Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: March 5, 2009
Heritage Park Rehabilitation and Nursing Center,	
Petitioner,	Civil Remedies CR1820 App. Div. Docket No. A-09-08
	Decision No. 2231
- v. -	
Centers for Medicare & Medicaid Services.	

DECISION

Heritage Rehabilitation and Nursing Center (Heritage or Petitioner), a skilled nursing facility located in Austin, Texas, requested review of the decision of Administrative Law Judge (ALJ) Keith W. Sickendick in Heritage Park Rehabilitation and Nursing Center, DAB CR1820 (2008) (ALJ Decision). The ALJ sustained the determination of the Centers for Medicare & Medicaid Services (CMS) imposing a per instance civil money penalty (CMP) of $6,300 against Heritage. The ALJ found that Heritage failed to comply substantially with the requirement at 42 C.F.R. § 483.25(h)(2), which states that facilities must ensure that "[e]ach resident receives adequate supervision . . . to prevent accidents." The accident at issue involved a resident's elopement from the facility.

For the reasons discussed below, we affirm the ALJ Decision.

Applicable law

Facility compliance with the participation requirements is determined through a survey and certification process. Sections

1819 and 1919 of the Social Security Act (Act); 42 C.F.R. Parts 483, 488, and 498.[1]

The federal statute and regulations provide for surveys to evaluate the compliance of skilled nursing facilities with the requirements for participation in the Medicare and Medicaid programs and to impose remedies when a facility is found not to comply substantially. Sections 1819 and 1919 of the Act; 42 C.F.R. Parts 483, 488, and 498.

A "deficiency" is defined as a nursing facility's "failure to meet a participation requirement specified in the Act or [42 C.F.R. Part 483]." "Substantial compliance" is defined as "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health and safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. "Noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." Id. "Immediate jeopardy" is defined a situation in which a provider's noncompliance "has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301.

CMS may impose per day or per instance CMPs if a facility is not in substantial compliance. In the case of a per-instance CMP, CMS may impose a CMP from $1,000 to $10,000, whether or not the noncompliance constitutes immediate jeopardy. 42 C.F.R. § 488.438(a)(2).

Board precedent has established that a skilled nursing facility must prove by the preponderance of the evidence that it is in substantial compliance. Batavia Nursing and Convalescent Center, DAB No. 1904 (2004), aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson, 129 Fed.Appx. 181 (6th Cir. 2005).

Background

On January 7, 2006, the Texas Department of Aging and Disability (state agency) completed a complaint survey of Heritage and found that it was not in substantial compliance with 42 C.F.R. § 483.25(h)(2). By letter dated February 7, 2006, CMS notified

[1] The current version of the Social Security Act can be found at www.ssa.gov/OP Home/ssact/comp-ssa.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table.

Heritage that it concurred with the findings of the state agency and was imposing a per instance CMP of $6,300 and other remedies not at issue here.

Heritage timely requested a hearing before an ALJ. The parties filed briefs and exhibits before the ALJ. The ALJ conducted a two-day hearing in Austin, Texas at which exhibits were admitted (see ALJ Decision at 2), two witnesses testified for CMS, and three witnesses testified for Heritage.

The ALJ's Findings of Fact and Conclusions of Law, and Heritage's Exceptions

The ALJ made numbered findings of fact 1 through 14. In the section of its Request for Review (RR) titled "Findings of Fact," Heritage states that it "takes exception to [findings 1 through 14] only to the extent that these factual findings are not relevant and provide no evidence in support of the Decision." RR at 3.

The ALJ's numbered findings of fact are as follows:

1. Resident 9, a 65-year-old male at the time of the survey, had a medical history of a cerebrovascular accident (CVA) with right-sided hemiparesis (partial paralysis of one side), senile dementia and psychosis, hypertension, hypercholesterolmenia (high cholesterol), peptic ulcer disease, gout, depression, and a seizure disorder. Joint Stipulation and Joint Statement of Issues Presented for Hearing, dated August 11, 2006. (Jt. Stip.) ¶ 8; CMS Ex. 13, at 32-33; P. Exs. 3, 5.

2. Resident 9 had a history of being evaluated as alert and oriented in three spheres -- person, place, and time. Jt. Stip. ¶ 9; Tr. 103; P. Ex. 4.

3. Resident 9 was assessed as moderately impaired in cognitive skills with poor decision-making. Tr. 15; CMS Ex. 13, at 7, 14.

4. Resident 9 was considered responsible for making his own health care decisions. Tr. 20; CMS Ex. 13, at 14.

5. Resident 9 was restricted to wheelchair mobility. Tr. 15; CMS Ex. 13, at 16, 21; Petitioner's Brief (P. Br.) at 3.

6. On November 30, 2005, Resident 9 left the facility unsupervised; he was assessed as an elopement risk and was

moved to the second floor of the facility as a result, and his location was monitored until January 1, 2006, when that intervention was discontinued because he made no more attempts to leave. Tr. 15-16; P. Ex. 4, at 1; CMS Ex. 13, at 1, 25, 29; P. Br. at 3.

7. Resident 9 was allowed to sit on the front porch of the facility on a regular basis. CMS Ex. 3, at 2; P. Ex. 4, at 1; Tr. 236.

8. On January 3, 2006, between 8:00 p.m. and 9:45 p.m., Resident 9 left the facility through the front door without signing out or notifying staff of his departure. Tr. 13; CMS Ex. 3, at 2; CMS Ex. 13, at 40; P. Ex. 6; P. Br. at 3.

9. Resident 9 left the facility property in the company of a non-family member, who was referred to as Linda. Tr. 13; P. Exs. 7, 8, 9; P. Br. at 3.

10. On January 3, 2006, at 9:45 p.m., staff noted Resident 9 was missing and began searching the facility and neighborhood for him. CMS Ex. 3, at 2; CMS Ex. 13, at 40.

11. On January 4, 2006, between 7:00 a.m. and 7:30 a.m., Resident 9 was found, by a passerby at a street corner about three to four blocks from the facility, sitting in his wheelchair. Tr. 17-18; CMS Ex. 3, at 1; CMS Ex. 13, at 40; P. Br. at 3.

12. When Resident 9 was discovered on January 4, 2006, he was wearing a T-shirt and boxer shorts, no socks or shoes, he was wet with urine, his skin was cold to touch, and he was shivering. Tr. 17-18; CMS Ex. 3, at 1; CMS Ex. 13, at 40, 59.

13. On January 4, 2006, Resident 9 was transported to the hospital, evaluated, and treated for hypothermia as his temperature was 94.4 degrees Fahrenheit orally. Tr. 18; CMS Ex. 13, at 32; P. Br. at 3.

14. During the evening on January 3, 2006, Resident 9 did not receive medication for which he had a physician’s order. CMS Ex. 3, at 4; CMS Ex. 13, at 3-5; Tr. 86.

ALJ Decision at 3-4.

The ALJ made the following numbered conclusions of law to which Heritage excepts. RR at 5.

2. Petitioner violated 42 C.F.R. § 483.25(h)(2) with respect to Resident 9.

3. Resident 9 suffered actual harm.

4. Petitioner was not in substantial compliance with program participation requirements based upon the regulatory violation and actual harm suffered by a resident.

5. The determination that immediate jeopardy was posed does not impact the amount of the PICMP and is not in issue before me.

6. A [per instance CMP] of $6300 is reasonable.

ALJ Decision at 4.

In a section of its Request for Review titled "Other Reasons for Appeal," Heritage states that it "excepts to the ALJ's Decision in its entirety because it is not based on substantial evidence in the record as a whole." Id. at 5.

Standard of review

Our standard of review on a disputed finding of fact is whether the ALJ decision is supported by substantial evidence on the record as a whole. Our standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. Guidelines - Appellate Review of Decisions of Administrative LawJudges Affecting a Provider's Participation in the Medicare andMedicaid Programs (Guidelines)(available on the DAB website at http://www.hhs.gov/dab/guidelines/prov.html).

Analysis

Section 498.82(b) of 42 C.F.R. requires a request for review to "specify the issues, the finding of fact or conclusion of law with which the party disagrees, and the basis for contending that the findings and conclusions are incorrect." In framing its appeal, Heritage appears to confuse the review standards for disputed findings of fact and disputed conclusions of law. Heritage does not dispute that the ALJ's numbered findings of fact were supported by substantial evidence. RR at 3. Rather, it "excepts to the ALJ's Decision in its entirety because it is not based on substantial evidence in the record as a whole." RR at 5. We take this statement, together with Heritage's exception to the ALJ's conclusions of law, to mean that Heritage is arguing

that the ALJ's factual findings do not provide a basis for his legal conclusions, including his ultimate conclusion that Heritage was not in substantial compliance with section 483.25(h). Below we explain why the ALJ did not err in concluding that his factual findings (numbered and unnumbered) support his legal conclusions. We also discuss whether factual findings that the ALJ did not include in his numbered findings of fact, but did include in his discussion supporting the numbered findings, are supported by substantial evidence.[2]

1. The ALJ did not err when he concluded that, based on its care of Resident 9, Heritage was not in substantial compliance with 42 C.F.R. § 483.25(h)(2).

Section 483.25 of 42 C.F.R. provides in relevant part:

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.
>
> * * *
>
> (h) *Accidents*. The facility must ensure that --
>
> * * *
>
> (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

The ALJ concluded that Heritage was not in substantial compliance with section 483.25(h)(2) based on the following legal principles and facts:

- An "accident" is a "an unexpected, unintended event that can cause a resident bodily injury." ALJ Decision at 7, citing State Operations Manual (SOM), App. P, Guidance to Surveyors, Tag F324; Woodstock Care Center, DAB No. 1726, at 4 (2000).[3] Resident 9's "unsupervised, unplanned, and

[2] We have fully considered all arguments raised by Heritage on appeal and reviewed the full record, regardless of whether we have specifically addressed particular assertions or documents in this decision.

[3] Heritage argues that the facts in the Woodstock (which was affirmed by the Sixth Circuit in Woodstock Care Ctr.

(continued...)

unknown" departure was an accident as that term is used in section 483.25(h). Id. Resident 9's unsupervised departure, even though volitional on the resident's part, was an elopement and an accident because it was not "planned or intended as part of . . . [Heritage's] delivery of professional quality services."[4] Id. at 8.

- In determining whether a facility has failed to provide adequate supervision to prevent accidents, the Board looks to whether "the facility knew or reasonably should have anticipated the risk of the kind of events that occurred and whether any reasonable means were available to prevent them without violating the residents' rights." ALJ Decision at 7, citing Woodstock, DAB No. 1726, at 26-27. While a facility may choose different means of addressing a foreseeable risk, "what is 'adequate' takes into consideration the resident's ability to protect himself or herself from harm." Id., citing Woodstock, DAB No. 1726, at 28-35; Windsor Health Care Center, DAB No. 1902, at 5 (2003), aff'd, Windsor Health Center v. Leavitt, 127 Fed. Appx. 843 (6th Cir. 2005). The specific injury that occurs need not be foreseeable as long as it was foreseeable that "the unexpected or unintended event could cause" injury. Id. at 8.

---

[3](...continued)
v. U.S. Dep't of Health and Human Servs., 363 F.3d 583 (6th Cir. 2003)) involved escapes by multiple residents "without responsive intervention to prevent exit seeking behavior" and concludes that, unlike Woodstock, it was in substantial compliance because "[t]here is not such evidence here." RR at 12; P. Reply at 2, n.5. This argument is not persuasive. The egregious facts in Woodstock do not preclude a conclusion that other fact patterns support a determination of noncompliance.

[4] As it did before the ALJ, Heritage continues to argue that Resident 9's departure was "volitional and intentional" and "cannot be characterized as an elopement or an accident." RR at 13, n.5. As stated above, the ALJ explained why the departure was both an accident under section 483.25(h) and an elopement. ALJ Decision at 8. Moreover, Heritage's own elopement policy defines elopement as a situation in which a resident, who is not on an "authorized leave or pass" and "cannot be located on the facility property." CMS Ex. 21, at 1. This certainly describes Resident 9's situation on January 3.

- That Resident 9 might try to elope was foreseeable because of his prior attempts to elope, most recently on November 30, 2006. ALJ Decision at 8-10. Indeed, Heritage recognized that he was an elopement risk when it moved him to the second floor because of elopement attempts prior to November 30 and when it created a care plan to prevent further elopements after his November 30 elopement attempt.[5] ALJ Decision at 8-9.

- Heritage did not implement reasonable means to prevent Resident 9 from eloping again because it did not adequately supervise residents' ability to exit through its front door generally or Resident 9's ability specifically. ALJ Decision at 7, 9-12. These failures allowed Resident 9 to elope on January 3, 2006. Id.

- Resident 9 suffered actual harm (hypothermia) as a result of being outside the facility and unsupervised. Id. at 3.

Heritage makes the following arguments challenging the ALJ's determination that it failed to substantially comply with section 483.25(h)(2).[6]

---

[5] The ALJ found that Heritage moved Resident 9 to the second floor after the November 30, 2005 elopement attempt. ALJ Decision at 3. While harmless error, the record shows that Heritage actually moved Resident 9 to the second floor prior to November 30 in response to an elopement problem. Heritage's Social Service Progress notes dated November 2, 2005 state:

> [h]e has not attempted elopement recently and continues to enjoy to sit out front. Resident has moved upstairs for safety precautions.

CMS Ex. 13, at 2; see also Tr. at 70. Moreover, in the Statement of Deficiencies (SOD), the surveyor reported that the social worker told her that Resident 9 "had a history of elopements and would say he was 'going home.'" CMS Ex. 2, at 16. Finally, Heritage does not dispute that Resident 9 was moved to the second floor to address his elopement risk. Tr. at 16.

[6] We note as background that Heritage makes repeated statements that are not supported by any evidence. For example, Heritage states that CMS stipulated that Resident 9, "with Heritage Park's full knowledge, voluntarily left the facility with his well-known girlfriend." RR at 2, citing Tr. at 13; see

(continued...)

First, Heritage argues that the January 3 "events were not reasonably foreseeable" because "Linda is apparently a girlfriend of Resident who he has left the facility with before without incident, and there was no reason for Heritage Park to fear for his safety" with Linda. RR at 13, citing Tr. at 203-204. It alleges further that because Resident 9 "sought to keep his relationship with Linda a secret, he presumably agreed to be dropped off some distance from the facility to prevent the discovery of his rendezvous." Id. at 13-14.

We reject this argument. While Heritage is correct that foreseeability is an essential consideration in assessing the adequacy of supervision, Heritage misdescribes the risk that the ALJ found it failed to foresee. ALJ Decision at 7-8. The risk that Heritage failed to foresee was that Resident 9 might elope from the facility if permitted to exit unsupervised. The ALJ discussed the reasons why he concluded that a further elopement attempt by Resident 9 was foreseeable. Id. at 8-10. These included the fact that Resident 9 had tried to elope before, most recently on November 30, and the fact that Heritage recognized he was an elopement risk when it created a care plan on November 30 to prevent further elopements. It is irrelevant to that risk that his elopement was facilitated by Linda or that it was allegedly unforeseeable that she would prove to be an irresponsible chaperone by leaving Resident 9 on a street alone. The fact that Linda was the ultimate agent of elopement is not material since Resident 9 might well have tried to leave by himself again or been picked up by some other person.[7]

---

[6](...continued)
also P. Reply at 2, n.6. The cited page contains no such stipulation. Heritage points to no evidence in the record at all that demonstrates that its staff knew at the time when or with whom Resident 9 left. The fact that the facility launched a search for him at 9:45 p.m. and called the police further belies Heritage's claim. Additionally, Heritage makes unsupported statements referring to Resident 9's "regular departures with Linda" (RR at 16, n. 7), to Linda as "a well-known acquaintance" (RR at 19), and to Resident 9's "well-known departures with Linda" (P. Reply at 5, at n.12). CMS correctly notes that the identity of the person with whom Resident 9 left on January 3 was not relevant (Tr. at 50), but it also correctly asserts that the record does not support Heritage's statements about its knowledge of Linda or the regularity of her presence (CMS Br. at 11).

[7] Heritage's Director of Nursing (DON) testified that
(continued...)

Heritage also argues in regard to foreseeability that Resident 9's compliance with the sign-out policy during the month of December (while he was on hourly monitoring) made further elopements unforeseeable. RR at 10, 20; P. Reply at 5. We find the ALJ's rejection of this position reasonable in light of Resident 9's elopement history, his prior noncompliance with the facility's sign-out policy, his poor decision-making capabilities, and the opportunity presented by his ability to exit through the front door unsupervised.

Second, Heritage contends that Resident 9 was "free to sign himself out of the facility" (RR at 7, citing Tr. at 158, 222) and that it could not "prevent [Resident 9's] chaperoned departure without violating his residents' [sic] rights" (RR at 14). It cites 42 C.F.R. § 483.10 and the Texas Administrative Code sections on resident rights to visit with other people and to be free of restraints.

Again, this argument mischaracterizes the basis of the citation, which was that Resident 9's departure from the facility was unknown to the facility and unsupervised by it, not that he should or could have been prevented from leaving altogether or with any individual.[8] The ALJ expressly recognized that Heritage

---

[7](...continued)
Resident 9 could not have actually succeeded in rolling himself away from the facility in his wheelchair because of the two speed bumps in the parking lot where it opens onto the two streets that front the facility. Tr. at 191-192. However, the surveyor testified that he might have been able to elope by wheeling himself down the sidewalk. Tr. at 125-126. Moreover, even if the speed bumps would have stopped him from leaving the parking lot, Heritage does not deny that it was unsafe for Resident 9 to be rolling himself among cars in the parking lot. CMS Ex. 9, at 16 (wife told surveyor that she and facility were concerned about Resident 9's safety if he wheeled himself off the porch). Further, the facility had also had problems with Resident 9's wife removing him without signing him out. The Administrator stated in the IDR submission that Resident 9 "had been placed on [one-hour] monitoring [in December] because he and his wife were non-compliant with" its sign-out policies. P. Ex. 1, at 3. Indeed, on January 3, the Administrator and DON originally suspected that the wife had removed Resident 9 from the facility. See CMS Ex. 9, at 7, 14-15.

[8] In its reply brief, Heritage's mischaracterization of (continued...)

could not have necessarily stopped Resident 9 from leaving with Linda, but he stated that "whether staff could have prevented the resident from leaving is not the issue. If staff had known that Resident 9 was leaving, staff could have ascertained where the resident was going, how long he was to be gone, who he was with, and thus ensured the resident went with proper clothing and medicine." ALJ Decision at 11-12. Such "staff supervision of the departure would have avoided the need to search the facility, to contact the police, and would likely have avoided Linda dropping the resident blocks away in his underwear and wet with urine." Id. at 12. Heritage offers no argument in rebuttal of the ALJ's inferences, all of which we find reasonable.

Further, as the ALJ pointed out, as a long-term facility, Heritage knew it was required to balance its responsibility to supervise residents' safety under section 483.25(h) with its responsibility to protect their rights under section 483.10. ALJ Decision at 12. The ALJ noted that, in amending Resident 9's care plan on November 30, 2005 and adopting interventions to prevent further elopements, Heritage balanced "any perceived conflict" in these responsibilities in favor of protecting him from the harm that unsupervised departures could cause." Id. The ALJ faulted Heritage for discontinuing, on January 1, the hourly-monitoring intervention required by Resident 9's care plan. Id. 9-10. He pointed out that Heritage made no showing that the care planning team had assessed the hourly monitoring to be ineffective or no longer needed based on "changes in [Resident 9's] medical condition, personal situation, or functioning." Id. at 9. While this discontinuance was noted in the care plan (CMS Ex. 13, at 25), the ALJ is correct that Heritage did not present any evidence as to the process it used in deciding to discontinue hourly monitoring or why it decided to go from hourly monitoring

---

[8](...continued)
the dispute is more extreme. It writes: "t]here is simply a disagreement about . . . whether Heritage Park has an obligation to imprison its residents and preclude them from leaving their home with well known family and friends" (P. Reply at 2) and "CMS's position on this issue requires prohibiting accompanied off-site visits with family and friends after a resident has one isolated, unaccompanied departure from a facility" (id. at 5). CMS took no such position in this case. Neither CMS nor the ALJ suggested that a facility should "imprison" residents or prohibit off-site visits. Instead, the issue is whether the facility took reasonable steps in light of the foreseeable risk of elopement to ensure that Resident 9 left the facility in an authorized manner.

to twice daily checks at shift changes (Tr. at 69, 112) while still allowing Resident 9 to sit on the front porch unsupervised.

Heritage's sign-out policy also reflects that Heritage was aware of its responsibility to take steps to protect residents from harm when they temporarily left the facility. That policy provides that all residents "leaving the premises should be signed out"; provides for how the facility ensures that medications that are scheduled during the absence will be administered; and instructs staff to contact the administrator or the DON if a resident tries to leave with an "unauthorized person" or if there are questions about the departure. CMS Ex. 13, at 31. Thus, Heritage failed to follow its own polices regarding departures, policies that are intended to protect all residents no matter what their mental or legal status.[9]

Third, Heritage alleges that it had "a number of interventions to prevent elopements generally." RR at 8. Among the interventions it cites are:

> The facility nursing staff located at the nurses station directly in front of the front door was to monitor during non business hours.
>
> The security system requiring a code to unlock this front door.

RR at 8, citing P. Ex. 1, at 3.

However, as the ALJ found, Heritage had not effectively implemented these interventions. The ALJ cited as credible the following "unrebutted" testimony (ALJ Decision at 11):

---

[9] The DON's testimony as to what he "would [] have been able to do" if he had seen Resident 9 "getting in the car with Linda" (Tr. at 203) was, at best, incomplete. He testified that: "We have a process. I would have requested that -- I would have requested that he sign out, and I would have allowed him to go." Id. at 204. That process included identifying who takes a resident and making provisions for the administration of scheduled medications, in this case anti-seizure medication. CMS Ex. 13, at 31. Moreover, as the ALJ pointed out, identifying Linda as the chaperone would have removed the ostensible motive for Linda's leaving Resident 9 four blocks from the facility and possibly prevented Resident 9's subsequent exposure to the cold and hypothermia. ALJ Decision at 10.

- a surveyor's testimony about how the "staff was not monitoring the front door particularly after 5:00 p.m" (id. citing Tr. at 77);

- a surveyor's testimony that a number of interviewed staff did not know which residents could be outside unsupervised (id. citing Tr. at 77-80); and

- a surveyor's testimony that "several residents had access to the code to the front door and would let other residents out" (id. citing Tr. at 87).

On appeal, Heritage fails to cite any portion of the record that would rebut this testimony. See RR at 17-18, 19, 21 (Heritage's discussion of its interventions). While Heritage's witnesses testified about what could be seen from various offices, receptionist desk, or nurses station (Tr. at 152-154, 204-205, 222-223), they did not dispute the surveyor's assertion (Tr. at 76-77, 160-163) that, particularly after 5:00 p.m., staff was not consistently monitoring the front door. Further, Heritage does not deny that the social worker told a surveyor that some residents knew the door code (CMS Ex. 2, at 16) or that residents could let other residents out according to the surveyor (Tr. at 87).[10] Rather, it argues that it could not reasonably determine which residents knew the code so, as a precaution, it changed the code every six months.[11] RR at 9. However, if staff had actually been monitoring the front door as Heritage alleged, it could have readily determined which residents were using the code. We conclude, therefore, that the ALJ's findings about staff's lack of monitoring, staff's lack of knowledge as to which residents could be outside unsupervised, and the ability of residents to let other residents out are supported by substantial evidence in the record as a whole.

Finally, none of the interventions that Heritage cites would have prevented Resident 9 from eloping since Heritage allowed Resident

---

[10] The DON testified that in January 2006 some family members also knew the code and could open the front door. Tr. at 206.

[11] Indeed, an employee stated on Heritage's investigation questionnaire that Resident 9 "was let out by male res. from [up]stairs per male res statement." CMS Ex. 13, at 44.

9 to sit on the front porch without supervision.[12] Tr. at 69-70. For example, a CNA told the surveyor that she saw Resident 9 sitting on the porch "many times when she came to work at 6:00 P.M." CMS Ex. 2, at 13. Indeed, the DON told the surveyor that a CNA had seen Resident 9 on the porch after dinner on the night of January 3 at 8:00 P.M. talking with another resident. CMS Exs. 2, at 12; 9, at 7; 13, at 40. Moreover, Heritage did not dispute the surveyor's testimony that, from the nurses station (which is where evening supervision of the front door was allegedly provided), one could not see the whole porch. Tr. at 162. If nursing staff had had an adequate view out the glass front door and were monitoring it, they presumably would have seen Resident 9 get in a car and depart with Linda on the night in question.

Finally, Heritage argues that allowing Resident 9 to sit unsupervised on the front porch was permissible since Resident 9's doctor did not restrict his sitting there. RR at 7, citing Tr. at 239-40. It argues that "per his treating physician, Resident 9 was allowed autonomy over his life and did not require a heightened level of supervision."[13] RR at 8.

The ALJ addressed this argument. The ALJ pointed out that the doctor "had determined at some time that Resident 9 needed skilled care in a long-term care facility," which showed that the doctor had determined that Resident 9 "was incapable of providing all his own care." Id. In other words, the doctor recommended that this resident, who was assessed as having "moderately impaired cognitive skills and poor decision-making" (Tr. 14; see CMS Ex. 13, at 7, 14), live in a facility that is required by law to ensure adequate supervision to prevent accidents. This indicates the doctor realized Resident 9 needed some level of supervision. Moreover, as the ALJ stated, "the fact that his

---

[12] We note that, while the witnesses referred to the area where Resident 9 sat as a "porch," it was level with the adjacent facility driveway and a resident could wheel himself from the porch into the driveway and parking lot. Tr. at 198-199. The front porch was not the only place where residents could sit outside. The DON testified that the facility had two secure outdoor sitting areas for residents. Tr. at 223.

[13] We note that the doctor was apparently not fully aware of or did not fully remember Resident 9's history of exit seeking behavior. He testified that the only elopement attempt of which he was aware prior to the January 3 incident was the one "about a month or so before that." Tr. at 252.

physician had not imposed restrictions upon Resident 9's sitting on the front porch or going on pass is no defense for [Heritage since the] regulation imposes upon [Heritage], not the physician, the obligation to protect its residents from foreseeable risks of accidental injury or harm." ALJ Decision at 9. Both Heritage's sign-out policy and its care plan for Resident 9 show that Heritage recognized that it was responsible for preventing unknown and unsupervised departures by residents, including Resident 9.

Therefore, we conclude that substantial evidence in the record as a whole supports the ALJ's findings of fact and that his findings provide a basis for his legal conclusion that Resident 9 did not receive adequate supervision to prevent accidents.

2. The ALJ did not err in concluding that the question of whether Heritage's noncompliance posed immediate jeopardy was not at issue before him.

Heritage argues that any noncompliance did not pose immediate jeopardy and that the ALJ erred in concluding he could not review the issue of immediate jeopardy. RR at 18.

The ALJ wrote:

> If a facility is not in substantial compliance with program requirements, CMS has the authority to impose one or more of the enforcement remedies listed in 42 C.F.R. § 488.406, including a [per instance CMP from $1000 to $10,000]. The range of the per instance CMP that may be imposed is not affected by CMS's declaration that there was immediate jeopardy. Thus, whether there was immediate jeopardy is not subject to review.

ALJ Decision at 13. The ALJ is correct. A finding of immediate jeopardy is a finding as to a level of compliance under 42 C.F.R. §§ 488.404 and 488.408. A facility may seek review of "[t]he level of noncompliance found by CMS . . . only if a successful challenge on this issue would affect" either "[t]he range of civil money penalty amounts that CMS could collect" or a "finding of substandard quality of care that results in the loss of approval" of a facility's "nurse aide training program." 42 C.F.R. § 498.3(b)(14); see also 42 C.F.R. §§ 498.3(b)(14) and (d)(1)(ii). As the ALJ explained, an immediate jeopardy finding does not affect the range of CMP amounts in a per instance CMP. As to the second basis for review, Heritage has made no assertion and presented no evidence that the immediate jeopardy finding resulted in the loss of approval for a nurse aide training

program. Therefore, the question of whether CMS correctly determined that the deficiency presented immediate jeopardy was not an issue before the ALJ.

Heritage asserts that a finding of immediate jeopardy "carries detrimental consequences" beyond federally imposed remedies, including a negative impact on "a managed care facility's ability to obtain a license or renewal of a license for current or new facilities." P. Reply at 4, n.10. While we have no reason to doubt the accuracy of this statement, the Part 498 regulations preclude Board review of the immediate jeopardy determination in this case because it was a per instance CMP.

3. The ALJ did not err in concluding that the amount of the CMP was reasonable.

The ALJ found that the amount of the CMP was reasonable based on the seriousness of the noncompliance, the harm suffered by Resident 9, and Heritage's culpability in failing to provide adequate supervision. ALJ Decision at 13.

Heritage does not offer arguments in rebuttal of the ALJ's bases for upholding the amount of the CMP. Rather, Heritage says that the ALJ erred because Heritage was in substantial compliance, any noncompliance did not pose immediate jeopardy, and there was no evidence that CMS considered all the factors in 42 C.F.R. §§ 488.438(f) and 488.404 in setting the CMP amount. RR at 22-23.

We have rejected the first argument as to substantial compliance. As to the second argument, we have determined that the ALJ could not review the immediate jeopardy determination. As to the third argument, Heritage is simply incorrect that CMS must prove that it "based its penalty on necessary factors." Id. at 23. The Board has repeatedly held that CMS does not have to present facts or arguments before the ALJ addressing its consideration of all of the regulatory factors described in 42 C.F.R. §§ 488.438 and 404. See Community Nursing Home, DAB No. 1807, at 21-26 (2002) and Emerald Oaks, DAB No. 1800, at 5-13 (2001).

Conclusion

For the preceding reasons, we uphold the ALJ's decision in its entirety.

/s/
Stephen M. Godek

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member