

NURSING HOME FINE UPHOLD FOR INADEQUATELY ADDRESSING SEXUAL INTERACTIONS BETWEEN COGNITIVELY IMPAIRED RESIDENTS - POLICY REVIEWS NEEDED

Last week, the United States Court of Appeals for the Seventh Circuit ("Court of Appeals") released an [opinion](#) that confirmed a Centers for Medicare & Medicaid Services ("CMS") assessment of an immediate jeopardy citation and an \$83,800 civil money penalty against a nursing home for inadequately addressing sexual interactions between cognitively impaired nursing home residents. The nursing home has a policy of intervening in sexual interactions only when a resident displayed outward signs of non-consent.

DISCUSSION

Illinois Department of Public Health Investigation

In 2014, the Illinois Department of Public Health ("IDPH") conducted a complaint investigation at an Illinois nursing home (the "facility"). The investigation centered on the sexual interactions between three residents with dementia and/or Alzheimer's to determine if the facility had violated then-regulation 42 C.F.R. Section 483.25(h). On September 28, 2016, CMS released a complete overhaul of Part 483 to Title 42 of the Code of Federal Regulations, the Requirements for States and Long-Term Care Facilities (the "Final Regulations"), and under those changes, 42 C.F.R. Section 483.25(h) is now 42 C.F.R. Section 483.25(d). Then-regulation 42 C.F.R. Section 483.25(h) provided that a facility must ensure that the resident environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents.

IDPH interviewed 11 of the facility's staff members including administrators, nurses and aides. IDPH found that the facility allowed residents to have consensual sexual interactions and that supervisors told the facility's staff that they were not to intervene or report sexual interactions unless a participant showed outward signs of non-consent. The staff did not follow up after the sexual interactions and continued to follow a non-intervention policy. One of the facility's staff members stated that, per the facility's policy, she was taught to "just separate, if no one resisting then it is ok." Another staff member said she was "taught to provide privacy and intervene if there is protesting by one of the residents." IDPH fined the facility \$83,800 and classified the deficiency as causing "immediate jeopardy," categorizing it as level J.

Administrative Law Judge Departmental Appeals Board Determinations

The facility challenged the citation and civil money penalty, and a hearing before an Administrative Law Judge ("ALJ") was held. The facility argued that residents, even those with cognitive impairments, have the right to engage in consensual intimate relationships. The facility also asserted that their staff was aware of the relationships between the residents and monitored them as necessary.

The ALJ noted that the facility had taken "meager action" to determine whether the two residents consented to the interactions, only belatedly inquiring with the residents as to the nature of the interactions. The ALJ also noted that one resident's lack of memory as to the incidents was only reflective of his Alzheimer's and could not be interpreted as consent. The ALJ determined that the other resident's denial of any relationship with the resident should have caused concern because it was "at best, misleading." The ALJ concluded that both resident statements "should have prompted further investigation."

The ALJ concluded that the facility's policy of intervening only when outward signs of non-consent were displayed was insufficient to determine consent, "especially where, as here, the victim has significant cognitive deficits." The failure to determine whether the interaction was consensual resulted in a second interaction between the two residents. The ALJ also concluded that the facility took no action thereafter to determine whether the resident had the capacity to consent or had in fact consented to the sexual interactions.

The ALJ wrote that there was "no question" that the two residents had been placed in immediate jeopardy. The ALJ determined that the facility's "misguided" non-intervention policy left residents at risk of victimization, "especially those with severe cognitive or other deficits which may have adversely impacted their ability to actively protest or object."

The ALJ found that the \$83,800 civil monetary penalty was reasonable considering the facility's level of culpability, history of noncompliance

and financial condition.

The facility appealed the ALJ's decision to the Departmental Appeals Board ("DAB"). The DAB **concluded** that the ALJ's findings were supported by substantial evidence.

Court of Appeals

The facility appealed the DAB decision and disputed whether its handling of the interactions was inadequate or hazardous. The facility argued that its policies were sufficient to monitor residents' sexual interactions in a way that "balances both the resident's need for privacy and dignity and the safety of each resident" and that the staff was taught to look for signs that a relationship was non-consensual. The facility claimed that, had a staff member, resident or anyone else suspected abuse, the staff member would have immediately acted in accordance with the facility's abuse prevention policy.

The Court of Appeals identified that: (1) the facility's staff was familiar with the residents' capabilities and behavior; (2) the facility did not undertake any investigation into whether the interactions were consensual or whether the residents had the capacity to consent; (3) the staff did not talk to the residents about their feelings about these "relationships"; (4) the staff did not document the residents' capacity for consent (or lack thereof) or communicate with residents' physicians for medical assessment of how their cognitive deficits impacted that capacity; (5) the staff did not discuss the developments with the residents' responsible parties and/or families; and (6) the staff did not record any monitoring of the behaviors or make any care plans to account for them.

The Court of Appeals wrote that residents who reside in facilities are entitled to the dignity of maintaining intimate relationships and when those persons are cognitively or physically impaired, that care must be taken by a facility to ensure that those intimate relationships are consensual. The Court of Appeals concluded that the evidence reflects that the facility failed to exercise this care. The Court of Appeals found that the facility's non-intervention policy led to the recurrence of sexual interactions and that the facility's deficiency was likely to cause, and may have actually caused, serious harm to the residents.

The Court of Appeals concluded that the citation and the categorization of immediate jeopardy were supported by substantial evidence.

PRACTICAL TAKEAWAYS

- Any time a facility has reason to suspect that a resident may not have the capacity to consent to sexual activity, the facility must ensure the resident is evaluated for capacity to consent.
- Facilities should carefully review and revise their policies and practices to ensure that they address staff attention to sexual activity of cognitively or physically impaired residents.

Hall Render has developed policies and procedures to assist skilled nursing facilities in achieving compliance with the Final Regulations. For more information about those policies and procedures or this about this topic, please contact:

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