

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

Neighbors Rehabilitation Center, LLC
Docket No. A-17-123
Decision No. 2859
March 22, 2018

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

Neighbors Rehabilitation Center, LLC (Neighbors, Petitioner) appeals a July 21, 2017 decision of an Administrative Law Judge (ALJ) upholding the imposition of a civil money penalty (CMP) totaling \$83,800 by the Centers for Medicare & Medicaid Services (CMS). *Neighbors Rehabilitation Ctr., LLC*, DAB CR4895 (2017) (ALJ Decision). CMS determined that Neighbors was not in substantial compliance with regulations requiring that each resident receive adequate supervision to prevent accidents, at a level that presented immediate jeopardy to residents.

The events on which CMS's determinations were based related to a number of episodes in which three residents in a dementia unit with varying degrees of cognitive impairment had encounters of a sexual nature. Neighbors viewed all the encounters as consensual with none of the residents protesting or resisting. Neighbors asserts that its policy respects the right of residents with dementia diagnoses to have intimate relationships. The ALJ concluded that Neighbors failed to properly supervise the residents because it failed to assess whether they were capable of consent and/or to evaluate meaningfully whether they actually did consent to the interactions given their degree of cognitive impairment. The ALJ also found that Neighbors failed to account for the interactions by monitoring the residents involved or making any appropriate changes to the residents' care plans. As a result, the ALJ concluded, the residents involved, and other severely cognitively impaired residents, were exposed to the likelihood of serious harm from unwanted sexual contacts.

For the reasons explained below, we conclude that the ALJ's findings are supported by substantial evidence and his conclusions are free of legal error. We therefore uphold the ALJ Decision and sustain the CMP as imposed.

Applicable legal authorities

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

A SNF’s compliance with Medicare participation requirements is verified through onsite surveys performed by state health agencies. *Id.* §§ 488.10(a), 488.11. Such surveys may be triggered by the receipt of complaints. *Id.* § 488.301 (definition of “abbreviated standard survey”). A state survey agency reports any deficiency (failure to meet a participation requirement) it finds in a Statement of Deficiencies (SOD). *Id.* §§ 488.325(f)(1), 488.331(a).

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

¹ On October 4, 2016, CMS issued a final rule that amended the Medicare participation requirements for long-term care facilities published in 42 C.F.R. Part 483. Final Rule, *Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities*, 81 Fed. Reg. 68,688 (Oct. 4, 2016). Our analysis and decision are based on the version of the participation requirements in effect in 2014 when the compliance survey at issue was performed. *Carmel Convalescent Hosp.*, DAB No. 1584, at 2 n.2 (1996) (applying the regulations in effect on the date of the survey and resurvey).

The introductory language of section 483.25, titled “Quality of care,” provides that “[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.” The specific requirement in that section relevant in this case provides as follows:

(h) Accidents. The facility must ensure that—

(1) The resident environment remains as free of accident hazards as is possible; and

(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

42 C.F.R. § 483.25(h).

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

Case background²

The state survey agency conducted a complaint survey of Neighbors, an Illinois SNF, from February 20, 2014 through February 26, 2014. The surveyors determined that Neighbors violated section 483.25(h) at the immediate jeopardy level based on their findings about interactions between three residents of the dementia unit who are identified as Resident 1, Resident 2, and Resident 3. All three residents had dementia diagnoses, but their levels of cognitive functioning, as indicated by Neighbors’ records, differed significantly, with Resident 1 higher in functioning than the other two. The ALJ made findings of fact concerning each of the residents based on the clinical and other records.³ As to Resident 1, the ALJ noted that he was assessed as of January 28, 2014 with:

² The factual information in this section is drawn from the ALJ Decision and the record and is presented to provide a context for the discussion of the issues raised on appeal. Unless otherwise noted, the facts stated here are undisputed.

³ On appeal, Neighbors acknowledges that these findings are “mostly true,” and identifies no error in them, but argues that additional “facts and nuances” are needed to evaluate the deficiency allegations. Request for Review (RR) at 3. We discuss those arguments in the analysis below.

. . . the highest score for “Cognitive Patterns” (i.e., a Brief interview for Mental Status (BIMS) score of 15); no problems with “Mood”; limited “Behavior” concerns (no hallucinations or delusions), although his behavior was considered worse since the prior assessment; answered all questions regarding his “Preferences for Customary Routine and Activities” without assistance; few limitations with his “Functional Status”; and “Active Diagnoses” that included non-Alzheimer’s dementia and depression (other than bipolar).

ALJ Decision at 5, citing CMS Ex. 23, at 13-22, 24-25.

In regard to Resident 2, the ALJ’s findings included the following:

Resident 2’s diagnoses included Alzheimer’s disease (primary diagnosis); dementia, unspecified with behavioral disturbance; amnesia, transient global; and loss of hearing. CMS Ex. 24 at 5.

Resident 2’s January 24, 2014 Minimum Data Set shows he had: highly impaired hearing; unclear speech; the ability to understand others sometimes; moderately impaired vision; a BIMS score of 99 due to inability to complete the interview; short-term and long-term memory problems; moderately impaired ability to make decisions; disorganized or incoherent thinking; a severity score of 99 for the Resident Mood Interview due to inability to complete interview; physical and verbal behavioral symptoms directed at others that could significantly intrude on the privacy or activities of others; wandered, and the wandering significantly intruded on the privacy and activities of others; the need for extensive assistance for transfers, mobility in bed, moving around his unit of Petitioner’s facility, dressing, toileting, and personal hygiene; balance and stability problems and used a wheelchair; and “Active Diagnoses” that included Alzheimer’s disease, Non-Alzheimer’s dementia, amnesia, and hearing loss. CMS Ex. 24 at 12-15, 17-18, 21-22, 24-25, 42.

On January 31, 2014, Petitioner’s staff was able to determine that Resident 2’s BIMS score was a 3 out of 15. CMS Ex. 32 at 11.

ALJ Decision at 5-6 (finding numbers omitted). Residents 1 and 2 were both males.

Resident 3 was a female diagnosed with Alzheimer’s disease who was assessed on January 14, 2014 with:

. . . highly impaired hearing; the ability to sometimes understand what others are saying; a BIMS score of 0 out of 15; wandered, and the wandering significantly intruded on the privacy or activities of others, and was worse than the prior assessment; the need for limited assistance for transfers, walking in her room, and bed mobility, but needed extensive assistance for dressing, toilet use, and personal hygiene; and “Active Diagnoses” that included Alzheimer’s disease and depression.

Id. at 6, citing CMS Ex. 25, at 12-13, 18, 21, 24-25.

It is undisputed that, in February 2014, a series of episodes occurred in which sexual or intimate contact occurred involving these residents. The ALJ made the following key findings of fact in relation to these events:

On February 4, 2014, a CNA observed Resident 1 “masturbating” Resident 2 in Resident 2’s room, but noted that [Resident 2] “was quiet and made no signs of object[ing].” CMS Ex. 23 at 47; CMS Ex. 24 at 49. In response to Petitioner’s inquiry into the matter, Resident 1 stated that he did not have any kind of a relationship with Resident 2 and Resident 2 stated that he could not recall any incident with Resident 1. CMS Ex. 29 at 1.

* * *

On February 5, 2014, Resident 2 indicated to a CNA at Petitioner’s facility that “I’ve heard theres [sic] rumors going around about me that im [sic] homosexual, I am not a homosexual, im [sic] married and have a wife.” CMS Ex. 24 at 49.

On February 8, 2014, one of Petitioner’s nurses found Resident 1 in Resident 2’s room “stroking” Resident 2’s penis. Resident 2 was quiet. The nurse told Resident 1 to leave Resident 2’s room, which Resident 1 did. CMS Ex. 23 at 47; CMS Ex. 24 at 52. In response to Petitioner’s inquiry into the matter, Resident 1 stated that he did not have any kind of a relationship with Resident 2 and Resident 2 stated that he could not recall any incident with Resident 1. CMS Ex. 29 at 2.

* * *

On February 11, 2014, Resident 2 fondled the breasts of Resident 3. CMS Ex. 14 at 1; CMS Ex. 21 at 6. Staff separated Residents 2 and 3. CMS Ex. 21 at 6. However, when Petitioner’s staff reported this incident to supervisors, staff were informed not to intervene unless a resident was resisting. CMS Ex. 14 at 1; *see also* CMS Ex. 21 at 6; Tr. 58.

Resident 2 sexually touched Resident 3 several times between February 11 and 20, 2014, including one incident when he touched Resident 3's vagina. CMS Ex. 12 at 1, 4-7; CMS Ex. 13 at 1-2; CMS Ex. 14 at 1; CMS Ex. 21 at 6, 9; CMS Ex. 22 at 1-2.

ALJ Decision at 6-7 (finding numbers, intervening finding, and footnote omitted). The ALJ also found that facility records showed Resident 2 repeatedly made inappropriate sexual comments and inappropriately touched staff members and female residents on multiple other occasions in February 2014. *Id.* at 7-8.

Standard of review

The standard of review on a disputed factual issue is whether the ALJ decision is supported by substantial evidence in the record as a whole. The standard of review on a disputed issue of law is whether the ALJ decision is erroneous. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs*, available at <https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/participation/index.html>.

Analysis

1. Neighbors' challenges to the ALJ findings of fact

- a. *The ALJ's findings relating to the three residents are supported by substantial evidence.*

As mentioned above, Neighbors does not dispute the accuracy of the ALJ's factual findings about the residents involved but disagrees with their "completeness" and suggests additional facts which it asserts were relevant and supported by the record as to the residents' conditions. RR at 2-5. We address these claims about additional facts as to each resident in turn.

i. Resident 1

Neighbors contends that the ALJ portrays Resident 1 as being "of sound mind" and incorrectly placed in the dementia unit resulting in risks to other residents. RR at 2. In fact, Neighbors argues, despite the "snapshot" shown by his high BIMS score, Resident 1 "exhibited cognitive impairments and was judged to be appropriate for placement on the dementia unit." *Id.* at 2-3 (record citations omitted).

Contrary to Neighbors' suggestion, the ALJ specifically mentioned Resident 1's dementia, among other diagnoses, and that the staff had determined that he "would benefit" from placement in the dementia unit, while also quoting the facility's own description of the resident as "higher functioning." ALJ Decision at 5, quoting CMS Ex. 23, at 61 (Resident 1 care plan, dated January 29, 2014). Neighbors does not deny the salient point that Resident 1 was significantly more cognitively intact than the other two residents and explicitly states that Resident 1 "had the highest level of function of the three residents in question." Reply Br. at 3. Neighbors does deny that this fact alone made "every single interaction" he had with his peers "a reason for concern or a hazard that requires immediate intervention, investigation, and care planning." *Id.* at 3-4.

This argument, like many of those Neighbors makes on appeal, suffers from the straw-man fallacy; that is, it persuasively attacks a position that the opposing party has never advanced. Neither CMS nor the ALJ suggested that every interaction with Resident 1 presented a hazard to other residents merely because he was higher functioning. The issue they identified was that the facility had an obligation to investigate the circumstances and consider what planning was called for **after** he was found to be repeatedly masturbating a more vulnerable resident in an adjoining room accessible through the shared bathroom and after he denied that the activity had occurred. The substantial differences in cognitive functioning between Resident 1 and Resident 2 is simply one relevant factor that should have been considered in determining whether the interactions between them were consensual and whether additional action needed to be taken to ensure the safety and dignity of both residents.

The ALJ's findings about Resident 1 are supported by substantial evidence. Neighbors has not identified any additional material facts concerning Resident 1 about which the ALJ should have made findings.

ii. Resident 2

Neighbors disputes the "picture" it contends that the ALJ "paints" of this resident as "completely unable to make his needs and desires known to his caregivers." RR at 3. On the contrary, Neighbors says, Resident 2 could communicate through "his verbalizations and his behaviors" if he did not like a touch or approach, such as by "yelling, hitting, cursing, gra[bb]ing, punching, etc." *Id.* (record citations omitted, internal quotation marks omitted).

Again, Neighbors misrepresents what the ALJ found about this resident as he did not find him completely unable to make needs and desires known. The ALJ's description of his cognitive and behavioral status recited the facility's own assessments, which included that he "sometimes" was able to understand others, that his "ability to make decisions"

was “moderately impaired,” that he had “physical and verbal behavioral symptoms” and “wandering” that could intrude on others’ privacy, and that his BIMS score was 3 out of 15. ALJ Decision at 5-6. The picture painted by the record is of an individual whose judgment and understanding were seriously impacted by his various diagnoses and who was dependent on staff for his care and protection.

We have reviewed the record citations on which Neighbors relies for the proposition that Resident 2 could adequately communicate his dislike of a touch or approach. *See* RR at 3. The first is the declaration of Administrator Pawn Thammarath, who states that Resident 2 had dementia but was “alert and oriented as to place and person,” and also that he was a “fairly new resident,” having been admitted by his wife when he “became verbally abusive and she could no longer care for him in her home.” P. Ex. 1, at 3. This declaration does not establish that Resident 2 had the capacity to form consent to sexual touching or to express effectively any decision to decline such interaction. If anything, the statement that his illness had caused him to become verbally abusive so that his wife was not able to control and care for him reinforces concerns raised by the facility’s own records that he might intrude on other residents, sexually or otherwise. The administrator also makes a blanket assertion that each of the three residents “had been diagnosed with dementia, but were still able to make decisions regarding their personal wants and needs.” *Id.* The question before the ALJ was not whether these residents could make any decisions about their wants and needs. The facility’s own records clearly establish that Resident 2 had limited ability to make decisions and low and varying understanding of others. In that context, the ALJ’s description of Resident 2’s functional level is supported by substantial evidence and we see no basis for modifying it based on the vague generalization by the administrator about decision-making.

Neighbors also relies on statements about Resident 2 by Director of Nursing (DON) Wyant, who said that this resident “had cognitive deficits, “did make inappropriate comments to staff but was redirectable,” “was able to communicate his wants and desires with staff,” and could make it known if “someone was touching him inappropriately.” P. Ex. 6, at 2-3. The DON then concludes that she “is not aware of [Resident 2] engaging in any inappropriate behavior before his discharge from the facility” and that Resident 2 “could consent to companionship.” *Id.* at 3.

The facility’s progress notes for this resident include comments that (on February 18, 2014) he “has been inappropriately touching female residents and staff for entire shift,” behaviors that continued even after staff wrote on his whiteboard (his means of communication in light of his hearing loss) to stop such behavior, and that, the next day (February 19, 2014), he was again “making inappropriate sexual comments to staff and other res[idents].” CMS Ex. 24, at 57. In light of the facility’s having recorded multiple instances of sexual behavior it assessed as inappropriate, the ALJ could reasonably give

less weight to the DON's testimony about Resident 2's behavior or capacity even if the DON believed that Resident 2's grabbing of Resident 3's private areas was consensual or appropriate. Moreover, the relevant question is not whether Resident 2 could consent to companionship as a general matter, but whether the facility actually engaged in an assessment of his capacity to consent to sexual interactions, assessed whether he did in fact consent to the interactions with Resident 1, and planned for how his interactions with Resident 3 and other female residents would be handled to protect the safety and dignity of all the residents. Neighbors identifies no such assessment or planning regarding Resident 2's sexualized conduct.

Neighbors also cites to Resident 2's care plan as evidence that he could express objections behaviorally. RR at 3. But the cited reference is to a "problem" with the resident in that he "resists care (taking medications, ADL assistance)." CMS Ex. 24, at 62. His resistance to care is manifested by "yelling, hitting, cursing, grabbing, punching, trying to choke." *Id.*; see also Tr. at 19-21 (surveyor acknowledges care plan record of resisting care by nonverbal actions); Tr. at 52 (DON reporting resident yelled, hit, kick, or scratched when he did not want to be touched). Such inappropriate responses to attempts at providing care, which the facility correctly viewed as a problem for which it needed to (and did) plan interventions and approaches, do not necessarily demonstrate that the resident was able to make judgments about consenting to sexual approaches or that he could be assumed to have consented to every touching to which he did not respond violently. Furthermore, the resident's care plan has another entry just five days later stating as a problem that the resident "has difficulty making needs known d/t [due to] hearing impairment and cognitive-linguistic impairments s/p dementia." CMS Ex. 24, at 60. Thus, the staff caring directly for the resident did not view him as consistently able to express his needs and wants, however strongly he might at times act out his resistance to some caregiving.

We do not find that Neighbors' arguments show any need to make additional findings of fact concerning Resident 2. The existing findings made by the ALJ fully address the material facts and are supported by substantial evidence.

iii. Resident 3

Neighbors contends that a full picture of Resident 3 would include her being "able to make her needs known and [be] vocal," and being "very particular" about who touched her, so that she would "kick or push the person touching her against her wishes." RR at 4 (record citations omitted). She was also "known to have male friends in the facility" and had sought male companionship. *Id.*

The bases on which Neighbors seeks these additional findings about Resident 3 are very similar to those discussed in relation to Resident 2. The administrator and DON opined that Resident 3 could “make it known” to staff if she did not want to be touched or interacted with by yelling, pushing or hitting (Tr. at 52), that she was known to “strike out, kick, spit at or push” someone trying to touch her even though she “may not have been able to verbalize consent or discontent” (P. Ex. 1, at 3), and that she had a “flirty personality” and “preferred the company of men” (P. Ex. 6, at 3).

The general observations that the resident liked male company and could physically react against some unwanted interactions are of limited relevance to questions of whether the facility responded appropriately to assess whether she was able to, and did, consent or consciously choose to engage in the episodes in which Resident 2 fondled her and whether the facility made appropriate care plans based on such an assessment in order to protect her safety and dignity. Moreover, we find the comments particularly unpersuasive given that the staff member who observed the first encounter reported that Resident 3 could not hear and did not understand what Resident 2 wanted, which is why she separated the residents for Resident 3’s “own safety” because Resident 2 was “very suggestive.” ALJ Decision at 12, quoting CMS Ex. 21, at 7. The surveyor also saw Resident 3 wandering in the unit asking “Where’s Ma?” which certainly suggests a degree of confusion that, at a minimum, would call for careful assessment of capacity and safety. CMS Ex. 12, at 9.

The only contemporaneous record cited in support of these assertions about Resident 3’s capacity to decline interactions is her care plan noting as a problem her resistance to care. CMS Ex. 25, at 59. The staff noted that she “resists care at times – taking a shower and changing her clothes. She will put dirty clothes back on She also refuses to take her medication, get out of bed and eat.” *Id.* It was not unreasonable, much less legally improper, for the ALJ to decline to infer from this record of the severely impaired resident’s erratic resistance to appropriate care (rather than to sexualized behavior) that she could be assumed to be consenting to all sexual touching to which she did not demonstrate physical resistance.⁴

Both the administrator and the DON made blanket assertions that all three residents were still able to make decisions about their personal wants and needs despite their dementia diagnoses. P. Ex. 1, at 3; P. Ex. 6, at 4. The ALJ gave considerably more weight to the contemporaneous records of the residents’ care and the statements made by direct care staff about the events at issue (discussed above and in the next section) than to these

⁴ The care plan also indicates that the resident had “socially inappropriate/disruptive behavioral symptoms,” such as rummaging, hoarding, and taking others’ belongings out of their rooms, and that she is “combative” to redirection. CMS Ex. 25, at 60, 66. These behavioral symptoms further reinforce her need for careful assessment and supervision.

conclusory opinions of management. Neighbors has given us no compelling reason to disturb the ALJ's choice in that regard. *See, e.g., Ridgecrest Healthcare*, DAB No. 2598, at 10 (2014) (“following our settled precedent, absent compelling reasons for not doing so, we defer to the ALJ's assessment of the credibility of witnesses and weighing of evidence”).

The ALJ's findings about Resident 3 are supported by substantial evidence. Neighbors has not identified any additional material facts about which the ALJ should have made findings.

- b. *Neighbors' contentions relating to the resident-on-resident episodes are without merit.*

Neighbors takes specific exception to only two findings of fact. The first disputed finding (#19 in the ALJ Decision) involved Resident 2's touching of Resident 3's breast on February 11, 2014, and stated that, when staff separated the residents and reported the episode to supervisors, “staff were informed not to intervene unless a resident was resisting.” ALJ Decision at 7. Neighbors describes this ALJ finding as a “characterization” that its policy required “a struggle or other overtly obvious sign” of resistance to intervene. RR at 4-5. According to Neighbors, its actual policy was “far more complex and nuanced” with its staff trained to “intervene and separate residents if they observe interactions that are unwanted,” to look for signs of abuse, and to respect the rights of residents, including “the right to engage in consensual relationships.” *Id.* at 5, citing P. Exs. 1 and 6 and Tr. at 53, 57 (Wyant testimony).

We do not accept the facility's characterization of the ALJ's finding and find no support in the record to support the claimed complexity and nuance of its policy. The words “struggle” and “overtly obvious sign” are Neighbors' words, not the ALJ's. Moreover, the ALJ finding is supported by the record because it credited statements that direct care staff made to the surveyor about their understanding of the facility's policy for dealing with sexual contact between residents and contemporaneous records of how the staff actually responded. For example, in discussing the first time Resident 1 was found in Resident 2's bed masturbating him (*see* ALJ Decision at 9), the ALJ cited a CNA who explained in an interview with the surveyor that “no one did anything – we were told it's OK because [they're] both adults and [Resident 2] didn't complain.” CMS Ex. 21, at 8. The ALJ therefore found that the facility “policy was only to intervene in a situation such as this if a resident protested at the actions of the other resident.” ALJ Decision at 9, citing CMS Ex. 21, at 8-9; CMS Ex. 23, at 47; and CMS Ex. 24, at 49 (progress notes of the two residents noting incident but showing no other action).

The second time the same situation was observed, the ALJ found, a nurse who did intervene was later counseled by the DON for “breaching the policy since Resident 2 was silent while Resident 1 was touching him.” ALJ Decision at 10, citing Tr. at 58-59; *see also* CMS Ex. 23, at 47. The DON agreed that she counseled the nurse because she considered the nurse’s action to be “incorrect.” Tr. at 58-59. The DON did not offer any explanation of her action that was inconsistent with the ALJ’s conclusion that the policy was that any intervention is inappropriate if the resident involved is not protesting or physically resisting.

There is no contemporaneous evidence of the complexity and nuance Neighbors now claims. At the hearing, the facility management witnesses described a policy of educating staff to closely watch residents “for any signs that a relationship is unwanted” and for “any change in status to determine that the relationship continues to be a conscious choice” while respecting that “two residents do have the ability to consent to a relationship” P. Ex. 1, at 2 (Administrator Thammarath Decl.). According to Neighbors’ administrator and DON, this “compassionate policy and procedure” means that the staff monitored residents with “intimate relationships” for “behaviors and signs of both consensual relationships and abuse,” because it is “the job of the facility” to monitor those relationships in such a way as to balance “both the resident’s need for privacy and dignity and the safety of each resident involved” *Id.* at 1-2; P. Ex. 6, at 3-4.

However, despite this testimony and Neighbors’ contention that its policy was more nuanced than the ALJ described, Neighbors does not deny the actual finding of the ALJ that the staff members who separated Resident 2 from Resident 3 “were informed not to intervene unless a resident was resisting.” ALJ Decision at 7. The surveyor recorded in the SOD that the activity aide who saw the February 19, 2014 episode⁵ reported her understanding that the staff “were taught to provide privacy and intervene if there is protesting by one of the residents.” CMS Ex. 12, at 4. The CNA mentioned above, who also observed this interaction, stated that they “split them up when [they] see it” and that she was taught that she should “just separate, if no one is resisting then it is ok.” *Id.*

Nor does the contemporaneous record support the existence of a policy of closely monitoring or reevaluating intimate relationships as alleged in the testimony. The progress notes in the record for these residents do not record any follow-up monitoring or observations after each episode to specifically assess the existence or nature of these supposed “relationships.” CMS Ex. 23, at 47 (Resident 1 noted later on February 4, 2014

⁵ Resident 2 was observed by staff touching Resident 3 in a sexual manner on February 11, 19, and 20, 2014. The staff explained to the surveyor that they did not report the incidents to management because “facility policy required intervention and reporting only if the victim protested.” CMS Ex. 38, at 4 (Surveyor Conley Decl.), citing CMS Ex. 14, at 1 (summarizing staff interviews) and CMS Ex. 21, at 6-9.

to be in day room “without behaviors” and early on February 5 as “[c]ontinues on Q 15 minute checks” with no “adverse behaviors” but no record of any other checks until February 8, 2014 episode); CMS Ex. 24, at 49 (Resident 2 had been punched in the face by an unnamed resident on February 3, 2014; progress review notes February 4, 2014 episode with Resident 1 saying Resident 2 “had no signs of objections,” follow-ups appear on lack of injury after punching, but nothing on the sexual encounter except Resident 2 commenting to CNA about “rumors” that he was “homosexual” and stating he was “married and [had] a wife”). No incident reports exist related to any of the episodes among these residents, and management was not aware of Resident 2 fondling Resident 3 repeatedly. CMS Ex. 12, at 6; *see also* P. Exs. 1 and 6 (administrator and DON do not deny statement in SOD to this effect). Neighbors does not identify any changes to any of the residents’ care plans to reflect assessment, monitoring or planning about their sexual behaviors and interactions in response to the reported episodes.

Whatever the management may have intended to be the facility policy for handling sexual contact between residents with dementia, the staff implementing that policy understood it to be as the ALJ found in his decision, i.e., that no action is called for unless “there was an express objection from a resident to the touching” or “if one [of the residents] were actively objecting.” ALJ Decision at 14. Moreover, the CNA’s confusion about whether she was supposed to separate residents or simply provide them privacy reinforces the lack of clear training on how to respond to sexual activity by residents. Neighbors did not present any of the staff members interviewed by the surveyor (apart from management) as witnesses, so the ALJ could reasonably conclude that the surveyor accurately reported their statements. Moreover, Neighbors did not present testimony from any nurses, CNAs, or other line staff or in-service documentation⁶ to substantiate that they received “complex and nuanced” training in how to determine that a “relationship” remained a “conscious choice” and what steps to take to closely monitor intimate relationships to protect safety and dignity. The absence of assessments or documentation of any follow-up monitoring or planning at the time of the episodes at issue further supports the ALJ’s finding that the policy, at least as implemented by staff, did not call for any action at all unless one of the residents involved in a sexual encounter protested or resisted overtly.

We conclude that finding #19 is supported by substantial evidence.

The second disputed finding (#20) stated, in relevant part, that “Resident 2 sexually touched Resident 3” ALJ Decision at 7. Neighbors takes exception to the finding that the touching was sexual on the grounds that it is not possible to know Resident 2’s intent. RR at 5.

⁶ Neighbors did submit its Abuse Prevention Program Facility Policy, which focuses mainly on staff conduct. P. Ex. 5. The policy does include some discussion of resident-on-resident abuse and of training new employees on “[s]ensitivity to resident rights and resident needs” but not on assessing whether resident interactions are conscious and consensual or on monitoring and care planning about such interactions. *Id.* at 3.

This finding is in essence merely a description based on the undisputed fact that Resident 2 repeatedly touched Resident 3's private areas (breast and vagina). Whether Resident 2 intended or understood his actions to be sexual in nature is not relevant to the issue of the facility's failure to assess and plan for the behavior and determine whether Resident 3 was capable of consent and actually did consent. In any case, the record is replete with evidence that the staff determined that Resident 2 was hypersexualized, particularly after the episodes with Resident 1. *See, e.g.*, CMS Ex. 12, at 4 (staff told surveyor resident's suggestive behaviors "more prevalent" since incident with Resident 1); CMS Ex. 14, at 1 (staff told surveyor Resident 2 "has been exhibiting hyper sexual behaviors" and nurse practitioner notified on February 19, 2014; CMS Ex. 32, at 11, 18 (progress notes that he "makes sexual remarks to staff during care" and staff "do not do his care alone;" makes "sexual comments," asks to "touch breast" during care). Evidently, Neighbors' staff understood Resident 2's behavior to be sexual in nature. We conclude that the ALJ's description of the touching as sexual is supported by substantial evidence.

2. Neighbors' challenges to the ALJ's legal conclusions

- a. *The ALJ's conclusion that Neighbors was not in substantial compliance with section 483.25(h) is free from legal error.*

The core dispute in this case arises less from any disagreement about the individuals or events at issue than from contrasting views of the significance to be attributed to the events. Neighbors takes exception to the ALJ's noncompliance conclusion on the grounds that he relied "primarily" on the surveyor's "observations and opinions" instead of the "testimony of staff" who knew the residents better and the facility documentation which Neighbors says clearly shows "patient-centered supervision" resulting in "safety and happiness" for the residents. RR at 5-6.⁷

The Board has articulated the application of section 483.25(h) in the context of sexualized behavior by residents with cognitive impairments as follows:

Section 483.25(h) requires a SNF to "ensure" that each resident receives "adequate supervision." "Ensuring" adequate supervision involves (among other things): (1) identifying safety hazards or risks of harm in a resident's environment; (2) devising and implementing a plan of supervision to

⁷ Neighbors also claims this conclusion "relies heavily" on finding that Resident 1 was inappropriately placed in the dementia ward, RR at 6, but the ALJ made no such finding as we have already explained. Indeed, the only apparent consideration given to moving Resident 1 off the ward was by facility staff prior to the survey, but the resident rejected the planned move and it did not occur. CMS Ex. 23, at 47-49 (progress notes from February 4 to 20, 2014).

minimize the hazards or risks; and (3) monitoring and assessing the effectiveness of a supervision plan on an ongoing basis. *See* [State Operations Manual], App. PP (guidelines for F371) (noting certain elements of adequate supervision in the section entitled “Intent”).

In applying section 483.25(h), the Board has held that a SNF’s supervision of a resident must “meet the resident’s assessed needs” and “reduce known or foreseeable accident risks to the highest practicable degree, consistent with accepted standards of nursing practice.” *Century Care of Crystal Coast*, DAB No. 2076, at 6-7 (2007), *aff’d*, *Century Care of the Crystal Coast v. Leavitt*, 281 F. App’x 180 (4th Cir. 2008). A SNF has flexibility to choose the methods of supervision so long as the chosen methods are adequate under the circumstances to protect the resident from known or foreseeable risks of harm. *Liberty Commons Nursing and Rehab – Alamance*, DAB No. 2070, at 3 (2007).

* * *

. . . As the Board has stated, section 483.25(h) places an “affirmative duty [on facility staff] to intervene and supervise . . . behaviorally impaired residents in a manner calculated to prevent them from causing harm to themselves and each other.” *Vandalia Park*, DAB No. 1940, at 18 (2004), *aff’d*, *Vandalia Park v. Leavitt*, No. 044283 (6th Cir. Dec. 8, 2005)

Libertywood Nursing Ctr., DAB No. 2433, at 7 (2011), *aff’d*, *Libertywood Nursing Ctr. v. Sebelius*, 512 F. App’x 285 (4th Cir. 2013).

Neighbors has framed its practices from the start of this dispute as respectful of residents’ friendships and choices and based on Alzheimer’s Association (AA) guidance. For example, in requesting informal dispute resolution at the state level, Neighbors quoted an AA brochure stating that residents “have the right to ‘seek out and engage in sexual expression and to be given privacy to carry on intimate relationships.’” CMS Ex. 33, at 2 (quoting attached AA brochure at 12). Neighbors characterizes CMS’s position, by contrast, as denying residents any right to companionship or association with others. Neighbors contends that the “only reason” that CMS deems the residents here “incapable of consenting to sexual activity . . . is their respective diagnoses of dementia.” *Id.* at 2.

Neighbors misrepresents the AA guidance and CMS’s position in this case, both of which focus on the importance of evaluating **individual** resident’s capacity for consent and need for protection, monitoring resident-to-resident contacts systematically, and planning care for the individual resident and situation. These steps are key to providing adequate

supervision to protect residents in any area which may present risks, and unwanted sexual touching is a foreseeable risk if staff is not trained to implement a policy of sensitively assessing sexual contact between residents with dementia and making appropriate care plans, so as to determine consent and manage behaviors.

The AA calls for facilities to engage in the balancing process of protecting both the right to intimate, consensual relationships which may “sometimes” mean stepping back and doing “nothing immediately,” and the right of “people with dementia” to be “protected from others,” meaning that facility staff “may need to act on their behalf for their own safety.” CMS Ex. 31, at 11. Staff should be trained to notify “someone in authority” who can consult the resident’s family or representatives, document observations of behavior and “intervene immediately and protect” the resident, if a resident is “being forced into a sexual situation, or is incapable of giving consent or is being harmed.” *Id.* at 12.

A dementia diagnosis does not automatically preclude a capacity to consent to sexual expression, but such a diagnosis does require a facility to at least inquire into that capacity on an individual basis if the resident becomes involved in sexual activity. The ALJ made clear that his finding was that Neighbors did not perform its own responsibility of making the necessary inquiry in order to assess the supervision the residents needed. Thus, the ALJ concluded the following as to Resident 2:

Resident 2, a resident with severe cognitive decline, nearly no hearing, and who was only mobile when in his wheelchair, was being sexually touched while lying in bed by a mobile, cognitively intact resident who had access to Resident 2’s room through an adjoining bathroom. This situation alone should have caused Petitioner to fully inquire as to whether Resident 2 consented to these actions, but instead only brought about some cursory questioning of the residents involved almost two weeks after the incidents.

ALJ Decision at 11. As to Resident 3, the ALJ concluded that her incapacity was so manifest on the record that he credited the surveyor’s opinion, based on her expertise (and her own observation of the resident), that Resident 3 “could not protest given her cognitive impairments, and this also prevented her from making a conscious decision to consent to engage in sexual behavior with other residents.” *Id.* at 12, quoting CMS Ex. 38, at 5 and citing Tr. at 35. As the Board has held in other contexts, some situations present “[i]rreducibly hard choices . . . between preserving freedom and dignity and preserving health and safety” for SNF residents, but a facility may not abdicate “its responsibility to its residents to engage in the struggle to optimize both aspects of their well-being to the maximum extent practicable.” *Woodstock Care Ctr.*, DAB No. 1726, at 35 (2000), *aff’d*, *Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 (6th Cir. 2003).

In that context, Neighbors could not meet that responsibility by merely presuming that lack of resistance implied consent. We agree with the ALJ that “[c]onsent is not assumed simply because a victim of a sexual assault does not object while the assault is taking place, especially where, as here, the victim has severe cognitive deficits.” ALJ Decision at 11. The lack of contemporaneous assessments or planning means there is no evidence that that the staff actually made any effort to determine whether the activities they happened to observe were desired and safe for the residents involved.⁸ It appears that the staff members reacted by either separating the residents or by taking no action, according to their diverse understanding of facility policy, with no record of any follow-up measures either way. Based on the records of the facility (and the lack of testimony to the contrary from the caregivers, as opposed to management, about what was done in response to the behaviors at issue), the ALJ could reasonably conclude that the non-interference amounted to a lack of supervision and care, rather than affirmative support of resident needs for companionship.

The ALJ’s conclusion is further supported by what the facility staff did not do based on the clinical records. They did not talk to the residents about their feelings about these “relationships”; they did not document the residents’ capacity for consent (or lack thereof) or communicate with residents’ physicians for medical assessment of how their cognitive deficits impacted that capacity; they did not discuss the developments with the residents’ responsible parties and/or families; they did not record any monitoring of the behaviors or make any care plans to account for them. In short, the facility did not provide adequate supervision to ensure that its residents would not be subjected to inappropriate sexual touching by other residents.

We find no legal error in the ALJ’s conclusion that Neighbors was not in substantial compliance as cited.

b. *CMS’s immediate jeopardy determination is not clearly erroneous.*

Neighbors asks us to overturn the ALJ’s conclusion upholding CMS’s immediate jeopardy determination. RR at 8. Neighbors points to no legal error in the ALJ’s conclusion but rather asserts again that a review of the facts will show it to have been in

⁸ Neighbors attempts to make a virtue of a fault in its failure to conduct any assessment or investigation after staff observed Resident 1 touching Resident 2. Neighbors acknowledges that, when asked about the interactions days afterward (when the administrator belatedly undertook an investigation), Resident 1 denied that they occurred and Resident 2 did not remember them. RR at 7. Neighbors construes this as support for the need to simply rely on the staff’s “impression” in the moment and claims staff observations ensured that no signs of abuse were shown in the days that followed each episode. *Id.* On the contrary, the fact that the residents were incapable of responding meaningfully to such inquiries days after the incidents, underscores the importance of doing an inquiry and assessment as close to the incident as possible, which could easily have been done here where staff observed the incidents as they happened.

substantial compliance and to have provided all three residents with “supervision, care planning, programming and other necessary care to ensure their comfort, safety and the safety of their peers” *Id.*

In reviewing an immediate jeopardy determination, the ALJ (and the Board) must defer to CMS’s determination absent a showing of clear error. 42 C.F.R. § 498.60(c)(2). This regulatory standard means, as the Board has explained, that a facility bears a heavy burden in challenging the assessment of immediate jeopardy, which, of necessity, includes an element of judgment. *Meadowwood Nursing Ctr.*, DAB No. 2541, at 14 (2013); *Britthaven of Havelock*, DAB No. 2078, at 29 (2007), and cases cited therein. The Board has also long held that immediate jeopardy need not be based on the occurrence of actual harm but, rather, requires only the “likelihood” that serious harm may result from the noncompliance. *Crawford Healthcare and Rehab.*, DAB No. 2738, at 17 (2016); *Woodstock*, DAB No. 1726, at 39.

The ALJ in this case cogently summarized why he concluded that Neighbors has shown no clear error in CMS’s determination that the noncompliance constituted immediate jeopardy:

There is no question that Petitioner placed Resident 2’s and Resident 3’s health in immediate jeopardy, because Petitioner failed to take appropriate action to determine whether they consented, or even had the capacity to consent, to sexual touching from others. Even though staff tried to intervene in some instances, Petitioner’s policy was not to intervene unless there was an express objection from a resident to the touching. This not only led to multiple instances where Residents 2 and 3 were sexually touched, but generally put the resident population at risk because Petitioner would only stop a sexual incident between residents if one were actively objecting. Under Petitioner’s misguided policy, all residents, especially those with severe cognitive or other deficits which may have adversely impacted their ability to actively protest or object, were potentially vulnerable and unprotected from being victimized in such situations.

ALJ Decision at 14.

Having found that the ALJ’s evaluation of the facts here was based on substantial evidence and that his conclusion on noncompliance was free of error, we can see in Neighbors’ arguments no basis to disturb his conclusion that CMS’s immediate jeopardy determination was not clearly erroneous.

- c. *The ALJ's conclusion that the CMP amount is reasonable is free from legal error.*

Finally, Neighbors argues that the CMP imposed here is unreasonably high and that such a “huge” sum as \$83,800 is unwarranted under the circumstances. RR at 9.

The total CMP of \$83,800 resulted from the sum of a \$5,150 per-day CMP for 16 days and \$100 per-day CMP for 14 days. CMS Ex. 8, at 1. We would be required to uphold a CMP of at least \$3,050 per day for the period during which we concluded that immediate jeopardy was present and at least \$50 per day for the period during which the immediate jeopardy was abated but noncompliance persisted. 42 C.F.R. §§ 488.438(a)(1)(i) (\$3,050 per day to \$10,000 per day range for immediate-jeopardy noncompliance), 488.438(a)(1)(ii) (\$50 per day to \$3,000 per day range for non-immediate-jeopardy noncompliance), 488.438(c)(2) (requiring CMS to shift the penalty amount from the higher to the lower range when immediate jeopardy is abated but noncompliance continues), and 488.408(e)(1), (2) (stating that an “administrative review authority” may not reduce a CMP to zero or review the exercise of discretion by CMS to impose a CMP). Hence, as a matter of law, the minimum CMP here would be \$49,500, or \$3,050 x 16 plus \$50 x 14.

The ALJ conducted a de novo review of the relevant factors and concluded that the CMPs imposed (which were in the lower areas of the applicable ranges) were appropriate in light of Neighbors’ history of prior noncompliance and its high culpability in the present case.⁹ ALJ Decision at 14-16, citing 42 C.F.R. §§ 488.438(f), 488.438(e)(3).¹⁰

Much of the facility’s argument on the CMP amount relies again on its version of the factual situation based on which it contends that its culpability, if any, was “minimal,” because it took “measures to ensure that each resident, even those with dementia, could interact with their peers in ways that support their personal well-being, dignity and right to self determination.” RR at 10. But, as explained above, this is precisely what Neighbors failed to do.

⁹ The ALJ also rejected Neighbors’ claim for a reduction in amount based on financial condition. ALJ Decision at 15-16. Neighbors has not pressed that claim on appeal, and we see no basis for disturbing the ALJ’s conclusion.

¹⁰ The relevant factors under 42 C.F.R. § 488.438(f) are: (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 referenced factors at 42 C.F.R. § 488.404 are: (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.

As to prior noncompliance, the ALJ found that a November 25, 2013 survey --

revealed a number of deficiencies at the D, E, and F level of scope and severity. CMS Ex. 36. More significantly for this case, Petitioner also had a G level deficiency (actual harm that is not immediate jeopardy) for a deficiency under F223 (Resident's right to be free from abuse or involuntary seclusion), as well as D and E level deficiencies under F323 (i.e., the deficiency cited in this case). CMS Ex. 36 at 1.

ALJ Decision at 15. Neighbors argues that the F323 deficiency in the prior survey was based on findings¹¹ that two residents were not supervised while eating and a resident was transferred without using a gait belt which are unrelated to the facts underlying the present case. RR at 9-10. Neighbors asserts that the prior noncompliance factor must be applied with "specificity" as to the facts (RR at 10), but we find no such restriction in the regulation, which explicitly provides for consideration of all prior noncompliance both "in general and specifically with reference to the cited deficiencies." 42 C.F.R. § 488.404(c)(2). Certainly, the repetition of identical fact patterns to those for which a facility has previously been held liable would be particularly significant. The Board has held, however, that the regulation does not require finding even a repeat of the same deficiency to enhance the appropriate penalty, and hence clearly it does not require the recurrence of identical facts underlying the deficiency. *Burton Health Care Ctr.*, DAB No. 2051, at 19 (2006) ("The regulation does not require that there be repeated deficiencies or extensive prior noncompliance in order for a facility's history of noncompliance to be considered in determining the CMP amount.").

We uphold the ALJ's conclusion that the CMP amount is reasonable.

¹¹ Neighbors refers to the November 2013 survey results as "allegations" (RR at 10) but offers no evidence that it appealed the findings, so we will presume them to be administratively final.

Conclusion

We sustain the ALJ Decision in its entirety and uphold the \$83,800 CMP imposed by CMS.

_____/s/
Sheila Ann Hegy

_____/s/
Constance B. Tobias

_____/s/
Leslie A. Sussan
Presiding Board Member