Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Crestview Acres,	)	Date: December 28, 2007
(CCN: 16-5299),	)	
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-05-610
	)	Decision No. CR1718
Centers for Medicare & Medicaid	)	
Services.	)	
	)	

DECISION

For the reasons set forth below, I reverse the Centers for Medicare & Medicaid Services' (CMS's) initial determination that Crestview Acres (Petitioner or facility) failed to substantially comply with participation requirements governing nursing home facilities. CMS presented evidence which suggested *prima facie* that Petitioner was not in substantial compliance with F Tags 324 and 223. However, Petitioner demonstrated, by a preponderance of the evidence, that it was in substantial compliance with the two requirements.

I. Background

Petitioner is a long-term care facility located in Marion, Iowa. Petitioner is authorized to participate in the federal Medicare program as a skilled nursing facility (SNF) and in the Iowa State Medicaid program as a nursing facility (NF). In response to a report received by the Iowa Department of Inspections and Appeals (state agency), an investigation was initiated and completed by the state agency on June 22, 2005. Specifically, the complaint related to the alleged sexual assault by a resident against another resident. The state agency determined, as reported in the CMS Form 2567 Statement of Deficiencies (SOD), that on May 21, 2005, Petitioner was not in substantial compliance with federal Medicare

and Medicaid participation requirements. CMS concurred with the state agency and, on July 25, 2005, CMS notified Petitioner that CMS was imposing a per instance civil money penalty (PICMP) in the amount $10,000 for the noncompliance described in the June 22, 2005 SOD at F Tags 324 and 223.

On September 23, 2005, Petitioner timely submitted a request for a hearing to challenge CMS's determination. The case was assigned to me for a hearing and decision.

A hearing was held before me on June 19-20, 2006, in Des Moines, Iowa. Kendall R. Watkins, Esq., appeared on behalf of Petitioner, and Harry Mallin, Esq., appeared on behalf of CMS. The proceedings are recorded in a transcript (Tr.) with pages numbered 1 through 309. CMS Exhibits (CMS Exs.) 1 through 14 were offered and admitted into evidence. Tr. at 10. Petitioner's Exhibits (P. Exs.) 1 through 2 were offered and admitted into evidence. Tr. at 11. Wendy Kuhse, a health facility surveyor (Tr. at 21-135), testified on behalf of CMS. Susan Tharpe, the facility's Director of Nursing (Tr. at 141-205); Gerry Lynn Braynard, the state agency surveyor who conducted the initial investigation (Tr. at 209-279); and Amy Sue Franco, a certified nurse assistant (CNA) employed at the facility (Tr. at 280-298), testified on behalf of Petitioner. The parties submitted post-hearing briefs (CMS Br. and P. Br., respectively) and reply briefs (CMS Reply and P. Reply, respectively).

II. Applicable Law and Regulations

The Social Security Act (Act) (42 U.S.C. § 1320a-7a(c)(4)) sets forth requirements for nursing facility participation in the Medicare and Medicaid programs, and authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations implementing the statutory provisions. Act, sections 1819, 1919. The Secretary's regulations governing nursing facility participation in the Medicare program are found at 42 C.F.R. Part 483.

To participate in the Medicare and/or Medicaid programs, a long-term care facility must maintain substantial compliance with program requirements. The regulations define the term "substantial compliance" to mean:

> . . . 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.

If a facility is found not to be in substantial compliance with program requirements, CMS has the authority to impose one or more of the enforcement remedies delineated at 42 C.F.R. § 488.406 which includes, among other things, imposition of a CMP. *See* Act, section 1819(h). CMS may impose a CMP against a facility as either a per day CMP or a per instance CMP, regardless of whether or not the deficiencies cited constitute immediate jeopardy. 42 C.F.R. § 488.430(a).

"Immediate jeopardy" is defined to mean:

> . . . 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.[1]

42 C.F.R. § 488.301.

When penalties are imposed for an instance of noncompliance, the penalties will be in the range of $1000 to $10,000 per instance. 42 C.F.R. § 488.438(a)(2).

In determining the amount of the CMP, the following factors specified at 42 C.F.R. § 488.438(f) must be considered:

1. The facility's history of noncompliance, including repeated deficiencies.

2. The facility's financial condition.

3. The seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404.

4. The facility's degree of culpability.

The Act and regulations make a hearing available before an Administrative Law Judge (ALJ) to a long-term facility against whom CMS has determined to impose a CMP. Act, section 1128A(c)(2); 42 C.F.R. §§ 488.408(g), 498.3(b)(12), (13). The hearing before an ALJ is a *de novo* proceeding. *Anesthesiologists Affiliated, et al.*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991).

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[1] *See also Beverly Health & Rehabilitation-Springhill*, DAB CR553 (1998).

In a CMP case, CMS must make a *prima facie* case that the facility has failed to comply substantially with participation requirements. To prevail, a long-term care facility must overcome CMS's showing by a preponderance of the evidence. *Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd*, *Hillman Rehabilitation Center v. United States Department of Health & Human Services*, No. 98-3789 (GEB) (D.N.J. May 13, 1999).

III. Issues

The issues before me are whether:

- the facility was in substantial compliance with federal participation requirements set forth at 42 C.F.R. §§ 483.25(h)(2) and 483.13(b);

- CMS's determination of immediate jeopardy is clearly erroneous;

  and

- the amount of the penalty imposed by CMS is reasonable, if noncompliance is established.

IV. Findings and Discussion

I make findings of fact and conclusions of law (Findings) to support my decision in this case. I set forth each Finding below in *italics* as a separate heading followed by a discussion of these Findings.

> *A. The preponderance of the evidence establishes that Petitioner was in substantial compliance with the requirements of 42 C.F.R. § 483.25(h)(2) (F Tag 324) and 42 C.F.R. § 483.13(b) (F Tag 223).*

A complaint survey was conducted by the state agency and completed on June 22, 2005. The SOD dated June 22, 2005 alleged, at F Tag 324 and F Tag 223, that Petitioner failed to comply substantially with the participation requirements delineated at 42 C.F.R. §§ 483.25(h)(2) at a K-level scope and severity (immediate jeopardy to resident health or safety) and 483.13(b) at a G-level scope and severity (isolated instance of actual harm that is not immediate jeopardy). CMS Ex. 2, at 1, 7. The regulation at section 483.25(h)(2) mandates that a facility must ensure that each of its residents receives adequate supervision and assistance devices to prevent accidents. *Id.* at 7. Section 483.13(b) of the regulation requires that a resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. CMS Ex. 2, at 1. The

state agency alleged that: (1) the facility failed to appropriately monitor one resident with increasing sexually-aggressive behavior towards others, and to implement interventions and procedures that ensured the safety of other residents (F Tag 324); and (2) the facility did not ensure residents were free from abuse (F Tag 223). *Id.* at 1, 7-8.

The allegations at F Tags 324 and 223 arise from the same set of facts relating to an incident involving Resident No. 4 (R4) and Resident No. 6 (R6). On the morning of May 21, 2005, the daughter of R6 went to the facility for a visit with her mother (R6). When she walked into her mother's room, the resident's daughter reportedly witnessed her mother in bed, undressed, with R4, who had his pants down. CMS Ex. 2, at 6, 15-16; CMS Ex. 13, at 4; CMS Ex. 3, at 6; CMS Ex. 14, at 104. Facility staff members were immediately summoned to the incident site. CMS Ex. 2, at 6, 16.

1. F Tag 324

The primary allegation in this case of an immediate jeopardy-level deficiency, cited at F Tag 324 of the June 22 SOD, alleges that Petitioner failed to appropriately monitor one resident with increasing sexual behaviors towards others, in violation of the regulation at 42 C.F.R. § 483.25(h)(2). CMS Ex. 2, at 7-8. The SOD further avers that the facility failed to implement interventions and procedures that ensured the safety of other residents. *Id*. at 8.

The allegation against Petitioner set out at F Tag 324 pertain to the actions of an individual identified as R4. CMS asserts that Petitioner had identified R4 as a resident with "escalating inappropriate sexual behaviors," to the point of establishing monitoring on an hourly basis approximately eight months after the resident was admitted to the facility. *Id.* CMS concluded that, although Petitioner was aware of the need to supervise R4 and, in fact, initiated hourly monitoring of the resident eight months after his admission to the facility, the supervision provided was "not to the extent necessary to prevent accidents from happening." *Id*. at 13.

The preponderance of the evidence does not support CMS's allegations. The evidence supports a conclusion that Petitioner was faced with a situation whereby one of its residents began to evidence increasingly inappropriate behavior. The evidence further supports a conclusion that Petitioner took the standard measures for diagnosing and care planning R4, but in addition, with each noted incident, Petitioner took further reactive and proactive measures in an effort to address R4's current situation and to prevent any future occurrences.

R4 was admitted into the facility on August 12, 2004. CMS Ex. 2, at 8; CMS Ex. 7, at 1. On August 27, 2004, a Mutli-Mental State Examination (MMSE) was conducted on R4. CMS Ex. 7, at 76. The resident was assessed as having a moderate degree of impairment, increased odds of dementia, and mild cognitive impairment. *Id.* Subsequently, R4 was evaluated and assessed as being situationally depressed, having dementia with depression, and possessing a family history of Huntington's disease. CMS Ex. 7, at 98, 103. R4 was also diagnosed with short-term and long-term memory problems, and was moderately impaired in decision-making skills. CMS Ex. 7, at 78. An assessment was conducted for R4, which resulted in the initiation of numerous care plans for the resident. The care plans addressed, among other things, issues relating to R4's alteration in thought process, impaired communications, and impaired physical activity. *See* CMS Ex. 7, at 78-84, 87-97. In response to R4's diagnosis of situational depression, Lexapro (an anti-psychotic medication) was prescribed and treatment commenced. CMS Ex. 7, at 63.

On September 26, 2004, R4 is noted to have approached a facility staff member and, grabbing her by the neck, he kissed her on the neck. CMS Ex. 7, at 63, 101. When asked to stop, R4 continued his advance which caused the staff member to push him away. *Id.* The resident was approached by a staff member to discuss his inappropriate behavior. *Id*. After a detailed discussion between R4 and his social worker, R4 acknowledged an understanding that his behavior toward the facility housekeeper was unwanted by her, uncomfortable to her, and that he was not to make such advances in the future. *Id.* In the interim, the housekeeper involved in this incident, as well as other female staff members, were advised not to enter the resident's room alone, but especially if it was uncomfortable for them to be in his presence. *Id.* On September 27, 2004, an assessment was conducted by the facility regarding this incident and corrective goals and objectives were established at that time. *See* CMS Ex. 7, at 101. Also in response to this occurrence, on September 28, 2004, a telefax was received from the resident's physician, Dr. Jerome Janda, ordering the commencement of Mallaril (an anti-psychotic) to R4, which was anticipated to aid in decreasing the resident's libido. CMS Ex. 7, at 52, 64. Also at that time, an order for a neurological consultation regarding R4 was received via telefax. CMS Ex. 7, at 41.

On October 12, 2003, it was noted that R4 had begun an ongoing friendship with a female resident (R1). CMS Ex. 7, at 64. The two residents were monitored by the staff for appropriateness of behavior, and discussions were conducted with each regarding the nature of their friendship. *Id.* Boundaries and guidelines were discussed and educational information disseminated to the two residents. *Id.* According to both residents, the friendship was welcomed and consensual. *Id.* at 66. However, with each inquiry, R4 became defensive and aggressive as he felt his privacy was being invaded.

The ordered neurological evaluation was conducted on November 5, 2004. CMS Ex. 7, at 10-11. The consulting neurologist concluded that dementia accounted for R4's "decline and capacity to care for himself with impaired insight, judgement [sic], and inappropriate behavior." *Id.* at 11. The consulting neurologist determined that further neuropsychological evaluation was unwarranted for further pattern documentation in that the resident was presently in a facility, and commenced administration of Reminyl for the treatment of dementia. CMS Ex. 7, at 11.

In November and December of 2003, it was documented that there had been no recent notations which referred to or described inappropriate sexual behavior displayed by R4. The staff had been briefed and made aware of R4's personality and the manner in which he rapidly converts routine "hugs and kisses" into a sexual encounter, thereby constantly remaining guarded and diminishing R4's opportunities for inappropriate sexual behavior. CMS Ex. 7, at 66, 67. However, the resident was noted as demonstrating socially inappropriate behaviors such as loud belching in front of other individuals and throwing trash on the floor. *Id.* Also during this period, Petitioner continued to monitor the effects of R4's medication regimen. On December 2, 2003, it was noted that R4's medication regimen had been altered. The administration of Lexapro was terminated and was substituted with Celexa (an anti-depressant). CMS Ex. 7, at 67, 98.

In a psychiatric consultation referral ordered by R4's attending physician, Dr. Whitters made the following notation in a memorandum dated December 23, 2003:

> [R4] was evaluated on 11/05/04 for dementia with psychosis and depression, rule out Huntington's Chorea, currently treated with Celexa 20 mg q.d., Seroquel 50 mg q.h.s., and Reminyl 4 mg b.i.d. The patient generally has been doing somewhat better, but still showing poor boundaries in terms of his sexuality and unwillingness and unable to be [sic] determine difference between acceptable and unacceptable behaviors.

CMS Ex. 7, at 18. Dr. Whitters' recommendation at that time was to increase R4's anti-dementia medication (Reminyl) and to begin administering Namenda. *Id.*; CMS Ex. 7, at 56.

On January 3, 2005, R4's room was changed in order to provide the resident with more personal privacy, in addition to moving him closer to the nurses' station which would allow for more frequent observation of the resident. CMS Ex. 7, at 101. During this period and through the month of January, there are no documented reports of inappropriate behavior by R4. *Id.*

Subsequently, staff reported that R4 was observed masturbating in his own room with the door partially open on February 2, 2005. Facility staff discussed this matter with the resident, emphasizing the importance of maintaining his privacy by pulling the dividing curtain closed and/or closing the door to his room. R4's care plan was updated to reflect this incident. CMS Ex. 7, at 68, 101.

On February 11, 2005, it was reported that R4 had previously "swatted" one of the facility volunteers on the buttocks and had hugged her in an "uncomfortable manner as if he were trying to 'give her a hickie.'" CMS Ex. 7, at 48, 68. The volunteer further stated that the only way she could get the resident to release her was by indicating how jealous her husband would be should he hear about the incident. *Id.* It was noted that education for facility volunteers warranted consideration, and that this instance should be explored further. *Id.* The resident's family was contacted regarding this incident.

A progress note dated February 14, 2005 indicated that R4 continued to demonstrate inappropriate social behavior, such as passing gas loudly in the facility dining room. CMS Ex. 7, at 68. However, on February 21, 2005, R4 was observed patting a female resident (R2) on the shoulder, then kissing her on the cheek, and concluded by patting R2 on the buttocks. CMS Ex. 7, at 70. R4 was approached by the social worker and advised that it was inappropriate to touch R2 in that manner. *Id.* When asked if he understood what the social worker was explaining to him, R4 acknowledged that he understood. However, approximately five minutes later, R4 was observed touching R2's posterior as they left the facility dining room. *Id.* The resident was again approached by the social service worker in an attempt to assure his understanding that such behavior is not appropriate in public and obtain his cooperation. CMS Ex. 7, at 70.

The facility staff received an order from Dr. Janda, dated March 4, 2005, to monitor R4's testosterone level. CMS Ex. 7, at 45, 57. The test results indicated an elevated testosterone level, however, no new orders were issued by the attending physician at that time. A telefax transmission was forwarded to Dr. Janda on March 29, 2005, stating that the resident's current medications were not working to curtail his negative behavior, and seeking guidance as to whether "further evaluation" or "appropriate placement" should be considered. CMS Ex. 7, at 59. An order for a consultation with the Dr. Whitters was issued. *Id.*

On April 7, 2005, R4 was seen by Dr. Janda. CMS Ex. 7, at 45. The resident's previous laboratory results regarding the high testosterone levels were also reviewed by Dr. Janda. *Id.* At that time, new orders for commencement of the administration of Premarin were issued. *Id.*; CMS Ex. 7, at 33, 60. Premarin is a female hormone replacement sometimes administered to men in an attempt to diminish aggressive sexual behavior. The resident's care plan was updated to reflect the inclusion of this intervention. CMS Ex. 7, at 98. Also on April 7, Petitioner commenced documentation of hourly checks of R4 for monitoring his movements within the facility. CMS Ex. 14, at 6-54.

During the period in late April and early May 2005, it was observed that the friendship between R4 and R2 was ongoing. CMS Ex. 7, at 71, 72. The residents were observed exchanging kisses initiated by R2. *Id.* at 71. Attempts to educate R4 on appropriate, acceptable public behavior, and to offer assistance and guidance in acquiring privacy for their encounters, were met by him with defensiveness and rejection of the instructional information. He would, in some instances, refuse to respond to any of the staff's inquiries. *Id.* at 72.

A neurological evaluation was conducted on R4 on May 10, 2005. CMS Ex. 7, at 12-13. Based on the evaluation, continuation of the current medication regimen was suggested. *Id.* at 13. It was further noted that, in the event of a worsening of R4's condition "and he [becomes] more disinhibited or even aggressive," a change to a more potent anti-psychotic medication may become necessary. *Id.* Further, a progress note entered by Dr. Janda on May 12, 2005 indicates that R4 appears to be calmer regarding his inappropriate sexual behavior. CMS Ex. 7, at 34.

Until May 21, 2005, there is no documentation to indicate any type of connection between R4 and R6. As of May 21, 2005, R6 was a 51-year-old female diagnosed as having Huntington's Chorea and dementia. CMS Ex. 9, at 1, 4, 9, 29. R6 was also diagnosed as having short-term and long-term memory deficits and moderately impaired decision making skills. CMS Ex. 9, at 32, 34, 36; CMS Ex. 2, at 16. It was also ascertained that R6 needed extensive staff assistance with bed mobility, transferring, ambulation,
dressing, toileting, and personal hygiene. CMS Ex. 9, at 32; CMS Ex. 2, at 16. On the morning of May 21, between 7:00 a.m. and 9:30 a.m., R4 was being monitored on 15-minute intervals. CMS Ex. 13, at 4; CMS Ex. 14, at 113. By all accounts, R4 was last observed by a CNA at 9:30 a.m. on the 300 hallway. CMS Ex. 13, at 4, 7; CMS Ex. 3, at 14. R6 was seen in her room by facility staff at 9:30 a.m. At approximately 9:45 a.m., R6's daughter entered her mother's room for a visit and discovered R4 either lying in bed with R6 or standing beside her bed with his pants around his knees. CMS Ex. 13, at 2, 4; CMS Ex. 14, at 104. R6's daughter immediately called for a nurse, and also contacted the police. CMS Ex. 13, at 2; CMS Ex. 3, at 6. Facility staff reported to R6's room. CMS

Ex. 2, at 16. The attending physician for both residents was contacted immediately. CMS Ex. 13, at 2, 4. Dr. Janda ordered that R6 be transported to Mercy Hospital emergency room for evaluation. CMS Ex. 9, at 49, 58. According to the hospital report, R6 had a tear at the vaginal opening, approximately one centimeter, with bleeding noted. CMS Ex. 2, at 17. On completion of the evaluation of R6 at the emergency room, the resident was returned to the facility. CMS Ex. 9, at 47. R4 was also ordered by Dr. Janda to be sent to a separate hospital for further evaluation. CMS Ex. 7, at 46, 73, 74. Instead of being returned to the facility on discharge, it was intended that R4 would be sent to another facility in consideration of the safety of the other residents at Petitioner's facility. CMS Ex. 7, at 46.

The preponderance of the evidence supports the conclusion that Petitioner did provide R4 with adequate supervision and, therefore, Petitioner was complying with the requirements of 42 C.F.R. § 483.25(h)(2) as of the June 22, 2005 survey.

Section 483.25(h)(2) mandates that a facility must ensure that each of its residents receives adequate supervision and assistive devices to prevent accidents. A facility is not required by this section of the regulation to assure that its residents never sustain accidents. The regulation does not impose a "strict liability" standard on a facility. The Board has, in numerous decisions, expounded on the requirements of section 483.25(h)(2). For example, the Board in *Residence at Kensington Place*, DAB No. 1963 (2005), noted its prior determinations regarding a purported strict liability standard. The Board reiterated its position that the regulation at section 483.25(h)(2) does not impose strict liability on facilities but, rather, "obligates the facility to provide supervision and assistance devices designed to meet the resident's assessed needs and to mitigate foreseeable risks of harm from accidents." *Kensington Place*, DAB No. 1963, at 9; *citing Northeastern Ohio Alzheimer's Research Center*, DAB No. 1935 (2004); *see also*, *Tri-County Extended Care Center*, DAB No. 1836 (2004); *Odd Fellow and Rebekah Health Care Facility*, DAB No. 1839 (2002). In *Kensington Place*, the Board concluded:

> . . . if a facility implements accident prevention measures for a resident but has reason to know that those measures are substantially ineffective in reducing the risk of accidents, it must act to determine the reasons for the ineffectiveness and to consider - and, if practicable, implement - more effective measures.

Kensington Place, DAB No. 1963, at 9.

In essence, a facility is not lacking if an accident occurs despite the fact that it has taken reasonable preventive measures. *Koester Pavilion*, DAB No. 1750, at 24, (2000). Further, the Board's decision in *Woodstock Care Center,* DAB No. 1726 (2000), as it relates to the nature of a facility's duty, is quite instructive. In that case, the Board found that a facility is obligated to take measures that are designed, to the extent that is practicable, to ensure that residents do not sustain accidents that are reasonably foreseeable. Based on the standards established in previous Board determinations, my decision in this case is based on my questioning whether R4 received the supervision and services that Petitioner had determined were necessary by care plans and comprehensive assessments. I have determined that the weight of the evidence establishes that Petitioner took reasonable steps to address R4's escalating inappropriate behavior. In light of the evidence and testimony presented in this matter, and the totality of the circumstances, I can only conclude that R4's inappropriate sexual overtures toward R6 particularly were unforeseeable. The May 21, 2005 incident occurred despite the implementation of preventive measures, and not in the absence of proactive and/or reactive intervention by Petitioner.

The testimony presented by Petitioner's witnesses at the hearing was both compelling and persuasive. In many instances, the testimony squarely contradicted the evidence and testimony put forth by CMS.

At the hearing, Petitioner called CNA Amy Sue Franco to give testimony as it pertained to her day-to-day interaction with both R4 and R6. CNA Franco stated that she had routinely provided R6's daily care, for the most part, since the resident's admission into the facility. Tr. at 282-283. Ms. Franco further stated that she also provided care for R4. *Id*. at 287. Ms. Franco indicated that, when she heard about the May 21 incident, she was "shocked" in that she did not believe him capable of such "sexually aggressive" behavior. *Id*. at 292. Ms. Franco further noted that she had never observed R4 and R6 in each other's company or room, or displaying any other type of interaction. *Id*. at 292.

On direct examination, Ms. Franco was also questioned regarding a "statement" attributed to her during the June 14, 2005 interview with surveyor Wendy Kuhse, and which served as support for the F Tag 324 deficiency citation. Ms. Franco testified that she did not forward a written statement to Ms. Kuhse on the matter, that she was not given the opportunity to review the written notes taken by Ms. Kuhse at the time of the interview, nor was she asked to review and sign the statement documented by Ms. Kuhse. Tr. at 286. On questioning, Ms. Franco stated that several statements attributed to her by Ms. Kuhse were inaccurate. Specifically, Ms. Franco testified that the statement denoting that R4 would grab her buttocks every day, and that she (Ms. Franco) considered R4 to be "sexually aggressive" was incorrect. Tr. at 287, 291. Ms. Franco stated that she told Ms.

Kuhse that R4 grabbed her buttocks "a couple" of times when she entered his room, but those occurrences numbered no more than three and that each instance took place shortly after R4's admission to the facility. *Id*. at 287. She reported the instances to the charge nurse and was instructed to take another employee with her when she needed to attend to R4. Once this intervention was in place, there were no additional instances of inappropriate behavior. *Id*. at 287-288.

The testimony of Petitioner's witnesses, Susan Tharpe (the facility's Director of Nursing) and Gerry Lynn Braynard (the first surveyor assigned to this matter), is very persuasive.

Ms. Tharpe actively participated in the surveys conducted by both Ms. Braynard (May 2005 survey) and Ms. Kuhse (June 2005 survey). At the hearing, Ms. Tharpe's testimony gave a clear and concise view of the measures taken by the facility as a result of the May 21 incident. Ms. Tharpe stated that she received a telephone call on May 21 from the charge nurse, Deb Allen, giving some details of the occurrence of the incident. Tr. at 143. Ms. Tharpe immediately gave instructions to Nurse Allen to contact the state agency to leave a voicemail message reporting the incident, in accordance with regulatory requirements.[2] Tr. at 144. When questioned about other procedural protocols in such matters, Ms. Tharpe testified of her intent to contact the Marion County Police Department to report the matter, however, R6's daughter had put in the call and they were arriving at the facility as Ms. Tharpe was providing instructions to Nurse Allen. Tr. at 144-145. Dr. Janda, the physician for both residents, was notified and orders were given by Dr. Janda to immediately remove R6 to the hospital emergency room for treatment. *Id.* at 145. Orders were subsequently given by Dr. Janda for R4's removal to a separate hospital for treatment and evaluation. *Id.* Ultimately, on the same day as the incident, R4 was permanently transferred from the facility. *Id.*

Ms. Tharpe also provided testimony regarding the interventions taken by the facility in response to R4's instances of inappropriate behavior. Ms. Tharpe stated that during her investigation, she reviewed the clinical record for R4 which documented, among other things, various interventions implemented by Petitioner as well as the interventions utilized by Dr. Janda. Tr. at 158. On admission, R4 had a diagnosis of being in mental decline. *Id.* at 159. A few weeks following R4's admission into the facility, a request for a neurological evaluation was submitted by the staff to Dr. Janda. Tr. at 158-159. Dr. Janda ordered the evaluation for the purpose of obtaining an "underlying diagnosis" for

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[2] Nurse Allen was instructed to leave a *voicemail* message with the Department of Inspections and Appeals because the incident occurred on a Saturday and the office was closed for the weekend.

the mental decline. *Id.* Shortly thereafter, R4 was noted as being sexually inappropriate with a facility staff member. *Id.* at 160. Ms. Tharpe stated that, when a resident exhibits a change in condition, whether physical or psychological, the protocol is to notify the resident's attending physician with an update. Tr. at 160. Ms. Tharpe further testified that the incident between R4 and one of the facility's staff (a facility housekeeper) was the first that inappropriate sexual behavior was observed in the resident. *Id.* Ms. Tharpe stated that R4's attending physician was sent a telefax advising of the resident's behavior and requesting authorization to commence the administration of the anti-psychotic Mellaril in an effort to diminish the resident's libido. *Id.*; CMS Ex. 7, at 52. Ms. Tharpe stated that she had not received any reports from the nursing staff of any inappropriate advances from R4, that his questioned behavior was limited to the period shortly after his admission to the facility, and the "only potential interaction [R4 has] had with another resident was with a woman . . . who reportedly was consenting and interested in having a friendship with [R4]." Tr. at 173, 174. As another intervention to address R4's behavior, in order to more closely monitor R4's movements, his room was changed so that he was now closer to the nurse's station. Tr. at 176-177. As each assessment/evaluation was conducted, R4's care plan was noted and updated to include the initiation of new goals and/or whether old goals had been met. Ms. Tharpe indicated that a resident receives either a full assessment or a quarterly assessment every three months, unless there is a noted change in a resident's condition, and then the care plan is updated as needed. In some instances, where there is a new diagnosis between evaluation periods, handwritten notations would be added to the care plan showing the new component. Tr. at 175. As an example, the witness referred to a handwritten entry noting R4's neurological evaluation on November 5, 2004 and indicating the diagnosis of dementia, psychosis and depression. Tr. at 175, *citing* CMS Ex. 7, at 103. In another instance, R4's care plan was updated in January 2005 to include the discovery of the resident's habit of masturbating multiple times per day and to indicate the resident's room change for closer monitoring and to permit more privacy for the resident. Tr. at 176, *citing* CMS Ex. 7, at 101. Ms. Tharpe provided testimony regarding the numerous instances where actions were taken by Petitioner to either proactively address R4's mental decline or in response to a specific incident. R4 was evaluated for a diagnosis relating to his mental decline (Tr. at 159, 160, 172); various drug therapies were initiated in an effort to control/diminish R4's libido (Tr. at 160-61, 184, 185); various tests/labs were conducted on the resident for diagnostic purposes (Tr. at 172, 173, 180-81); ongoing monitoring of R4 was implemented and increased (Tr. at 166, 176-77, 185, 187); education of the facility staff regarding day-to-day interaction with the resident was instituted (Tr. at 169, 182); and numerous attempts to provide education to R4 regarding appropriate/inappropriate behavior were initiated (Tr. at 167, 179).

In October 2004, when the facility discovered R4's "relationship" with one of the female residents (R1) at the facility, both residents were interviewed to educate them on proper public behavior and their right to request privacy in intimate situations, and to ensure that the interaction between the two was consensual. *Id.* at 166-168. Further, the staff was also put on notice to monitor and observe the residents on an ongoing basis to make certain that the interaction between them remained appropriate and concordant *Id.* at 168.

In November 2004, the neurological evaluation ordered by Dr. Janda was conducted. The conclusion drawn was that R4's mental decline was due to dementia. Tr. at 172. The consulting neurologist recommended the administration of the drug Reminal, and a CT Scan and an EEG, which were subsequently carried out. *Id.*

Ms. Tharpe's overall testimony emphasized that, in each instance of concern regarding R4, the facility responded appropriately and provided the necessary assessment and intervention to provide adequate care for the resident.

Gerry Lynn Braynard was the surveyor who conducted the initial complaint survey in May of 2005. She had, at one time, been described by the director of the state agency as "one of the Department's most experienced complaint investigators." Tr. at 212. Ms. Braynard stated that she received the assignment to investigate the incident on May 25, 2005 (the incident occurred on May 21). Ms. Braynard testified that, as part of her investigation, she reviewed the facility's clinical records, and conducted interviews with staff members and residents connected to R4. Tr. at 223. Specifically, there were three areas of supervision pinpointed for review, in addition to the May 21 incident: the housekeeper who had reported inappropriate advances by R4; the instances of alleged consensual relationships between R4 and three females residents; and the instance involving a volunteer worker at a facility activity. *Id.* at 224. In each of the three collateral situations, Ms. Braynard stated that she interviewed each of the individuals directly involved. Based on these interviews and record review, Ms. Braynard testified that at the point prior to her removal from the case, she was unable to find any denial of critical care or strong evidence of Petitioner's failure to appropriately respond to each incident reported involving R4. Tr. at 223. After speaking with each of the three female residents associated with R4, Ms. Braynard stated she was able to conclude that in two of the three instances the intimate attention was consensual and, in one instance, where the attention was unwelcome the female resident advised R4 that the attention was unwelcome, and that he ceased his advancements and the individuals were able to maintain a platonic relationship. *Id.* at 227, 228. Based on her in-house interviews and review of the facility records, Ms. Braynard stated it was her opinion that R4 did not pose

a threat to any of the female residents in the facility. Tr. at 229. She further opined that she saw nothing in R4's relationship with the three female residents which would "support a finding of either abuse or improper supervision on behalf of the facility." *Id.* at 230.

Ms. Braynard also stated that her investigation revealed that the numerous interventions imposed by Petitioner were adequate. As to the situations involving R4's practice of masturbation and his inappropriate behavior toward the facility housekeeper, Ms. Braynard stated that the facility's response of educating R4 on better timing and setting for such behavior and the housekeeper regarding R4's behavior and preemptive precautions when entering the resident's room were appropriate and adequate. Tr. at 233-234. Additionally, she stated that the facility's practice of keeping R4's treating physician "closely apprised" of the resident's behavior was an appropriate intervention. *Id.* at 235-236. After review and compilation of more than 700 pages of work product, Ms. Braynard expressed her conclusion that, overall, she did not have any concerns regarding Petitioner's level of staff monitoring and supervision meeting the requirements of the Federal Certification Standards. *Id.* at 237.

In another line of questioning, Ms. Braynard stated that she communicated her initial conclusions to various representatives and superiors of the state agency during a telephone conference. Tr. at 237. Ms. Braynard indicated that at the time she was given this assignment, her perceived charge was to evaluate whether the facility could have predicted the May 21 incident and, if so, whether all reasonable measures had been taken to prevent the incident from happening. Tr. at 242. Based on the interviews conducted and review of the clinical documents, Ms. Braynard concluded that there was no way that the facility could have foreseen the occurrence of the May 21 incident. *Id.* She averred that "[a]s terrible as it is or was, I did not see where the facility should have expected something like that to happen." *Id.* She was able to further conclude that, for the instances of inappropriate behavior which did occur involving R4, the facility took appropriate action. *Id.* Toward the end of her part of the investigation, Ms. Braynard stated that it became obvious to her that the intended outcome of the investigation was for the allegations to be founded. *Id.* at 260. She further opined that, during this period, there was a similar case, involving an unrelated facility, within the state agency. *Id.* Ms. Braynard indicated that it was common knowledge throughout the organization that the state agency hierarchy wanted support for the other case. *Id.* Ultimately, Ms. Braynard communicated her findings to her superiors at the state agency during a telephone conference on June 2, 2005. Tr. at 247. During the telephone conference, Ms. Braynard stated that she overheard an individual in the background, a voice she identified as that of Ann Marie Brick, say "she's not on our side" or "she's going down the wrong path." *Id.* at 263. Ms. Braynard testified that she was subsequently removed from the case by the

Bureau Chief. Tr. at 237. She stated that she was told of the "high profile nature" of the case and the need to have someone else to re-investigate the matter. *Id.* at 237-238. CMS's sole witness, Wendy Kuhse, the surveyor who replaced Gerry Lynn Braynard and issued the June 22, 2005 SOD was less than persuasive, and her testimony was contradicted by both the evidence and the testimony presented at the hearing.

On direct examination, Ms. Kuhse stated that, in June 2005, she was assigned to investigate that matter at Petitioner's facility involving the May 21 incident. Tr. at 25-26. She opined that she was, intentionally, given very little information regarding the nature of the case and asked to take a fresh look at the matter. *Id.* at 26, 27. Ms. Kuhse was aware that the investigation had been initiated by another surveyor who was no longer assigned to the case. *Id.* She was not provided with any information compiled by the first surveyor during the initial investigation. *Id.* Direct examination was brief and straight-forward.

On cross-examination, Ms. Kuhse was questioned regarding her extensive notations in the June 22, 2005 SOD, on the F Tag 324 citation, regarding R4's relationship with female residents other than R6. Tr. at 51-57, 58-70. Ms. Kuhse conceded that, based on interviews conducted and review of the facility records, there was no indication that R4's relationship with R1, R2, or R5 was anything other than consensual. Tr. at 54, 55, 62. The witness further acknowledged that, in each instance, there was no evidence of any sexual contact between R4 and any of the three female residents. *Id.* at 53-54, 56, 62.

As to the witness's references in the SOD to R7 (CMS Ex. 2, at 15), there is a question as to the reliability of the statement made by the resident. Allegedly, R4 is reported as having approached R7 from behind, rubbed her shoulders, kissed her; she, in turn, felt pressured to engage in some form of sexual activity. CMS Ex. 2, at 15. Ms. Kuhse confirmed that R7 had a diagnosis of paranoid schizophrenia and has a history of suffering from hallucinations. Tr. at 64, 65. Ms. Kuhse indicated that, according to the facility staff, R7 lodges daily non-health complaints, among other things, regarding several issues including relationship issues. Tr. at 66. When asked if she thought R7 to be a "reliable, accurate, and interviewable person" based on her medical history, Ms. Kuhse replied that she never made such a determination - she did not recall interviewing her. *Id.* at 66. Aside from the allegations made by R7, there is no corroborating evidence (*i.e.*, reports to the staff, staff witnesses, etc.) to substantiate R7's assertions.

The SOD example relating to R3 notes that:

> Resident #3 "commented Resident #4 was trying to touch her breasts, not sure if really happened." The nurses notes and social service notes for Resident #3 did not include documentation of this alleged incident, nor a follow up be located in Resident #3's medical chart. Resident #3 stated Resident #7 had also been approached by Resident #4.

CMS Ex. 2, at 15.

As to this example, Ms. Kuhse acknowledged that she did not interview this particular resident. Tr. at 67.

Clearly, there are significant deficiencies in CMS's documentary evidence and testimony which Petitioner has sufficiently rebutted as to F Tag 324.

2. F Tag 223

The basis for the deficiency cited under F Tag 223 is Petitioner's alleged failure to keep one of its residents free from abuse. "Abuse" is defined as:

> the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.

42 C.F.R. § 488.301.

CMS contends that the facts in this case establish that Petitioner was on notice of the episodes of increasingly aggressive sexual behavior being exhibited by R4 and should have taken "more effective measures" of prevention to circumvent the potential for any abuse. CMS Br. at 14. CMS also notes that, while a single, isolated incident of abuse does not automatically create a deficient situation, there is a presumption of noncompliance with the regulation which the facility is obligated to overcome by proving that it took the necessary steps to prevent abuse from occurring. *Id.*, *citing Oakwood Manor Nursing Center*, DAB CR818, at 7 (2001). CMS further contends that, "contrary to Petitioner's conclusion that 'Respondent is asserting that Petitioner allowed Resident #6 to be injured willfully by Resident #4[,]' Respondent is actually asserting that Petitioner's failure to protect Resident #6 from sexual abuse was tantamount to neglect." CMS Reply at 4.

Petitioner asserts that because R4 suffers from dementia, Huntington's Chorea and lacks a cognitive thought process, he lacks the ability to form an intent to cause harm to others. P. Br. at 19.

A facility is deemed to be noncompliant under section 483.13(b) if it knows or should have known of the potential for abusive behavior and does not take reasonably necessary steps to prevent the abuse from happening. *Cedar View Good Samaritan*, DAB CR997, at 24, *aff'd in part*, DAB No. 1897 (2003).

As thoroughly discussed in Discussion IV.A.1, the preponderance of the evidence substantiates a finding of Petitioner's substantial compliance with F Tag 223 as cited in the June 22, 2005 SOD. The evidence supports the conclusion that Petitioner was presented with a situation where a resident displayed increasingly inappropriate behavior in spite of the facility's best effort put forward to maintain control.

Petitioner's staff was aware of R4's inappropriate behavior. As discussed above, ongoing and increasingly-vigorous measures were taken by the staff to address the resident's behavior. Even though there was a record of R4's relationship with other female residents, there was no record of any type of behavior indicating actual sexual contact with either the residents or facility staff. There were no indicators that would have given Petitioner reasonable warning that the incident involving R4 and R6 would be so foreseeable as to require vigilance or prevention. Prior to the actual incident on May 22, there is no evidence which would lead a reasonable person to expect, or fear, or anticipate that R4 would commit a sexual assault on R6. The instances cited by CMS regarding the relationships with the female residents and the facility staff (the housekeeper and the volunteer) were not of a nature comparable in force, character, goal, setting, intimacy, or result to what appeared to have happened on May 22, 2005. Further, any contact was either consensual or isolated episodes which did not recur once boundaries/interventions were established by the facility.

In addition, the record is clear as to R4's mental state. Throughout R4's clinical record are diagnoses of dementia, depression, and cognitive impairment. CMS Ex. 7. One would be hard pressed to find, under these circumstances, that R4 had the requisite willfullness to cause injury or harm to R6. The finding in *Beverly Health and Rehabilitation of Williamsburg*, DAB CR653, *aff'd*, DAB No. 1748 (2000), is applicable to the facts in this case. In *Beverly Health*, a resident previously diagnosed with dementia, short/long term memory deficits, impaired cognitive skills, and manifestations of inappropriate behavior, attempted to unplug her roommate's breathing apparatus. In

that case, the resident's rationale for "pulling the plug" was that it made too much noise. The ALJ dismissed the deficiency for the lack of any evidence of the resident's intent to cause harm to her roommate, which the ALJ noted was a "requisite element" of the definition of "abuse." The ALJ further stated that:

> . . . Resident #2 is a demented individual who has moderately impaired cognitive skills and who engages in irrational conduct. I could reasonably infer from this evidence that the resident lacks the capability to engage in willfully injurious conduct.

In fact, as Petitioner points out, the witness for CMS, Ms. Kuhse, testified that she concluded that R4 did not intend to cause harm to R6. Tr. at 132.

In view of the foregoing, I find that the evidence does not support CMS's allegation of Petitioner's failure to protect R6 from abuse. On the contrary, the evidence shows that Petitioner was quite diligent in taking increasing measures to address each situation which arose with regard to R4's inappropriate behavior. Petitioner took progressive measures to counteract R4's behavior. Based on the foregoing, I conclude that Petitioner was in substantial compliance with 42 C.F.R. § 483.13(b) and CMS is, therefore, not authorized to impose a per-instance CMP in the amount of $10,000 against Petitioner.

V. Conclusion

I do not address the issue of whether immediate jeopardy was present because Petitioner complied substantially with Medicare participation requirements. Nor do I discuss the issue of reasonableness of CMS's remedy determination because CMS is not authorized to impose remedies where Petitioner has complied substantially with Medicare participation requirements.

/s/
Richard J. Smith
Administrative Law Judge