Ms. Catanzaro, MDS coordinator, later indicated 15 minute checks were discontinued due to no behaviors, but there is no documentation that the checks were discontinued for this reason. CMS Ex. 15 at 1. The record indicates Resident 1 was taking both Lexapro and Premarin on January 17, 2012, or earlier, indicating neither of these medications were added to Resident 1's treatment plan as a response to his subsequent behaviors. CMS Ex. 17 at 90; P. Ex. 6 at 4-11.

In this case, redirection would not have prevented Resident 1 from sexually assaulting Resident 2, particularly in moments when he was not supervised. Even viewing the record, in the most favorable light, Countryside performed 15 minute checks for only a month until October 4, 2012. P. Ex. 24 at 145-156; CMS Ex. 15 at 2; CMS Ex. 16 at 14. It is unclear whether the 15 minute checks would have been sufficient to prevent Resident 1 from sexually assaulting Resident 2; however, after October 4, 2012, there is no evidence the checks were performed at all. There is also no reason provided in the documentation for why the checks were discontinued, and no reasons are provided in Resident 1's care plan. CMS Ex. 17 at 44.

A March 27, 2013 interview with Employee I, an LPN, indicates that in December 2012, a male CNA, Employee Y, reported to her that Resident 1 attempted to "grope" him. CMS Ex. 16 at 6. Employee I indicated she did not report this to anyone at the time, and that she should have reported it as inappropriate sexual behavior. CMS Ex. 16 at 6. Ms. Aromola and Ms. Morton indicate "a review of Resident #1's record revealed no documentation regarding this incident." CMS Ex. 16 at 6. Ms. Aromola conducted a March 28, 2013 telephone interview with Employee Y, a CNA who reported concerns to the LPN in December 2012 regarding the fact Resident 1 was "touchy-feely" during personal care. CMS Ex. 14 at 6. The record does not indicate that Countryside took steps to re-evaluate Resident 1's care plan after his attempted groping of male staff members.

Ms. Aromola, the first state surveyor on the scene and a licensed nursing home administrator (Tr. at 24), testified she was concerned that Countryside had not addressed Resident 1's risk for re-offending in the facility as the care plan did not address his risk for re-offense from day one. Tr. at 45. Ms. Aromola indicated she believed sex offenses should be care planned similar to other concerns and diagnoses. Tr. at 69-70.

Although Countryside claims Resident 1's care plan was reviewed, it was not updated or revised after November 2012, in spite of the clear evidence the current interventions had failed to curb Resident 1's inappropriate sexual behavior. CMS Ex. 15 at 1. It was not revised even though in January 2013, staff thought Resident 1 was again attempting to offend with Resident 4. CMS Ex. 17 at 24; P. Ex. 24 at 120. A March 28, 2013 interview with Regina Malloy, MDS Coordinator and LPN indicates she was aware of the

definition of Frotteurism, but the diagnosis was not on Resident 1's diagnosis sheet because that code is not in their system. CMS Ex. 15 at 1. Instead, Ms. Malloy used the broader "psychosexual disorder" code which Frotteurism fell under, and this appeared on the resident's diagnosis sheet. CMS Ex. 15 at 1. In the same interview, Ms. Catanzaro, another MDS Coordinator, said she and Ms. Malloy reviewed Resident 1's care plan periodically, but it had not been updated or revised since November of 2012 because there were no new behaviors. CMS Ex. 15 at 1. Ms. Catanzaro indicated 15 minute checks were discontinued due to no behaviors observed. CMS Ex. 15 at 1.

Resident 2 was a 56-year-old male in March of 2013 with diagnoses including abdominal pain, convulsions, anxiety, depressive disorder, hypertension, psychosis, and quadriplegia. CMS Ex. 18 at 1. Resident 2's care plan did not include mention of interventions to prevent unwanted sexual advances by Resident 1. CMS Ex. 18. There is insufficient evidence to show Countryside properly considered the threat of unwanted sexual advances from Resident 1 and how to prevent those advances, despite the fact Countryside placed the two residents as roommates.

Based on the record in this case, Countryside failed to properly revise the care plans for Residents 1 and 2, and Countryside was, therefore, not in substantial compliance with 42 C.F.R. §§ 483.20(d) and 483.20(k)(2).

3. ***Countryside was not in substantial compliance with 42 C.F.R. § 483.75 and 42 C.F.R. § 483.25(h) from December 8, 2012, through April 3, 2013, because Countryside failed to appropriately supervise Resident 1 to prevent re-offense, despite clear warning signs being present.***

The regulation at 42 C.F.R. § 483.75 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.

The regulation also includes specific requirements to comply with federal, state, and local laws and professional standards and in other areas, including licensure, training, registry verification, in-service education, staff qualifications, provision of laboratory, radiology and other diagnostic services, and clinical records. 42 C.F.R. § 483.75(a)-(p). The language of section 483.75 is such that any failure of management which adversely affects a resident constitutes a violation. 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).

Any failure of management that adversely affects a resident constitutes a violation of section 483.75. I have found that Countryside violated the Medicare participation requirements at sections 483.13(b), 483.20(d), and 483.20(k)(2). As explained below, I uphold CMS's conclusion that these violations posed immediate jeopardy. The same evidence that supports these deficiency findings also supports my conclusion that Countryside failed to comply with the administration requirement at 42 C.F.R. § 483.75 and the supervision requirement at 42 C.F.R. § 483.25(h).

***4. CMS's determination that Countryside's deficiencies posed immediate jeopardy was not clearly erroneous.***

Immediate jeopardy exists when 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. An ALJ must affirm an "immediate jeopardy" determination unless Countryside shows that it is clearly erroneous. 42 C.F.R. § 498.60(c)(2). The "clearly erroneous" standard imposes a heavy burden on SNFs, and CMS may prevail where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *See Barbourville Nursing Home v. CMS*, DAB No. 1962 at 11 (2005) (citing *Florence Park Care Ctr. v. CMS*, DAB No. 1931 at 27-28 (2004). The regulation does not require that a resident actually be harmed. *See Lakeport Skilled Nursing Ctr. v. CMS*, DAB No. 2435 at 8 (2012).

Countryside asserts that the duration of the proposed CMP and the finding of immediate jeopardy cannot be justified because Countryside, in September of 2012, had already implemented safeguards to prevent any conceivable harm. P. Prehearing Br. at 23. Countryside further asserts no event involving Resident 1 occurred from his admission in December 2011 until March 18, 2013, indicating immediate jeopardy to the residents was not present. P. Post-Hearing Br. at 21.

CMS contends that Countryside did not comply with the abuse and neglect, care planning, administration, and supervision regulations, caused actual harm, and placed residents at risk for serious injury. CMS Pre-Hearing Br. at 20; CMS Post Hearing Br. at 18. CMS further argues that each of Countryside's deficiencies posed immediate

jeopardy to residents, and that Countryside cannot overcome the heavy burden required to refute a finding of immediate jeopardy. CMS Post Hearing Br. at 18.

There is no doubt that Countryside placed Resident 2 and other residents in immediate jeopardy. The evidence in the record shows that Countryside's conduct resulted in direct harm to Resident 2 and potential harm to other residents that was likely to cause serious injury, harm, impairment, or death to a resident. 42 C.F.R. § 488.301. Therefore, CMS's determination that immediate jeopardy lasted from December 8, 2012, through April 3, 2013, is not clearly erroneous.

***5. CMS's determination of the amount and duration of the CMP is reasonable.***

In determining whether the per-day CMP amounts imposed against Countryside 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).

In the present case, CMS ultimately imposed a CMP of $6,850 per day for 117 days of immediate jeopardy (December 8, 2012, through April 3, 2013), and $100 per day for 16 days of substantial noncompliance that was not immediate jeopardy (April 4, 2013, through April 19, 2013), for a total CMP of $803,050. P. Posthearing Br. at 2; Tr. at 11-13.

Countryside argues that the amount of the CMP is unreasonable based on Countryside's lack of culpability and lack of history of noncompliance. P. Post-Hearing Br. at 22. After considering the factors in the regulations, I conclude that the CMP amounts imposed in this case are reasonable.

Countryside has a history of noncompliance that includes various deficiencies dating back to 2005, and one other instance of immediate jeopardy consisting of a finding of noncompliance at tags F224 (Staff Treatment of Residents), F309 (Quality of Care), and

F505 (Promptly notify the attending physician of the findings) based on a survey from May 25, 2007. CMS Ex. 9 at 4.[6]

Countryside's culpability in this matter is fairly high. As indicated above, Countryside directed all its efforts to stop Resident 1 from re-offending with Resident 4, but made little effort to protect other residents. In fact, Countryside placed Resident 1 with an especially vulnerable resident, Resident 2, with little to no supervision. This was in spite of the fact that the facility's staff was keenly aware that Resident 1's frotteurism was reoccurring, after he groped and attempted to grope staff members, and after Resident 1 had targeted Resident 4, a highly vulnerable resident like Resident 2.

In regard to the scope and severity of the deficiency, CMS properly determined that Countryside's deficiency was at the immediate jeopardy level from December 8, 2012, through April 3, 2013, due to the potential for Resident 1 to sexually touch other residents because Countryside failed to properly supervise him during this period. I also conclude that CMS properly continued to penalize Countryside at a non-immediate jeopardy level from April 4, 2013, through April 19, 2013.

Based on the factors above, I conclude that the $6,850 per day CMP during the immediate jeopardy period is reasonable and a $100 per day CMP is reasonable for the period below the immediate jeopardy level. The $6,850 per day CMP is in the mid-range for immediate jeopardy matters (i.e., per-day CMPs for immediate jeopardy can be from $3,050 to $10,000). 42 C.F.R. § 488.438(a)(1)(i). The middle range is appropriate in this case.

## VI. Conclusion

I affirm CMS's determination that Countryside was not in substantial compliance with Medicare program participation requirements and that Countryside's substantial noncompliance posed immediate jeopardy to residents. Further, I conclude that a $6,850 per day CMP from December 8, 2012, through April 3, 2013), and $100 per day from April 4, 2012, through April 19, 2013, is reasonable.

/s/

Scott Anderson
Administrative Law Judge

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[6] Although Countryside has a subsequent history of noncompliance (*see Countryside Rehabilitation and Healthcare Ctr.,* DAB CR4547 (2016)), I do not consider that in determining the CMP in this case.