

Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Maysville Nursing and Rehabilitation
Docket No. A-17-101
Decision No. 2874
May 31, 2018

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

Petitioner Maysville Nursing and Rehabilitation, a Medicare nursing facility, appeals an Administrative Law Judge (ALJ)'s decision sustaining the Centers for Medicare & Medicaid Services' (CMS's) determination to impose civil money penalties (CMPs) totaling \$168,500 for violating federal requirements for the care of nursing facility residents and the administration of nursing facilities. The cited deficiencies arose from Maysville's failure to protect one resident from repeated pursuit, attempts to touch, and touching, by another resident. In upholding CMS's determination, the ALJ found that the deficiencies were at the immediate jeopardy level and that the CMPs imposed were reasonable. *Maysville Nursing & Rehab.*, DAB CR4859 (2017) (ALJ Decision). We sustain the ALJ Decision.

Legal background

Nursing facilities that participate in the Medicare program must be in "substantial compliance" with the requirements for long-term care facilities in 42 C.F.R. Part 483, subpart B, which include, as relevant here, requirements for resident care facility administration. 42 C.F.R. §§ 488.400, 483.1.¹ As relevant here, these regulations require facilities to assess residents and develop comprehensive care plans for residents, to respond to changes in a resident's condition, to protect residents from abuse, neglect and other mistreatment, and to investigate allegations of abuse. Facilities must also maintain complete and accurate clinical records, and be administered in a manner that enables them to use their resources effectively and efficiently to attain or maintain the highest

¹ Effective November 28, 2016, the requirements for long-term care facilities in Part 483 subpart B were revised and redesignated. Final Rule, *Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities*, 81 Fed. Reg. 68,688, 68,848 (Oct. 4, 2016); 82 Fed. Reg. 32,256 (July 13, 2017) (technical corrections). We rely on the regulations in effect when the state agency performed the survey(s) that formed the bases for CMS's determination of noncompliance. *Carmel Convalescent Hosp.*, DAB No. 1584, at 2 n.2 (1996) (The Board applies the regulations in effect on the date of the survey and resurvey.).

practicable physical, mental, and psychosocial well-being of each resident. 42 C.F.R. §§ 483.10, 483.13, 483.20, 483.75.

Under agreements with the Secretary of Health and Human Services, state survey agencies inspect facilities to verify compliance with the Medicare participation requirements. *Id.* §§ 488.10(a), 488.11; *see also* Social Security Act (Act) §§ 1819(g)(1)(A), 1864(a).² A state agency reports any “deficiencies” it finds in a statement of deficiencies (SOD). A “deficiency” is any failure to comply with a Medicare participation requirement, “noncompliance” is “any deficiency that causes a facility to not be in substantial compliance,” and “substantial compliance” means “a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.” 42 C.F.R. § 488.301.

CMS may impose one or more remedies on noncompliant facilities, including per-day CMPs. 42 C.F.R. §§ 488.402(b), (c), 488.406, 488.408(d)(1)(iii), (iv), (e)(1)(iii), (iv), 488.430(a). CMS may impose a per-day CMP of \$50-\$3,000 per day for noncompliance at a level less than immediate jeopardy, and a per-day CMP of \$3,050-\$10,000 per day for noncompliance that poses immediate jeopardy. *Id.* §§ 488.408(d)(1)(iii), (e)(1)(iii), 488.438(a)(1).

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, which is a determination about the level of noncompliance, unless the petitioner shows that it is clearly erroneous. *Id.* § 498.60(c)(2).

Background and ALJ Decision

Case history

The state agency, the Kentucky Cabinet for Health and Family Services, conducted a complaint survey of Maysville from August 18 through September 11, 2014, and alleged that Maysville had eight deficiencies, each alleging noncompliance with one or more of the requirements for long-term care facilities in the regulations in subpart B of Part 483. The state agency alleged, and CMS agreed, that Maysville was not in substantial compliance with regulations requiring that nursing facilities protect residents from abuse,

² The current version of the Act can be found at https://www.ssa.gov/OP_Home/ssact/ssact-toc.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, cross-reference tables for the Act and the United States Code can be found at http://uscode.house.gov/table3/1935_531.htm and https://www.ssa.gov/OP_Home/comp2/G-APP-H.html.

report and investigate allegations of abuse, respond immediately to significant changes in a resident's condition (by consulting with the resident's physician and notifying the resident's legal representative or family), periodically assess a resident's condition and update the resident's care plan and treatment accordingly, maintain accurate clinical records, and administer the facility in a manner that will attain or maintain the highest practicable well-being of each resident – all at the immediate jeopardy level beginning on July 26, 2014. ALJ Decision at 2-3; CMS Exhibit (Ex.) 21 (SOD); 42 C.F.R. §§ 483.10(b)(11), 483.13(b), (c), 483.20(k), 483.75, 483.75(l). The cited regulations also require that the facility develop and implement policies and procedures to ensure compliance with these requirements.

The state agency completed a revisit survey on December 3, 2014, based on which CMS determined that the facility returned to substantial compliance on September 11, 2014, and that the immediate jeopardy had ended on September 3, 2014. ALJ Decision at 3; CMS Ex. 2. CMS imposed CMPs of \$4,300 per day for the 39 days of immediate jeopardy (July 26-September 2, 2014) and \$100 per day for the eight days of substantial noncompliance below the immediate-jeopardy level (September 3-10, 2014) (\$168,500 total CMPs). *Id.*

Maysville requested a hearing to challenge the survey findings, including the Immediate Jeopardy determination, as well as the CMPs. The ALJ convened a video conference hearing on January 11, 2017, and admitted CMS's exhibits 1 through 29, and Maysville's exhibits (P. Exs.) 1 through 6. The ALJ sustained all eight deficiency findings CMS alleged, as well as the total CMPs CMS imposed. The ALJ concluded that, "from July 26 through September 10, 2014, the facility was not in substantial compliance with Medicare program requirements," that "from July 26 through September 2, 2014, its deficiencies posed immediate jeopardy to resident health and safety," and that the CMPs CMS imposed were "reasonable." ALJ Decision at 1, 18.

Summary of core facts

This case arises from multiple incidents of one Maysville resident's aggressive behaviors towards another resident beginning on July 26, 2014. We first set out herein a summary of those incidents, based primarily on the ALJ's factual findings. We do so because those incidents are common to, and are at the root of, all of the deficiencies that we will address in more detail later, in the "Analysis" section of our decision. We then briefly address another core ALJ finding – that Maysville deliberately did not document these incidents at the management's direction – because that finding, which Maysville does not specifically dispute, underlies all of the ALJ's deficiency determinations that we uphold.

At the time of the first incident on July 26, 2014, Resident 2 (R2) was an 89-year-old man with Parkinson's disease, depression, and other serious disorders. Prior to July 26, 2014, R2 was "cognitively intact," having scored "15 out of 15 on his mental status

exam” in January, April and June 2014. The resident who was the target of R2’s conduct, identified as Resident 1 (R1), was a 74-year-old, “seriously demented” woman who had “a multitude of conditions, including Alzheimer’s disease, advanced dementia, and anxiety” and “limited” “verbal skills,” and had scored zero on her mental status exam, “indicating that she was severely impaired.” ALJ Decision at 5, 6.

Prior to July 26, 2014, R2 “had not displayed any aggressive or otherwise inappropriate sexual behavior.” *Id.* at 6. Then, the ALJ found, the following happened:

- On July 26, 2014, a nurse aide, alerted by a visitor to the facility, saw R2, in the hallway, in his wheelchair, with his hand in the waistband of R1’s pants. The nurse aide reported the incident to two licensed practical nurses (LPNs), who reported it to the facility administrator, who told staff to conduct 15-minute checks of R2 and *not to document the incident*.³ *Id.*
- On July 27, 2014, R2 twice attempted to enter R1’s room, succeeded once, tried to reach R1’s genital area, was impeded by an over-the-bed table, and was separated from R1 by staff. Staff reported this incident to the administrator, who instructed staff to continue 15-minute checks of R2. *Id.* at 6-7.
- On July 28, 2014, R2 put his hands under R1’s shirt. Staff reported the incident to the director of nursing, and the facility administrator administered a mental status examination on which R2 scored a “7,” meaning severe impairment. *Id.* at 7.
- On July 30, 2014, after R2 “was continuing to stalk⁴ R1,” Maysville “finally” consulted his physician, Dr. Wallingford, “about the behavioral changes, describing increased confusion and ‘inappropriate behaviors’ toward another resident.” *Id.* at 8. Dr. Wallingford ordered R2 tested for a urinary tract infection and transferred to a hospital for psychiatric evaluation. Before being sent to the hospital, R2 scored 10 on another mental status examination, indicating moderate impairment. *Id.* R2 was readmitted to Maysville on August 4, 2014, after which staff were directed to conduct 15-minute checks which they did not do consistently, and R2 was seen with his hand down R1’s pants. *Id.* at 8, 15. (Of

³ The ALJ noted that, because the management directed staff not to document the incidents, the record does not include contemporaneous documentation or incident reports, and that the evidence of incidents is derived from surveyor notes and witness testimony, some of which the ALJ noted was self-serving and unreliable and much of which the ALJ said was imprecise as to details like dates and times of the incidents. ALJ Decision at 6 n.3. We discuss this further in the next subsection.

⁴ The ALJ used the term “stalk” here when characterizing R2’s conduct toward R1. We note that the Commonwealth of Kentucky’s Revised Statutes Chapter 508 defines the crime of “stalking” in that state. Neither the ALJ’s use nor our quotation of the ALJ’s use of the term “stalk” in this appeal constitutes an opinion on whether R2’s conduct constituted a violation of the Kentucky stalking criminal statute, and no such legal conclusion is necessary or relevant to our analysis of Maysville’s appeal.

the ALJ's findings about R2's actions towards R1, Maysville disputes only that R2 was seen with his hand inside R1's pants after his return from the hospital on August 4, 2014.)

- The record exhibits on which the ALJ relied also show that on August 9, 2014, Maysville sent R2 back to the hospital for another evaluation after he twice attempted to enter R1's room. *See* CMS Ex. 17, at 8 (hospital discharge summary).

The ALJ also made another important finding – that Maysville's "management directed staff *not to document these incidents . . .*" ALJ Decision at 6 n.3 (ALJ's italics) (citing CMS Ex. 26, at 51, 52, 55, 57, 66, 68, 69, 70). Specifically, the ALJ found, based on records of state agency surveyor interviews with facility staff, that after the first touching incident on July 26, 2014, the facility administrator, Cortney Burkhart, "told staff to conduct 15-minute checks on R2 but *not* to document the incident" (*id.* at 6 (citing CMS Ex. 26, at 51, 57-60)) and that "– at management's direction – staff did not document any incidents" of R2 laying his hands on R1 (*id.* at 12) that form the basis of CMS's enforcement action here. Consequently, the ALJ found, "the record contains no contemporaneous documentation or incident reports," and "the evidence of abuse is derived from the surveyor interview notes and witness testimony," some of which "is self-serving and unreliable, and much of which is not precise, especially regarding dates and times." *Id.* at 6 n.3. Maysville does not specifically dispute the ALJ's finding that Maysville's management directed staff not to document the incidents, but contends that it did not attempt to conceal R2's abuse of R1. Request for Review of ALJ Decision (RR) at 4. However, CMS need not show that Maysville concealed the fact of abuse. Nonetheless, the deliberate failure to document abuse, which underlies the ALJ's determinations that Maysville failed to maintain complete and accurate records, investigate abuse, properly update R2's care plan, and govern itself effectively, placed Maysville in noncompliance with many of the regulatory requirements at issue.

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>; *see also Golden Living Ctr. – Frankfort v. Sec'y of Health & Human Servs.*, 656 F.3d 421, 426-27 (6th Cir. 2011) (holding that this is "the correct standard of review").

Analysis

- I. The ALJ’s determinations that Maysville in its care of R1 and R2 was not in substantial compliance with the requirements for long-term care facilities are supported by substantial evidence and are free of legal error.

The ALJ addressed and sustained the deficiencies in four categories, each under a numbered “finding of fact/conclusion of law”: failure to respond to a significant change in R2’s condition; failure to prevent, document, and respond to R2’s abuse of R1; failure to revise R2’s care plan based on timely assessments of his condition; and failure to govern itself in a manner that helped residents attain their highest practicable well-being. We address each finding of fact/conclusion of law separately.

A. The ALJ’s finding of fact/conclusion of law number 1 – that Maysville was not in substantial compliance with 42 C.F.R. § 483.10(b)(11) – is supported by substantial evidence and is free of legal error.

1. Regulation and the ALJ Decision

The ALJ made the following “finding of fact/conclusion of law” number 1:

The facility was not in substantial compliance with 42 C.F.R. § 483.10(b)(11) because staff did not immediately consult a resident’s physician or notify his family about a significant change in his physical, mental, or psychosocial status and a need to alter his treatment significantly.

ALJ Decision at 4.

Section 483.10 addresses “Resident rights.” Subsection 483.10(b)(11), headed “*Notification of changes*,” provides that a facility “must immediately . . . consult with the resident’s physician” and “notify the resident’s legal representative or an interested family member” when there is “[a] significant change in the resident’s physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications)” or “[a] need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment)[.]”

The ALJ found that Maysville failed to consult with R2’s physician and notify his family of the significant changes in him and in his conduct, which occurred during the period July 26-30, 2014, and of the consequent need to significantly alter his treatment, as the regulations required. *Id.* at 6-9. The significant change occurred when R2 groped, attempted to grope, and approached R1 daily; scored markedly lower than before on a

mental status exam, and was described by staff “as ‘confused,’ which he had not been previously”; and “required hospitalization and testing.” *Id.* at 9 (also finding that “a previously mentally competent resident suddenly began to engage in sexually inappropriate behaviors with an incompetent resident and was unable to explain why”). The ALJ reasoned that “[t]his represented a significant change in [R2’s] mental, psychosocial, and, perhaps, physical status, as well as a need to alter treatment significantly.” *Id.*

Notwithstanding the change in R2’s behavior and mental acuity, Maysville’s management ordered staff not to document his touching of R1 and did not consult R2’s physician, Dr. Wallingford, until *after* R2 “was continuing to stalk R1” on July 30, at which point Dr. Wallingford ordered R2 transferred to a hospital for psychiatric evaluation, and “Administrator Burkhart also finally notified R2’s family member (his daughter-in-law, who was also Administrator Burkhart’s aunt) of the behavioral changes.” *Id.* at 6-8. Thus, the ALJ concluded, “[f]acility staff were therefore obligated to consult immediately his physician and notify his family of the change” but “failed to do so,” meaning that “the facility was not in substantial compliance with 42 C.F.R. § 483.10(b)(11).” *Id.* at 9.

2. Discussion

Maysville on appeal “believes that it did substantially comply with” the requirements in section 483.10(b)(11) that “[a] facility must immediately . . . consult with the resident’s physician; and if known, notify the resident’s legal representative or an interested family member” when there is “[a] significant change in the resident’s physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either *life threatening conditions* or *clinical complications*)” or “[a] need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment).” RR at 3-4 (quoting 42 C.F.R. § 483.10(b)(11) (internal quotation marks omitted) (alteration except first in original) (Maysville’s italics)). Maysville then states:

As discussed in its pre- and post-hearing briefs, to which Maysville directs the Board now for more in-depth review, the facility properly followed the situation to determine whether any changes in Resident #2 were to the level of significant [sic] and then dealt with these changes accordingly in compliance with the regulations at issue. As such, Maysville should be found in substantial compliance and the penalty either waived or significantly reduced.

Id. at 4.

This argument provides no basis to reverse the ALJ's determination. Maysville alleges compliance with the regulation and references its briefing below but does not identify or allege any actual error of fact or law by the ALJ. Maysville's request for review of the ALJ Decision does not comply with the regulation requiring that it "must specify the issues, the findings of fact or conclusions of law with which the party disagrees" and, also, "the basis for contending that the findings and conclusions are incorrect." 42 C.F.R. § 498.82(b).

The Board's *Guidelines* for this appeal, provided to Maysville with the ALJ Decision, similarly state that "[y]our request for review must specify each finding of fact and conclusion of law with which you disagree, and your basis for contending that each such finding or conclusion" by the ALJ "is unsupported or incorrect" and that the Board "expects that the basis for each challenge to a finding or conclusion *in the ALJ decision or dismissal* will be set forth in a separate paragraph or section and that the accompanying arguments will be concisely stated." *Guidelines*, "Starting the Review Process" at ¶ (d) (italics added). The *Guidelines* further instruct that "[a] submission (including the request for review) **may not incorporate by reference** a brief or parts of a brief previously submitted to the ALJ." *Id.*, "Additional Rules Applicable to Both Electronic and Non-Electronic Filing" at ¶ (c) (emphasis added).

The Board has held, based on these requirements, that it "may decline to consider an issue that is 'unaccompanied by argument, record citations, or statements that articulate the factual or legal basis for the party's objection *to the ALJ's findings*'" and "may summarily affirm a factual or legal finding if a party's presentation of an issue regarding that finding is such that the Board cannot discern the legal or factual basis for the party's disagreement with it." *Batavia Nursing & Convalescent Inn*, DAB No. 1911, at 57 (2004), *aff'd*, *Batavia Nursing & Convalescent Ctr. v. Thompson*, 143 F. App'x 664 (6th Cir. 2005), quoting *Wisteria Care Ctr.*, DAB No. 1892, at 10 (2003) (italics added). And when an appellant nursing facility sought to incorporate by reference its written arguments to the ALJ, as does Maysville, the Board cited the *Guidelines* and stated that "[w]e therefore do not consider arguments contained in the brief before the ALJ but not set out on appeal." *River City Care Ctr.*, DAB No. 2627, at 18 (2015), *aff'd*, *River City Care Ctr. v. U.S. Dep't of Health & Human Servs.*, 647 F. App'x 349 (5th Cir. 2016).

These requirements are not mere formality, and Maysville's failure to comply with them is significant. The ALJ addressed and rejected Maysville's arguments, and Maysville has provided no reason to conclude that the ALJ erred in doing so.

Specifically, the ALJ rejected Maysville's claim to have consulted Dr. Wallingford on July 29, finding Maysville's evidence not "particularly reliable or persuasive in establishing that they *consulted* him about the resident's behavioral changes" on that date, as opposed to simply notifying him, and finding "no evidence that staff explained the nature of R2's problem to his physician" prior to July 30. ALJ Decision at 7 (ALJ's

italics), citing CMS Ex. 6, at 6, and CMS Ex. 26, at 36, 161. The ALJ cited the “contrast between Dr. Wallingford’s July 29” progress notes “simply say[ing] that [R2’s] physician authorized a psychiatric exam ‘as needed’” and his order on July 30 for “immediate hospitalization and testing, which shows that he considered the changes significant,” as indicating that Wallingford “was not fully informed of the problem until July 30.” *Id.*

The ALJ accurately cited Board decisions holding that the consultation required by section 483.10(b)(11) “involves more than merely informing or notifying the physician” and “requires a dialogue with and a responsive directive from the resident’s physician as to what actions are needed; it is not enough to merely notify the physician of the resident’s change in condition” and that “the facility must provide the physician with all the information necessary to properly assess any changes to the resident’s condition and what course of action is necessary.” *River City Care Ctr.* at 8 (quoting *Magnolia Estates Skilled Care*, DAB No. 2228, at 9 (2009)) (internal quotation marks omitted); ALJ Decision at 7. The Board held in those decisions that it “has long made clear that ‘immediate’ consultation means exactly that,” as CMS adopted the requirement of “immediate” consultation over its initial proposal for consultation within 24 hours, following objections from commenters.⁵ *River City Care Ctr.* at 7-8; *Magnolia Estates Skilled Care* at 8-9 (citing *The Laurels at Forest Glenn*, DAB No. 2182, at 13 (2008) (citing 56 Fed. Reg. 48,826, 48,832-33 (Sept. 26, 1991))); ALJ Decision at 5.

The ALJ also correctly rejected “Petitioner[’s] argu[ment] that R2 did not undergo a significant change because he was already suffering from dementia,” because there was “no objective evidence to support the proposition that he was demented prior to July.” ALJ Decision at 8 (citing P. Post-Hearing Br. at 8, and P. Ex. 1, at 3, 4). Even if he had been, the ALJ found, “as of June 2014, the facility’s own testing showed that his mental status was intact” and, “[m]ost important, everyone agrees that he had never exhibited behavioral issues before” he began his aggressions towards R1 on July 26. *Id.* (citing CMS Ex. 8, at 4).

Maysville argues that R2’s change of condition was not serious enough to require Maysville to immediately consult his physician because there were no “*life-threatening conditions or clinical complications.*” RR at 4 (italics in original). Despite Maysville’s emphasis on this aspect of section 483.10(b)(11), its argument shows no error in the ALJ’s finding, even assuming R2’s change did not entail “life threatening conditions.” The ALJ concluded that the “sudden[.]” change in R2’s behaviors and mental status represented both “a significant change in his mental, psychosocial, and, perhaps, physical status” *and* “a need to alter treatment significantly” which also triggers the requirement for immediate physician consultation. ALJ Decision at 9.

⁵ The ALJ found that Maysville’s policy on notification of significant changes was “a problem” because it required notification not immediately but within 24 hours except in medical emergencies. ALJ Decision at 5 (citing CMS Ex. 29, at 10).

In failing to specify what about the ALJ’s analysis of its arguments is unsupported or incorrect, Maysville essentially asks the Board to evaluate the record and reach a different conclusion than did the ALJ. That is not our role. When an ALJ has rendered a decision on the evidentiary record, the Board “does not re-weigh the evidence or overturn an ALJ’s choice between two fairly conflicting views of the evidence”; instead, “the Board determines whether the contested finding could have been made by a reasonable fact-finder tak[ing] into account whatever in the record fairly detracts from the weight of the evidence that the ALJ relied upon.” *River City Care Ctr.* at 4 (citing *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 488 (1951)) (internal quotation marks omitted). In other words, as an appellate body, we do not “substitute our judgment for the ALJ’s even if a different choice could have justifiably been made in a de novo review.” *Estes Nursing Facility Civic Ctr.*, DAB No. 2000, at 6 n.4 (2005) (citing *Cnty. Skilled Nursing Ctr.*, DAB No. 1987 (2005) (citing *Universal Camera Corp.*, 340 U.S. at 488)).

We conclude that the ALJ’s finding of fact/conclusion of law number 1 is supported by substantial evidence and is free of legal error.

B. The ALJ’s finding of fact/conclusion of law number 2 – that Maysville was not in substantial compliance with 42 CFR §§ 483.13(b), (c) and 483.75(l)(1) – is supported by substantial evidence and free of legal error.

1. Regulations and the ALJ Decision

The ALJ made the following “finding of fact/conclusion of law” number 2:

The facility was not in substantial compliance with 42 CFR §§ 483.13(b) and (c) and 483.75(l)(1) because its administration and staff did not follow the facility’s policies and procedures for preventing abuse, and they did not immediately report or thoroughly investigate instances of abuse or potential abuse. In fact, the facility attempted to conceal the abuse by failing to maintain records of the incidents.

ALJ Decision at 9.

Section 483.13 states that a resident “has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion,” § 483.13(b), and that the facility “must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents,” § 483.13(c). The facility must “ensure that all alleged violations” of those policies “involving mistreatment, neglect, or abuse” are “reported immediately to the administrator . . . and to other officials in accordance with State law”; must “thoroughly investigate[]” all alleged violations and “prevent further potential abuse” during the investigation and report the “results of all investigations” to the administrator and other officials “in accordance with

State law” within 5 working days, and take “appropriate corrective action” if the violation is verified. 42 C.F.R. § 483.13(c)(2)-(4). The regulations define “abuse” as “the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.” *Id.* § 488.301; ALJ Decision at 9.

As the ALJ noted, the word “willful” in the definition of abuse means only that the actions of the person committing abuse (including a facility resident) “were ‘deliberate’ rather than accidental or inadvertent.” ALJ Decision at 12 (citing *Merrimack Cnty. Nursing Home*, DAB No. 2424, at 5 (2011)); *Britthaven, Inc., d/b/a Britthaven of Smithfield*, DAB No. 2018, at 4 (2006) (holding that “section 483.13(b) does not require that the purpose of the actor be to inflict harm, but rather requires that the action have been undertaken deliberately”); and *Singing River Rehab. & Nursing Ctr.*, DAB No. 2232, at 13 (2009).

Section 483.75(l)(1) states: “The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are— (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized.” Maysville’s records policy requires “that the nurse supervisor/charge nurse ‘record in the resident’s medical record information relative to [the] changes in the resident’s medical/mental condition or status[,]’” and its abuse policy “requires the charge nurse to complete an incident report and obtain a written, signed, and dated statement from the person reporting the incident” and that witness reports “must be in writing, signed, and dated.” ALJ Decision at 14, citing CMS Ex. 29, at 2, 5, 6, 10.

The ALJ found it “difficult to overstate the level of Petitioner’s noncompliance with sections 483.13(b) and (c)” where Maysville “did not keep R1 free from sexual abuse” and failed to investigate the abuse as required by the regulations and Maysville’s policies. “Over a period of four days,” the ALJ found, R2 “stalked and harassed [R1], sometimes managing to lay hands on her,” which constituted “abuse” as defined in the regulations and Maysville policy (defining sexual abuse as including “sexual harassment, sexual coercion, or sexual assault”). ALJ Decision at 11 (citing 42 C.F.R. § 488.301); CMS Ex. 29, at 3, 8 (Maysville policies), and CMS Exs. 15; 17, at 2; and 26, at 36, 60 (facility & hospital records & surveyor notes reporting R2’s sexually acting out and inappropriate behaviors towards a female resident). Yet, the ALJ found, Maysville failed to investigate the abuse, contrary to the regulations and facility policies that “require the facility to report immediately and to investigate thoroughly *all alleged* violations.” ALJ Decision at 13 (ALJ’s italics). Although “facility staff dutifully reported the abuse to the facility administrator, [she] did not report the incidents to the appropriate state officials; she did not investigate the violations; indeed, at her direction, no incident reports were prepared.” *Id.* The ALJ concluded that “[b]ecause the facility here did not keep its residents free from abuse and did not implement its own policies for preventing abuse, it was not in substantial compliance with sections 483.13(b) and 483.13(c).” *Id.*

The ALJ rejected Maysville’s argument that R2 merely engaged in “inappropriate touching” that did not “rise to the level of sexual abuse due to the cognitive status of the residents in question” and Maysville’s “plainly false . . . claim that the alleged abuse was limited to one isolated incident.” *Id.* at 12 (quoting P. Ex. 3, at 1-2) (internal quotation marks omitted). The ALJ found that Maysville had “absolutely no credibility” in claiming that the alleged abuse was limited to one isolated incident, after which staff began 15-minute checks, effectively preventing further problems, “inasmuch as – at management’s direction – staff did not document any incidents.” *Id.* The ALJ found that “the record contains evidence sufficient to establish ongoing abuse” and, specifically, that “[i]n addition to the July 26 (hands-in-pants) incident, we have evidence of R2 stalking R1, entering her room, attempting to touch her, and putting his hands under her shirt.” *Id.*

The ALJ also rejected Maysville’s argument that “no resident was harmed as a result of R2’s actions” and that R1 “did not appear” to be upset, where “the facility did not assess properly R1’s condition” or her “reaction to the abuse,” contrary to its policies, which “required someone from the social services department to monitor the victim of the abuse or possible abuse.” *Id.* at 13 (citing CMS Ex. 29, at 5). The ALJ found that “[n]o one from social services or any other department carefully observed R1” and that “the curt physician report, generated after R1 had been admitted to the hospital and days after the abuse began (July 31)” was not sufficient to bolster Maysville’s claim. *Id.* The ALJ also found it not material whether R1 experienced actual harm because Maysville had “failed to protect her ‘from reasonably foreseeable risks of abuse,’” placing it out of substantial compliance. *Id.* (citing *Holy Cross Village at Notre Dame, Inc.*, DAB No. 2291, at 7 (2009)).

Regarding section 483.75(l)(1) and the requirement to maintain complete and accurate records, the ALJ concluded that Maysville “violated the regulations and its own policies because . . . its administrator directed the nursing staff *not* to document the incidents of abuse or suspected abuse and not to prepare incident reports.” *Id.* at 14 (ALJ’s italics).

2. Discussion

On appeal, Maysville alleges a “discrepancy of CMS’s allegation that inappropriate touching occurred upon Resident #2’s first return from the hospital” on August 4, 2014. RR at 5. Specifically, Maysville disputes that R2 had his hand in R1’s pants on August 4, 2014, asserting that its records show that neither of the two employees (“SRNAs” 2 and 7) who described the incident to the surveyors was on duty when R2 returned from the hospital at 5:00 p.m. on August 4, 2014.⁶ RR at 5. Maysville also argues that “there is no corroboration of these incidents by the nurses” to whom the SRNAs “apparently

⁶ According to Maysville, SRNA stands for “State Registered Nurse Aid.” P. Pre-Hearing Br. at 3.

reported their respective incidents,” and that the nurses “on duty over the next several days plainly noted that no behaviors were exhibited by Resident #2.” *Id.* Maysville cites notes of surveyor interviews with the nurses whom the SRNAs said they had informed, which record the nurses as having been unaware of any touching incidents in the days after R2 returned from the hospital, and a “timeline” in the surveyor notes, which does not reflect the touching incident upon R2’s return from the hospital. *Id.* (citing CMS Ex. 26, at 7-8, 56, 68, 111-12).

Under “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.” *Ridgecrest Healthcare*, DAB No. 2598, at 10 (2014) (citing *Van Duyn Home & Hosp.*, DAB No. 2368, at 10-11 (2011) (citing *Koester Pavilion*, DAB No. 1750, at 20-22 (2000))). Maysville has not furnished compelling reasons for not deferring to the ALJ’s finding that R2 again groped R1 after returning from the hospital on August 4, 2014.

Contrary to Maysville’s argument, the ALJ did not find that R2 groped R1 *on* August 4, at a time when Maysville says the SRNAs were not on duty. The ALJ found that R2 returned from the hospital on August 4, 2014 (which is not disputed), and that “following his return from the hospital, R2’s abusive behavior did not stop. CMS Ex. 26 at 36, 63 (reporting that his hand was in R1’s pants, ‘you could see it clearly’).” ALJ Decision at 15.

The surveyors’ notes of interviews with SRNA 2 (on August 21, September 4, and September 10, 2014) and with SRNA 7 (on September 4, 2014) show them as firm in their recollections of having seen R2 with his hands in R1’s pants *at some point after R2’s return to Maysville from his first hospitalization*, though they were uncertain as to the precise date. CMS Ex. 26, at 61-64. SRNA 2, whose interview notes the ALJ quoted, is reported as saying “I think” it was the day R2 returned from the hospital and also that the SRNA was “not sure” and “uncertain” of the date. SRNA 2 did, however, recall having seen R2 with his hand “more than ½ way in [R1’s] pants you could see it clearly. It was after he came back from the hospital” and having “no doubt his fingers [were] touching her pubic area.” *Id.* at 61-63. The surveyors’ notes show that SRNA 7 described seeing R2, possibly in a separate incident around the same time, in R1’s room “putting his hand up the pants leg & was at about the groin area” of R1 when SRNA 7 entered the room and “redirected” R2. *Id.* at 64. SRNA 7 said that it “might” have been the Monday that R2 returned from hospital but that she was “not sure.” *Id.*

Some of the pages Maysville cites as the surveyors’ “timeline” instead contain a printed summary of the surveyors’ interviews which does report that SRNAs 2 and 7 saw R2 groping R1 after his return from the hospital, although they were not sure of the dates. CMS Ex. 26, at 7, *cited in* RR at 5. The surveyor who prepared the timeline (CMS Ex. 26, at 161-62) testified during cross examination that she had not finished her investigation at the time she prepared the timeline, and Maysville has provided no reason

to question her testimony. Tr. at 18; *see also id.* at 34 (agreeing on redirect that the timeline is based on partial information).

Maysville’s arguments provide no compelling reasons for not deferring to the ALJ’s finding that R2 continued to grope R1 after the initial undisputed incident on July 26, 2014, including after R2 returned from the hospital on August 4, 2014. Substantial evidence supports the ALJ’s finding of fact/conclusion of law.

Maysville also argues that its care of R1 met the standards the Board has applied in its decisions, that “a facility must ‘take reasonable steps to protect residents from potentially injurious acts which *it knew or should have known* might occur and which might be willful[.]’” RR at 4-5 (quoting *Honey Grove Nursing Ctr.*, DAB No. 2570, at 3 (2014))⁷ (Maysville’s italics); and (citing *Pinehurst Healthcare & Rehab. Ctr.*, DAB No. 2246, at 6 (2009) (“[p]rotecting and promoting a resident’s right to be free from abuse necessarily obligates the facility to take reasonable steps to prevent abusive acts, regardless of their source”)). Maysville also cites an ALJ decision it describes as holding⁸ that “an *isolated* incident of abuse does not automatically render a skilled nursing facility deficient under 42 C.F.R. § 483.13(b)” and argues that it “took the necessary steps to prevent any further potential abuse.” *Id.* at 5 (citing *Oakwood Manor Nursing [Center]*, DAB CR818 (2001)) (Maysville’s italics).

We agree with the ALJ that R2’s apparently ongoing ability to inappropriately touch R1 on several occasions demonstrates Maysville’s failure to substantially comply with the regulations by protecting, from further abuse, a compromised resident who was dependent on Maysville for her care and well-being. Maysville’s argument that the July 26, 2014 incident was “isolated” and therefore, ostensibly, not evidence of substantial noncompliance with section 483.13(b), is without support in the record. To the contrary, as Maysville acknowledges, there were two instances of R2 touching R1. However, Maysville labels those as “isolated instances” without explaining why they are analogous to the single and merely alleged “isolated” incident in *Oakwood*. RR at 10.⁹ First, ALJ decisions do not carry precedential weight and are not binding on the Board or other ALJs. *Lopatcong Ctr.*, DAB No. 2443, at 12 (2012); *Universal Health Care – King*, DAB No. 2383, at 9 (2011). Second, the present case is distinguishable from *Oakwood* regarding section 483.13(b) because, as discussed above, substantial evidence supports

⁷ *Aff’d, Honey Grove Nursing Ctr. v. Dep’t of Health & Human Servs.*, 606 F. App’x 164 (5th Cir. 2015).

⁸ We do not agree that this was the ALJ’s holding in *Oakwood*, which the ALJ decided based on the “aggressive” and “diligent” measures the nursing home took in response to allegations of sexual abuse of a resident in that case. *See Oakwood* at 17.

⁹ Maysville does not identify the second incident in which it admits that R2 touched R1, in addition to the initial groping on July 26, 2014, but Maysville presumably references July 28, 2014, when R2 put his hand under R1’s shirt. ALJ Decision at 7.

the ALJ's finding of at least one other instance of R2 touching R1, after R2's return from the hospital on August 4, 2014.

Maysville also argues it substantially complied with the requirement to maintain complete and accurate records, 42 C.F.R. § 483.75(l)(1), because "Resident #2's care plan plainly reflects updates beginning on July 26, 2014 to reflect the need for monitoring to prevent further incidents" and "[a]ll affirmative evidence indicates the facility's staff were aware of the need for monitoring and intervention." RR at 7. This does not address the ALJ's determinations that "[n]o one disputes that standard nursing practice requires nursing staff to document, in nursing notes and incident reports, all instances of abuse or suspected abuse" and that Maysville "violated the regulations and its own policies because . . . its administrator directed the nursing staff *not* to document the incidents of abuse or suspected abuse and not to prepare incident reports." ALJ Decision at 14 (ALJ's italics). Maysville as noted does not dispute that staff were told not to document R2's physical abuse of R1, deliberate omissions that could not have benefited the residents, much less any staff reliant on accurate, complete records to care for those residents.

Maysville offers nothing to refute the ALJ's finding that Maysville did not investigate reports that R2 had physically abused R1. ALJ Decision at 13, 16. Maysville does not explain how it could have complied with the requirement that "all alleged violations are thoroughly investigated" when its administrator ordered staff not to document R2's physical abuse of R1. 42 C.F.R. § 483.13(c)(3). Maysville also does not address the ALJ's finding that the facility did not properly assess R1's reaction to the abuse, contrary to Maysville's policies. ALJ Decision at 13.

Regarding the requirement to "*implement* written policies and procedures that prohibit mistreatment, neglect, and abuse," 42 C.F.R. § 483.13(c) (italics added), Maysville argues that its "approach to the incidents involving Resident #2 and Resident #1 was consistent with its policies and procedures when considering all policies and procedures in place." RR at 6. The ALJ found that Maysville "did not implement its own policies for preventing abuse" after detailing the specific steps Maysville's policy required for responding to abuse, most notably that it investigate all *allegations* of abuse by completing concrete tasks such as interviewing witnesses and staff and obtaining signed, written witness reports, measures that, the ALJ found, Maysville did not implement despite repeated instances of abuse. ALJ Decision at 10-12, 14 (citing CMS Ex. 29).

Maysville cannot credibly claim it implemented its policies, where "neither the administrator, her designee, nor anyone else bothered to interview the witnesses, much less prepare written, signed and dated witness reports, as required by the facility's policy and federal regulations." ALJ Decision at 12. Nor has Maysville cited any authority that would permit us to conclude that a facility may comply substantially with section 483.13(c) by successfully implementing only *some* of its policies concerning abuse of residents.

Maysville faults the ALJ for not considering that “Maysville also has a policy on ‘Sexuality’ which informs Maysville staff how to approach instances of alleged inappropriate behavior.” RR at 6 (citing CMS Ex. 29, at 13). The ALJ did, however, reject Maysville’s argument that it was constrained in dealing with R2 by the need to avoid “shaming” him, which its sexuality policy forbids. The ALJ found that “no one has suggested that R2 should have been ‘shamed’” and that “both R2 and R1 required a level of protection that the facility should have provided without ‘shaming’ or punishing any of its residents.” ALJ Decision at 12. Maysville has not explained how the ALJ erred, or how its sexuality policy is relevant in light of Maysville’s admitted failure to even document R2’s groping of R1.

Maysville’s arguments provide no basis to disturb the ALJ’s finding of fact/conclusion of law number 2, which we conclude was based on substantial evidence and not legally erroneous.

C. The ALJ’s finding of fact/conclusion of law number 3 – that Maysville was not in substantial compliance with 42 C.F.R. § 483.20 – is supported by substantial evidence and free of legal error.

1. Regulations and the ALJ Decision

The ALJ made the following “finding of fact/conclusion of law” number 3:

The facility was not in substantial compliance with 42 C.F.R. § 483.20 because its administration and staff did not revise a resident’s care plan based on a comprehensive assessment of his change in condition.

ALJ Decision at 14.

Section 483.20, “Resident assessment,” requires that the facility “must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident’s functional capacity.” Based on the assessment, the facility must develop a comprehensive care plan “within 7 days after completion of the comprehensive assessment;” the plan must be prepared “by an interdisciplinary team, that includes the attending physician” and be “[p]eriodically reviewed and revised by a team of qualified persons after each assessment,” § 483.20(k)(2), and the “services provided or arranged by the facility must— (i) Meet professional standards of quality; and (ii) Be provided by qualified persons in accordance with each resident’s written plan of care,” § 483.20(k)(3).

Maysville had “a policy for developing individualized care plans” that “generally echoes the requirements of the regulations to base each resident’s plan on his or her assessment” and provides that “assessments are ongoing and care plans are to be revised ‘as

information about the resident and the resident's condition changes.” ALJ Decision at 14 (citing CMS Ex. 29, at 1). The policy further provides that “[a]n interdisciplinary team is responsible for updating care plans when ‘*there has been a significant change in the resident’s condition.*’” *Id.* (ALJ’s italics).

The ALJ found Maysville not in substantial compliance because Maysville did not update R2’s care plan “‘after every verified incident’” as it claimed, and the intervention added on July 26, 2014 – 15-minute checks, in response to what the care plan described only as “‘redirected from [R1’s] room’” and (in an undated entry) “‘inappropriate behavior’” – proved ineffective in curbing R2’s actions towards R1. ALJ Decision at 15 (citing CMS Ex. 4, at 1). The ALJ also found that upon R2’s return from the hospital on August 4, 2014, Maysville did not change the intervention (15-minute checks) and, moreover, “did not check on R2 every 15 minutes as required.” *Id.* (citing CMS Ex. 26, at 41 (surveyor notes of interview with Maysville’s administrator, reporting her as saying she was not sure why 15 minute checks of R2 were not done during August 4-8, 2014)). The ALJ found that “[n]ot surprisingly” R2’s behaviors did not stop after he returned from the hospital, but also that it was “unlikely” that the intervention of 15-minute checks “would have been any more effective than it was previously.” *Id.*

2. Discussion

Maysville disputes the ALJ’s finding that it did not update R2’s care plan, stating that the plan “was specifically updated after every verified incident,” and asserts that “the 15 minute checks and monitoring implemented on July 26, 2014 were successful in preventing harm to Resident #1.” RR at 7. Maysville chooses its words carefully. While suggesting that its intervention(s) must have been successful because R1 was not *harmed* by R2 (and we do not find here that R1 was not or could not have been harmed in any way), Maysville does not deny that, as the ALJ found, the intervention of 15-minute checks did not prevent R2 from pursuing and approaching R1 on multiple occasions, or from touching her at least two times, after the initial groping incident on July 26, 2014. Maysville’s assertion that it updated R2’s care plan after every “verified incident” rests on its assertion, which we rejected above, that R2 did not grope, touch or otherwise physically abuse R1 upon his August 4, 2014 return from the hospital.

Maysville also argues that in not adding interventions to R2’s care plan after his first hospitalization, it relied on the conclusions of “the hospital and Resident #2’s primary care physician” that R2 could return to the facility “without conditions or supervision” and thus complied with the requirement that the care plan be reviewed and revised by a team of “qualified persons.” RR at 7; 42 C.F.R. § 483.20(k)(2).

The record does not indicate that Maysville engaged in the deliberate, thoughtful care planning the regulations demand in response to R2’s sexual aggressions, and does not indicate any error by the ALJ. The document Maysville cites as R2’s care plan, CMS

Exhibit 4, lists only the following with respect to what the plan calls “inappropriate behavior”: redirected from R1’s room and 15-minute checks on July 26, 2014, the date of R2’s first known groping of R1; his hospitalizations from July 30 - August 4 and August 9-12, 2014; 15-minute checks on August 4, 2014; and a change of rooms on August 12, 2014. CMS Ex. 4, at 1. The 15-minute checks were manifestly unsuccessful in addressing R2’s behaviors and even that intervention was discontinued for no stated reason during the period between the two hospitalizations. ALJ Decision at 15 (citing CMS Ex. 26, at 41 (surveyor reporting that administrator was not sure why 15-minute checks were not done August 4 through 8, 2014)).

Maysville argues that this “alleged failure to implement Resident #2’s 15-minute checks upon his first return from the hospital [is] immaterial” as “[b]oth the hospital and Resident #2’s primary care physician concluded he could return to the facility without conditions or supervision” and Maysville was “advised by qualified persons that it did not need to alter Resident #2’s treatment.” RR at 7 (citing CMS Ex. 26, at 19; CMS Ex. 17, at 9; and CMS Ex. 16, at 8). The cited documents do not support this claim. Two are a discharge summary and discharge instructions from R2’s second hospital stay that began August 9, 2014. Neither states that R2 required no supervision upon his return from the hospital; the discharge instructions, moreover, are aimed at the patient, not the facility, and consist of seemingly generic instructions and advice such as “Stay active” and “Stop Smoking!” CMS Ex. 16, at 8. The page of surveyor notes Maysville cites shows that R2’s physician was not available to be interviewed but that a psychiatric nurse practitioner stated that R2 *did* need supervision at the facility. CMS Ex. 26, at 16, 19. None of these records show that R2’s care plan was “[p]eriodically reviewed and revised by a team of qualified persons” in response to R2’s changes in condition and physical behaviors towards R1. 42 C.F.R. § 483.20(k)(2).

We conclude that the ALJ’s determination that Maysville was not in substantial compliance with the care plan requirements of section 483.20 is based on substantial evidence and free of legal error.

D. The ALJ’s finding of fact/conclusion of law number 4 – that Maysville was not in substantial compliance with 42 C.F.R. § 483.75 – is supported by substantial evidence and free of legal error.

1. Regulations and the ALJ Decision

The ALJ made the following “finding of fact/conclusion of law” number 4:

The facility was not in substantial compliance with 42 C.F.R. § 483.75 because the facility was not governed in a manner that enabled it to use its

resources effectively to attain or maintain the highest practicable physical, mental, and psychosocial well-being of its residents.

ALJ Decision at 15.

Section 483.75 states, in its prefatory paragraph, 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 ALJ found Maysville noncompliant because its other deficiencies posed immediate jeopardy to resident health and safety and “were directly attributable to administrative failures” by Maysville. *Id.* at 16.

2. Discussion

Maysville argues it “was in substantial compliance with 42 C.F.R. § 483.75” because “Resident #2’s onset of behaviors was immediately addressed through intervention and then through two behavioral assessments performed by qualified physicians during two separate hospitalizations.” RR at 6. Maysville also disputes that its other deficiencies jeopardized resident health and safety. RR at 8-10.

As the ALJ noted and the parties acknowledge, a deficiency in administration under section 483.75 may derive from noncompliance with other requirements for long term care facilities in Part 483. ALJ Decision at 15-16; RR at 6; CMS Resp. at 18; *see, e.g., Fireside Lodge Retirement Ctr., Inc.*, DAB No. 2794, at 13 (2017); *Stone Cnty. Nursing & Rehab. Ctr.*, DAB No. 2276, at 15-16 (2009); *Odd Fellow & Rebekah Health Care Facility*, DAB No. 1839, at 7 (2002); *Asbury Ctr. at Johnson City*, DAB No. 1815, at 11 (2002), *aff’d*, *Asbury Ctr. v. Dep’t of Health & Human Servs.*, 77 F. App’x. 853 (6th Cir. 2003). In those decisions the Board explained that a 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” where it “has been shown to be so out of compliance with program requirements that its residents have been placed in immediate jeopardy[.]” ALJ Decision at 16 (quoting DAB Nos. 1815, at 11; 1839, at 7; 2276, at 15-16).

Below, we uphold the ALJ’s conclusion that CMS’s immediate jeopardy determinations for the other deficiencies were not clearly erroneous, the standard the regulations impose. 42 C.F.R. § 498.60(c)(2). We also agree with the ALJ that “the failures here were directly attributable to administrative failures” because Maysville “disregarded facility policies when it failed to investigate and report timely allegations of resident abuse[.]” “fell short in protecting R1 from a potential abuser” and “affirmatively prevented staff from documenting instances of abuse.” ALJ Decision at 16.

Maysville argues it substantially complied because R2’s “onset of behaviors was immediately addressed through intervention and then through two behavioral assessments performed by qualified physicians during two separate hospitalizations.” RR at 6. This misstates the record. As we found above, Maysville failed to protect R1 from abuse by R2, investigate the abuse, implement consistently the minimal interventions (15-minute checks) in R2’s care plan, revise the care plan when R2 continued to stalk and abuse R1, and respond to the changes in R2’s condition signaled by the abuse and his declining mental status. That R2 did not display his troublesome behaviors while at the hospital but then resumed them upon returning to the facility undermines Maysville’s attempt, on appeal, to shift to the hospital physicians its own responsibility for accurately assessing R2’s conditions. Finally, there is also no dispute that Maysville’s management directed staff not to document R2’s groping of R1. That deliberate flouting of the regulations and Maysville’s own policy alone was a failure of the administration that set the tone for Maysville’s inadequate response to the situation it faced and underlay Maysville’s other failures. *See, e.g., Magnolia Estates Skilled Care*, DAB No. 2228, at 22-23 (2009) (failures to implement or diligently administer facility policies/procedures for reporting/investigating accidents and other incidents supported determination that facility was not administered in a way that enabled residents to achieve highest practicable well-being). CMS need not show that Maysville concealed the fact of abuse.

We conclude that the ALJ’s determination that Maysville was not in substantial compliance with the facility administration requirement in section 483.75 is based on substantial evidence and free of legal error.

II. CMS’s determination that Maysville’s noncompliance was at the immediate jeopardy level as of July 26, 2014 is not clearly erroneous.

“Immediate jeopardy” is “a situation in which the [facility’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. Maysville, aside from again denying its noncompliance, argues that the “no more than two isolated instances of touching” and attempts at touching it says it prevented by “successful intervention” caused “no more than minimal discomfort” that “ha[s] not compromised either resident’s ability to maintain/reach their highest practicable physical, mental and psychosocial well-being.” RR at 9-10.

Maysville’s assertions do not warrant reversing CMS’s immediate jeopardy determination, which the ALJ upheld. The regulations governing this case mandate that “CMS’ determination as to the level of noncompliance” – i.e., that the noncompliance is at the immediate jeopardy level – “must be upheld unless it is clearly erroneous.” 42 C.F.R. § 498.60(c)(2). The Board has repeatedly held that under the clearly erroneous standard, “CMS’s immediate jeopardy finding is presumed to be correct, and the facility has a heavy burden to overturn it.” *Maysville Nursing & Rehab. Facility*, DAB No. 2317,

at 11 (2010) (citing *Stone Cnty. Nursing & Rehab. Ctr.* at 17, and cases cited therein); ALJ Decision at 16 (citations omitted) (also noting that the Board “has sustained determinations of immediate jeopardy where CMS presented evidence ‘from which [o]ne could reasonably conclude’ that immediate jeopardy exists.”). The Board has further explained that, under this standard, “the harm or threatened harm caused by the noncompliance is presumed to be serious, and the facility has the burden to rebut the presumption with evidence and argument showing that the harm or threatened harm did not meet any reasonable definition of ‘serious.’” *Libertywood Nursing Ctr.*, DAB No. 2433, at 18 (2011) (citations & some internal quotation marks omitted), *aff’d*, *Libertywood Nursing Ctr. v. Sebelius*, 512 F. App’x 285 (4th Cir. 2013).

Maysville has not met that heavy burden. Maysville’s arguments minimize the potential harm posed by its failure to respond adequately to R2’s sexually aggressive behaviors. Above, we rejected Maysville’s contention that there were only two incidents of R2 sexually groping R1 that were somehow “isolated.” Its claim that R1 suffered only “minimal discomfort” does not meet Maysville’s burden because, as the ALJ observed, the definition of immediate jeopardy does not require that a resident suffer actual harm. ALJ Decision at 17; *see, e.g., Neighbors Rehab. Ctr., LLC*, DAB No. 2859, at 18 (2018) (Board has “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”) (citing *Crawford Healthcare & Rehab.*, DAB No. 2738, at 17 (2016); and *Woodstock Care Ctr.*, DAB No. 1726, at 39 (2000), *aff’d*, *Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 (6th Cir. 2003)). As noted earlier, Maysville does not address the ALJ’s finding that Maysville did not properly assess R1 following the abuse as required by facility policy. ALJ Decision at 13. Thus, as the ALJ found, Maysville “is not in a position to claim that she suffered no injury.” *Id.* at 17.

The ALJ succinctly described the potential harm caused by R2’s failure to respond properly to R2’s abuse of R1, which included the deliberate decision of Maysville’s management not to document the abuse:

R2 suddenly began to engage in sexually aggressive behavior while his cognitive function dropped dramatically (from essentially normal to severely impaired). No one knew why. Yet no one consulted his physician or notified his family, errors that are likely to cause serious injury or harm to both R2 and the victim of his sudden aggression.

Moreover, by their very nature, incidents of sexual abuse and harassment are likely to cause serious injury or harm. Beyond that, management’s refusal to investigate and report allegations of abuse - indeed its deliberate attempt to cover-up the incidents - creates a dangerous situation for all of the facility residents.

Id. Maysville’s arguments on appeal, including its unsupported factual assertions, show no fault in the ALJ’s analysis.

Maysville also argues that any immediate jeopardy ended on August 12, 2014, when it moved R2 to a room further away from R1, after which there were no further incidents of groping R1, and that there was no immediate jeopardy while R2 was hospitalized. As with CMS’s determination of the existence of immediate jeopardy, “CMS’s determination of . . . the duration of the immediate jeopardy . . . is presumed to be correct, and [the facility] has a heavy burden to demonstrate clear error in that determination.” *Liberty Health & Rehab of Indianola, LLC*, DAB No. 2434, at 13 (2011) (citing *Brian Ctr. Health & Rehab./Goldsboro*, DAB No. 2336, at 9 (2010)). Maysville again fails to meet this burden. In particular, its deliberate failure to document the abuse, and its failures to investigate and respond appropriately to the abuse, evince at the least a disregard for the requirements of the regulations and its own policies that could affect its care of residents other than R2 and R1. Its argument that all immediate jeopardy was removed during R2’s hospitalizations ignores the threat posed to all residents by its failure to follow federal requirements and its own policies for preventing and responding to abuse.

Moreover, as CMS points out, Maysville in response to the survey findings filed an “allegation of compliance” asserting that it had abated the immediate jeopardy as of September 3, 2014, which CMS accepted. CMS Ex. 28, at 1; CMS Ex. 1; CMS Resp. at 22. Notably, the allegation of compliance committed Maysville to take actions beyond simply altering its care of R2 and R1, which impacted its care of all residents, such as reviewing *all* resident assessments and care plans for completeness and accuracy and interviewing *all* male residents (in addition to female residents) to determine whether they, too, had been touched inappropriately. CMS Ex. 28, at 2-3; CMS Ex. 23, at 6. This is significant, as the Board “ordinarily holds that a [facility] cannot be regarded as having returned to substantial compliance, or abated immediate jeopardy, until measures specified in an approved plan of correction, or plan to remove immediate jeopardy, have been implemented.” *Countryside Rehab. & Health Ctr.*, DAB No. 2853, at 27 n.12 (2018) (citing *Meridian Nursing Ctr.*, DAB No. 2265, at 20-21 (2009) (affirming the determination of a multi-day immediate jeopardy period because, although certain corrective measures had been taken prior to the survey, the facility had not taken all actions that staff had determined to be necessary to abate immediate jeopardy), *aff’d, Fal-Meridian, Inc. v. U.S. Dep’t of Health & Human Servs.*, 604 F.3d 445 (7th Cir. 2010); and *Brian Ctr. Health & Rehab./Goldsboro* at 11 (“having specified certain systemic corrective measures in its abatement plan, measures that go beyond the disciplining of any single employee, [the facility] cannot be regarded as having abated the immediate jeopardy until the date those measures were implemented”)). Maysville’s allegations that it reduced the threat that one resident posed to another resident while not having completed the actions it promised to ensure the protection of all residents do not show clear error in CMS’s determination of the duration of immediate jeopardy.

Thus, the ALJ did not err in concluding that CMS's determination that Maysville's noncompliance posed immediate jeopardy was not clearly erroneous.

III. The ALJ's conclusion that the CMP amounts are reasonable is free from legal error.

CMS imposed CMPs of \$4,300 per day for the 39 days of immediate jeopardy (July 26-September 2, 2014) and \$100 per day for the eight further days of noncompliance that was not immediate jeopardy (September 3-10, 2014) (\$168,500 total CMPs). CMS Exs. 1, 2; ALJ Decision at 3. The ALJ found these amounts reasonable, “[c]onsidering the relevant factors” specified at 42 C.F.R. § 488.438(f), which are 1) the facility's history of noncompliance; 2) the facility's financial condition; 3) factors specified in 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). ALJ Decision at 17-18. The factors in 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. In doing so, the ALJ found that the \$4,300 per-day CMPs were “at the very low end of the range” for per-day immediate jeopardy CMPs (\$3,050 - \$10,000), and that Maysville did not claim its financial condition affected its ability to pay the CMP. *Id.* at 18. The ALJ concluded that Maysville's “administration deliberately disregarded the policies in place to protect residents from abuse . . . declined to investigate and report allegations of abuse[;] disregarded professional standards of practice and directed its nursing staff not to document instances of abuse and alleged abuse” and was “culpable for these very serious failings.” *Id.*

On appeal, Maysville states that CMS had not cited it for having a history of noncompliance or repeat deficiencies (which the ALJ noted) and that the CMPs “should be limited appropriate for the days the perpetrator was hospitalized as argued above.” RR at 10. Above, we rejected Maysville's argument that R2's temporary absences from the facility temporarily abated its noncompliance. Maysville has shown no error in the ALJ's findings.

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

Conclusion

We sustain the ALJ Decision and uphold the immediate-jeopardy CMPs of \$4,300 per day for the period July 26 through September 2, 2014, and of \$100 per day for the period September 3 through September 10, 2014.

/s/
Christopher S. Randolph

/s/
Constance B. Tobias

/s/
Susan S. Yim
Presiding Board Member