Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Asheville Health Care Center
(CCN: 34-5418),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-08-429

Decision No. CR2214

Date: August 13, 2010

DECISION

Petitioner, Asheville Health Care Center (Asheville), challenges the decision of the Centers for Medicare and Medicaid Services (CMS) that it was not in substantial compliance with program participation requirements. Petitioner also challenges CMS's imposition of remedies, which includes: a civil money penalty (CMP) totaling $266,600; and loss of Petitioner's ability to operate a nurse aide training and competency evaluation program (NATCEP) for two years. For the reasons discussed below, I find that Petitioner was out of substantial compliance with participation requirements during the relevant period. In addition, I find that Petitioner's noncompliance with 42 C.F.R. § 483.25(h) posed immediate jeopardy, and the remedies imposed are reasonable.

I. Background

Asheville is a skilled nursing facility (SNF) in Swannanoa, North Carolina. On February 4-7, 2008, the North Carolina State Survey Agency (State Agency) completed a recertification and complaint investigation survey at Petitioner's facility to determine if Asheville was in compliance with Federal participation requirements for nursing homes participating in the Medicare and Medicaid programs.

By letter dated March 5, 2008, CMS notified Petitioner that it was out of substantial compliance with participation requirements of the Medicare and Medicaid programs, and that conditions in the facility constituted immediate jeopardy to resident health and safety, as well as substandard quality of care. The survey also found that corrective action was taken, and the immediate jeopardy was abated. Accordingly, CMS imposed remedies that included: a CMP of $3,550 per day effective November 24, 2007 through February 6, 2008, the period in which immediate jeopardy conditions were present; a CMP of $100 per day effective February 7, 2008, which was to continue until substantial compliance was achieved or Petitioner was terminated; a denial of payment for new admissions (DPNA) effective March 20, 2008, if Petitioner was still out of substantial compliance on that date; loss of NATCEP; and mandatory termination on August 7, 2008, in accordance with 42 C.F.R. § 489.53. CMS Exhibit (Ex.) 2, at 2-3.

Following a revisit survey and a complaint investigation on March 11-12, 2008, CMS notified Petitioner by letter, dated March 28, 2008, that Petitioner remained out of substantial compliance at a non-immediate jeopardy level. CMS Ex. 2, at 5-6. As a result, the CMP of $100 per day effective February 7, 2008 would continue until substantial compliance was achieved or the provider agreement was terminated. In addition, the DPNA remained in effect March 20, 2008, and mandatory termination of the provider agreements was effective August 7, 2008, if the facility remained out of substantial compliance on that date. *Id*. at 6-7.

The State Agency conducted a revisit on March 27, 2008 and found Petitioner in substantial compliance, effective March 17, 2008. *Id.* at 9. As a result, CMS cancelled the DPNA and termination action. *Id.* Thus, the CMP of $3,550 per day was in effect for 74 days, and the CMP of $100 per day was in effect for 39 days, for a total CMP of $266,600.

Petitioner first used the Informal Dispute Resolution Process (IDR) to dispute the deficiency of Tag F 323. CMS Ex. 4, at 1. By letter dated April 9, 2008, the IDR panel decision upheld the F 323 deficiency and stated, in pertinent part:

> Based on review of the statement of deficiency dated 2/7/08 and information provided by the facility, the following facts are not disputed:
>
> The resident exited the building unsupervised on 10/19/07 and 11/24/07.
> Nursing documentation of 10/19/07 prior to exit noted escalation of paranoia and confusion.
> The resident became an elopement risk when she exited the building 10/19/07.
> No evidence of acute monitoring following the 10/19/07 elopement was noted by nursing.
> No evidence of acute monitoring following the 10/19/07 elopement was made available.

> No assessment of elopement risk was completed until 11/20/07 after the second exit.
> Nursing staff failed to communicate occurrences to administrative staff.
> Resident Council members voiced concerns related to security due to residents who had gotten out of the facility unsupervised.
> The time the resident was out of the building for each exit was undetermined.
> The resident was a compromised individual with variable cognition who voiced intent to go home on 10/19/07, and to go across the road 11/24/07.
> The facility provided a statement that acute monitoring occurred after the 10/19/07 elopement. However, evidence of monitoring was not provided to the survey team or to the IDR panel members in the supporting documentation submitted by the facility and received on 03/05/08. No additional information refuting the 2567 [Statement of Deficiencies] was presented to the IDR panel for review.

CMS Ex. 5, at 2.

Petitioner requested a hearing by letter dated May 5, 2008. This case was initially assigned to Administrative Law Judge (ALJ) Jose A. Anglada on May 8, 2008. In accordance with the briefing schedule of ALJ Anglada's initial order, CMS filed an exhibit list, pre-hearing brief, and exhibits on September 11, 2008. Petitioner filed the same on October 10, 2008. On February 19, 2009, this case was transferred to me for hearing and decision. On April 24, 2009, I set a hearing date of August 31 – September 4, 2009, which was held in Asheville, North Carolina. A 1,136-page transcript (Tr.) of the hearing was prepared. Both parties submitted briefs and reply briefs (CMS and P. Reply). I admitted P. Exs. 1-9 and CMS Exs. 1-37. Testifying for CMS were State Agency surveyors Deborah Robinson, Janet Spivey, and Karen Roquemore. Testifying for Petitioner were: Ronald Allen, Petitioner's Environment Service Director (supervisor for housekeeping and laundry); Jill Dixon, licensed practical nurse (L.P.N.); Cynthia Brantley, Geriatric Nurse Practitioner; Blair Holl, M.D., Petitioner's Medical Director; Maureen Davis, Petitioner's Administrator; and Connie Cheren, R.N., M.S.W.,[1]

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[1] Petitioner presented Ms. Cheren as an expert witness for the survey and certification processes for nursing homes participating in the Medicare and Medicaid programs. Tr. at 821. CMS did not object at the hearing. Tr. at 823. However, CMS argues in its post-hearing reply brief that no weight should be given to Ms. Cheren's testimony because it was irrelevant and not credible. CMS Reply Br. at 9. I agree. I did not find Ms. Cheren's testimony to constitute an expert opinion. For example, Ms. Cheren asserted that R6 did not leave a safe area or the facility premises, because R6 was not harmed or injured during the elopement. Tr. at 837-38, 1084. Whether harm or injury occurred is irrelevant to a violation of 42 C.F.R. § 483.25(h). *See supra* Part IV. As another

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President and Owner of Quality Care Assurance, a company that provides consultative services to nursing homes.

II. Issues

1. Whether Petitioner was out of substantial compliance with Medicare participation requirements; and

2. If Petitioner was out of substantial compliance with 42 C.F.R. § 483.25(h) (Tag F323), whether CMS's determination that Petitioner's noncompliance posed immediate jeopardy to the health and safety of the residents was clearly erroneous; and

3. If Petitioner was out of substantial compliance with participation requirements, whether the remedies imposed are reasonable.

III. Applicable Law

Petitioner is considered a long-term care facility under the Social Security Act (Act) and regulations promulgated by the Secretary of the Department of Health and Human Services (Secretary). The statutory requirements for participation by a long-term care facility are found at section 1819 and 1919 of the Act, and at 42 C.F.R. Part 483. Sections 1819 and 1919 of the Act vest the Secretary with authority to impose CMPs and other remedies against a long-term care facility for failure to comply substantially with participation requirements.

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[1] example, Ms. Cheren defined the term "premises" to determine elopement as an area within property lines. Tr. at 837-38. She stated that she based that definition on both her experience regulating nursing homes and being involved in nursing home cases, as well as on definitions found in Webster's Dictionary. Tr. at 835, 1078. That definition is contrary to the facts of numerous cases where elopements were found based on a resident's undetected exit from the facility itself. Further, the purpose of the regulation is not whether an accident (or elopement) occurs, as Ms. Cheren emphasized. Rather, it is whether the facility has provided supervision and assistance devices adequate to prevent an accident. *Kenton Healthcare, LLC*, DAB No. 2186, at 12 (2008) (refusing to determine whether all of the exits were "elopements," because the issue is not the exits per se, or whether the resident was found on or off facility property, but the lack of supervision that resulted in the exits). Ms. Cheren did not provide testimony that I consider expert opinion, and I do not give her testimony the weight of an expert opinion.

Pursuant to the Act, the Secretary has delegated to CMS the authority to impose various remedies against a long-term care facility that is not complying substantially with federal participation requirements. State survey agencies, on behalf of CMS, may survey facilities that participate in Medicare to ascertain whether the facilities are complying with participation requirements. 42 C.F.R. §§ 488.10 –.28, 488.300 – .335. Under Part 488, CMS may impose a per instance, or per day, CMP against a long-term care facility, when a State survey agency ascertains that the facility is not complying substantially with participation requirements. 42 C.F.R. §§ 488.406, 488.408, 488.430. The regulations in 42 C.F.R. Part 488 also give CMS a number of other remedies that can be imposed if a facility is not in compliance with Medicare requirements.

Pursuant to 42 C.F.R. Part 488, CMS may terminate a long-term care facility's provider agreement, when a survey agency concludes that the facility is not complying substantially with federal participation requirements. CMS may also impose a number of alternative enforcement remedies in lieu of, or in addition to, termination. 42 C.F.R. §§ 488.406, 488.408, 488.430. In addition to termination and the alternative remedies that CMS is authorized to impose, pursuant to section 1819(h)(2)(D) of the Act and 42 C.F.R. § 488.417(b), CMS must impose the "mandatory" or "statutory" DPNA. Section 1819(h)(2)(D) requires the Secretary to deny Medicare payments for all new admissions to a SNF, beginning three months after the date on which such facility is determined not to be in substantial compliance with program participation requirements. The Secretary has codified this requirement at 42 C.F.R. § 488.417(b).

The regulations specify that a CMP that is imposed against a facility on a per-day basis will fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of the CMP, from $3,050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. § 488.438(a)(1)(i), (d)(2). The lower range of CMP, from $50 per day to $3,000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). There is only a single range of $1,000 to $10,000 for a per instance CMP, which applies whether or not immediate jeopardy is present. 42 C.F.R. §§ 488.408(d)(1)(iv); 488.438(a)(2).

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. Immediate jeopardy is defined as "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." *Id.* The Act and regulations make a hearing before an ALJ available to a long-term care facility against which CMS has determined to impose a CMP. Act Section 1128A(c)(2); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing before an ALJ is a de novo proceeding. *Anesthesiologists Affiliated*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991).

A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); *see* 42 C.F.R. §§ 488.330(e), 498.3. However, CMS's choice of remedies, or the factors CMS considered when choosing remedies, is not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance that CMS found if a successful challenge would affect the amount of the CMP that CMS could collect or impact upon the facility's NATCEP. 42 C.F.R. § 498.3(b)(14)(i), (ii). CMS's determination as to the level of noncompliance "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). This includes CMS's finding of immediate jeopardy. *Woodstock Care Ctr.*, DAB No. 1726, at 9, 38 (2000), *aff'd*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (Board) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except where that finding was the basis for an immediate jeopardy determination. *See, e.g., Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). ALJ Review of a CMP is governed by 42 C.F.R. § 488.438(e).

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 Rehab. Ctr.*, DAB No. 1611 (1997), *aff'd*, *Hillman Rehab. Ctr. v. U.S. Dep't of Health & Human Servs.*, No. 98-3789, 1999 WL 34813783 (D.N.J. May 13, 1999).

IV. Findings of Fact, Conclusions of Law, and Discussion

My findings of fact and conclusions of law are set forth in bold and are followed by my analysis.

During the February 2008 survey, Petitioner was found out of substantial compliance with the following participation requirements: 42 C.F.R. § 483.25(h) (F Tag[2] 323, at a scope and severity level (SS)[3] J); 42 C.F.R. § 483.35(i)(2) (F Tag 371, SS E); 42 C.F.R.

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[2] An F Tag designation refers to the part of the State Operations Manual (SOM) that pertains to the specific regulatory provision allegedly violated, as set out in the statement of deficiencies (SOD).

[3] CMS and a state use scope and severity levels when selecting remedies. The scope and severity level is designated by an alpha character, A through L, which CMS or the state agency selects from the scope and severity matrix published in the SOM, section 7400E. *See* 42 C.F.R. § 488.408. A scope and severity level of A, B, or C indicates a deficiency that presents no actual harm but has the potential for minimum harm. Facilities with deficiencies of a level no greater than C remain in substantial compliance.

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§ 483.15(e)(1) (F Tag 246, SS D); 42 C.F.R. § 483.25(a)(3) (F Tag 312, SS D); 42 C.F.R. § 483.25(k) (F Tag 328, SS D); and 42 C.F.R. § 483.75(l)(1) (F Tag 514, SS D). CMS Ex. 1.

In this decision, I discuss the immediate jeopardy Tag at F 323, and only the non-immediate jeopardy Tags at F 246, F 312, and F 328. I am not required to make findings of fact and conclusions of law on deficiencies that are not necessary to support the remedies imposed, as is the case here where the CMPs imposed are at almost the minimum for per-day CMPs at both the immediate and non-immediate jeopardy levels. *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904, at 21-22 (2004); *Cmty. Skilled Nursing Ctr.*, DAB No. 1987 (2005); *Golden Living Ctr. – Frankfort*, DAB No. 2296, at 3 n.2 (2009). Thus, I do not address all five of the non-immediate jeopardy deficiencies that the surveyors cited.

1. **Petitioner was out of substantial compliance with the participation requirement at 42 C.F.R. § 483.25(h) (F Tag 323, SS J).**

Pursuant to 42 C.F.R. § 483.25, in pertinent 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—
> (1) The resident environment remains as free of accident hazards as is possible; and
> (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

42 C.F.R. Ch. IV (10-1-07 Edition). The requirements of this regulation have been explained in numerous Board decisions. *See, e.g., Golden Age Skilled Nursing & Rehab.*

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A scope and severity level of D, E, or F indicates a deficiency that presents no actual harm but has the potential for more than minimal harm that does not amount to immediate jeopardy. A scope and severity level of G, H, or I indicates a deficiency that involves actual harm that does not amount to immediate jeopardy. Scope and severity levels J, K, and L are deficiencies that constitute immediate jeopardy to resident health or safety. The matrix, which is based on 42 C.F.R. § 488.408, specifies which remedies are required and optional at each level based upon the frequency of the deficiency, i.e., whether a deficiency is isolated, part of a pattern, or widespread. 42 C.F.R. § 488.301.

Ctr., DAB No. 2026 (2006); *Woodstock Care Ctr.*, DAB No. 1726 (2000), *aff'd*, *Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 (6th Cir. 2003).

The Board has stated with regard to subsection (h)(1),

> The standard in section 483.25(h)(1) itself – that a facility "ensure that the resident environment is as free of accident hazards as possible" in order to meet the quality of care goal in section 483.25 – places a continuum of affirmative duties on a facility. A facility must determine whether any condition exists in the environment that could endanger a resident's safety. If so, the facility must remove that condition if possible, and, when not possible, it must take action to protect residents from the danger posed by that condition.

Laurelwood Care Ctr., DAB No. 2229, at 8 (2009) (quoting *Me. Veterans' Home – Scarborough*, DAB No. 1975, at 5 (2005)). The Board states further that section 483.25(h)(1) clearly informs facilities that they must ensure that the resident environment remains as free of accident hazards as possible. The Board cites 42 C.F.R. § 483.20(b) in noting that other program requirements in the regulations require nursing home facilities to engage in a comprehensive assessment of a resident's needs.

Although section 483.25(h) does not make a facility strictly liable for accidents that occur, it does, under subsection (h)(2), require the facility to take all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents. *Woodstock Care Ctr. v. Thompson*, 363 F.3d at 590 (holding a skilled nursing facility must take "all reasonable precautions against residents' accidents"). Facilities have the "flexibility to choose the methods of supervision" to prevent accidents so long as the methods chosen constitute an adequate level of supervision under all circumstances. *Golden Age*, DAB No. 2026, at 11 (citing *Woodstock*, 363 F.3d at 590).

> The Board has confirmed that the measures that a facility adopts to care for its residents are evidence of the facility's evaluation of what must be done to attain or maintain a resident's highest practicable physical, mental and psychosocial well-being, as required by section 483.25. *Woodland Village Nursing Ctr.*, DAB No. 2053, at 8-9 (2006), *aff'd*, *Woodland Village Nursing Ctr. v. U.S. Dep't of Health & Human Servs.*, 239 Fed. App'x 80 (5th Cir. 2007), citing *Spring Meadows Health Care Center*, [DAB No. 1966,] at 16-18 [(2005)] (addressing facility failures to observe their own policies for resident care). Failure to fully employ those measures as intended may thus be . . . evidence that the facility failed to provide residents with needed care and supervision as required by the regulation.

Cedar Lake Nursing Home, DAB No. 2288, at 6-7 (2009).

The February 7, 2008 statement of deficiencies reflects that Petitioner:

> [F]ailed to assess, identify, develop and implement a plan of care, and failed to monitor to prevent one (1) of six (6) sampled residents, with wandering behaviors, from exiting the building unsupervised. On two occasions Resident # 6 propelled her wheelchair through the two sets of double doors at the front/main entrance and exited the facility unnoticed and unsupervised. [4]

CMS Ex. 1, at 9.

Resident 6

Resident 6 (R6) was first admitted to the facility on September 17, 1998, at the age of 64. P. Ex. 1, at 1; CMS Ex. 9, at 13. R6's admitting diagnosis included: subdural hematoma with memory loss and fall; seizures; depression; hypertension; emphysema; panic disorder; and accidental benzodiazepine overdose. P. Ex. 1, at 1. R6's updated diagnosis through the end of 2001 included: paranoid ideation; transient ischemic attack; dementia; hypothyroidism; and pneumonia. *Id.* In December of 2003, R6 was readmitted after hospitalization with an admitting diagnosis that included, inter alia: major depression with severe psychosis; mild dementia; abnormal EEG; seizure disorder; vitamin B-12 deficiency; and hypertension. *Id.* at 2.

According to R6's plan of care, during the period from April 2006 to January 2008, R6: had potential for drug related side effects from the use of psychotropic medication; was at risk for bleeding due to use of anti-coagulation therapy; had potential for falls due to history of seizures, CVA with left hemiparesis, dementia, psychosis, and psychotropic medications usage; was unable to complete ADL tasks independently related to emphysema, COPD, history of CVA with left hemiparesis, depression with psychosis, seizures, and dementia; had cognitive loss due to dementia; had impaired respiratory status; and history of seizures was noted. *Id.* At 10-19. From January 2007 to January 2008, R6 also had pain "c/o leg pain tingeling [sic]." *Id.* at 21. And from September 2007 to January 2008, R6 had mood and behaviors requiring Depakote for paranoid behaviors and Klonopin for diagnosis of anxiety, psychotic disorder. *Id.*, at 22.

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[4] Petitioner argues that "[i]n the SOD, CMS did not differentiate between its grounds for asserting noncompliance with subsection (1) and subsection (2) of § 483.25(h)," which is "a material due process violation because it deprives the provider of adequate notice, forcing it to guess the basis for the government's conclusions under each subsection." P. Br. at 14. I find no merit to this argument. The SOD clearly state both the failure to provide an environment free of hazards under subsection (1), and the failure to provide adequate supervision to mitigate foreseeable risks of harm under subsection (2).

The Facility

Asheville is a 106-bed facility. Tr. at 668. It is located in a rural area, east of Asheville. *Id.* The facility is located off a five-lane highway. P. Ex. 3, at 22. The front entrance to the facility has two sets of glass doors, which can only be opened manually using a push bar. Tr. at 95, 676; P. Ex. 3, at 2. In between the two sets of doors is a little breezeway. Tr. at 95. Outside the doors is an overhang with a drive directly in front of the door, and to the left is a parking lot. Tr. at 95; P. Ex. 3, at 5. Three parking spaces line the sidewalk along the front of the facility, two of which are marked for handicap use. P. Ex. 3, at 19. Beyond the three parking spaces is a grassy area and then the rest of the parking lot. Tr. at 96. To the left of the three parking spaces, at an angle in front of them, is the entrance into the facility from the highway. *Id.*

The facility is not a locked facility in that two of the doors, the main entrance to the facility and a back door that is used as an employee entrance, remain unlocked with no alarm during the day from 7:00 AM to 11:00 PM, seven days a week. Tr. at 636, 677, 775. All other doors to the facility are locked and alarmed. Tr. at 710-13. The facility employs a receptionist at a desk in the front of the facility from 10:30 AM to 7:00 PM, Monday through Friday, but not on weekends. Tr. at 383, 720, 722, 774.

The facility screens patients and only admits those who would be safe in such an environment. Tr. at 639, 678. In the event a resident's condition changes and is no longer safe in such an environment, the facility transfers the resident to a more appropriate facility. Tr. at 678-79.

The Elopements

On October 19, 2007, a Friday, the first elopement occurred. Tr. at 476. The receptionist on duty that day was the first to spot R6 outside, and he returned her to the facility.[5] Tr. at 730. The receptionist did not testify at the hearing. No one is certain how long R6 was outside before the receptionist saw her, or how R6 got through the front doors. Tr. at 780-81, 785-86. A nurse's note reporting R6's elopement was entered at 3:11 PM. Tr. at 786; CMS Ex. 9, at 96. The prior nurse's note for that day was entered at 2:28 PM, noting R6's increased confusion. It also noted how R6 had grabbed the nurse who was distributing medications, as well as a resident who was being propelled in a wheelchair by another resident. CMS Ex. 9, at 96. At the time of the survey, the surveyors never received clarification from the staff as to where R6 was found outside of the facility. Tr. at 256. Based on interviews, the surveyors believed R6 was found on the sidewalk outside the front door of the facility. *Id.* Testimony during the hearing, and a diagram of

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[5] Until conducting an investigation in preparation for this hearing, the facility believed that a CNA found R6. Tr. at 730. After interviewing every CNA, none of whom had found R6, it was determined that the receptionist was the first to find R6. *Id.*

the facility grounds that was submitted to the IDR panel, indicate that R6 was found in the parking lot in one of the parking spaces just off the sidewalk aligning the front of the building.[6] Tr. at 507; CMS Ex. 4, at 57. However, at the hearing, Petitioner pointed to a progress note for R6 summarizing the elopement, which reads that R6 was found "outside front door in [wheelchair] on sidewalk [without] supervision." Tr. at 505; CMS Ex. 9, at 96.

On November 24, 2007, a Saturday, the second elopement occurred. The testimony of both the surveyors and staff indicate that no incident report was filled out. Tr. at 78-79, 458-60, 694. It was never established how long R6 was outside the facility, and, because it was a weekend, the receptionist was not there. Tr. at 79, 92-93, 453, 785. Nobody saw or knew how R6 exited the building that day. Tr. at 450, 785. Ronnie Allen, the Environmental Service Director who supervises housekeeping and laundry, testified that he had just clocked out of work and was driving from the back of the building, where he was parked, to the exit at the front of the building, when he saw R6 sitting in the third parking space, furthest away from the front door with her cordless telephone. Tr. at 409, 414-16. Mr. Allen got out of his car to talk to R6 and tried to get her to return to the facility. Tr. at 415-16. At that time, Todd Brown, who was reporting to work, entered the parking lot, and he told Mr. Allen that he would go inside to get help. Tr. at 416. Within a few minutes, a nurse[7] who saw Mr. Allen and R6 through the front window, came out and returned R6 inside the facility. Tr. at 416. Mr. Allen believes he was outside with R6 a total of 6-7 minutes, at most. Tr. at 417. The nurse's progress note summarizing this elopement reads:

> Resident found outside (out front) by family member visiting. Res[ident] stated, "I know whats going on and I'm going across the street to use the phone." Brought resident in immediately and nurse notified the POA [power of attorney]. Resident very anxious carrying her telephone in the [wheelchair]. Medicated [with] prn Ativan for the anxiety. Will monitor closely for inappropriate behaviors. Supervisor and D.O.N. notified of the situation.

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[6] The administrator testified that the map is mismarked due to her mistake. She explained that she delegated the duty of making the map and did not verify it appropriately before submitting it to the IDR panel. Tr. at 733-34. At the hearing, she testified that she is now certain R6 was found directly outside the front doors of the facility. Tr. at 734.

[7] Conflicting testimony exists as to which nurse retrieved R6. Mr. Allen testified that Frankie Beaver retrieved R6. Tr. at 417. Ms. Dixon, R6's nurse, testified that she retrieved R6. Tr. at 441. According to Petitioner's brief, they both retrieved R6. P. Br. at 10.

CMS Ex. 9, at 94. The nurse's note immediately preceding this one indicates R6 was exhibiting signs of paranoia and was very concerned that her medications were going to kill her. *Id.* The day before, R6 had fallen out of bed, and she was still being monitored for latent injuries at the time of the elopement. *Id.*

No documentation exists that R6 signed herself out of the facility before exiting the facility on either occasion. Tr. at 267.

CMS's summarized its arguments as follows:

> On October 19, 2007, R6 exited Asheville Health Care Center unnoticed and unsupervised for an unknown period of time and was found outside in the front parking lot of the facility. Asheville did not take any corrective measures to prevent further elopement. On November 27, 2007, R6 exited to the front parking lot again, and was found by a visitor as R6 was propelling her wheelchair toward a five lane highway running in front of the facility.[8] Again, Asheville did not take any corrective measures until the time of the February 2008 survey. R6 had myriads of mental and physical health problems such as dementia of Alzheimer's type, hallucination, paranoia, confusion, anxiety, seizure disorder, neuropathy, restless leg syndrom[e], tremor, congestive heart failure[], COPD, polypharmacy, and history of falls. Asheville failed to provide an environment that is free of accident hazards over which it had control, because two of its exit doors had no alarms and no supervision to prevent unauthorized access. Asheville also failed to provide adequate supervision and assistance devices to prevent R6 from eloping and being exposed to the likelihood of suffering serious harm. As such, Asheville failed to be in substantial compliance with 42 C.F.R. § 483.25(h).

CMS Br. at 1.

There are no nurse's or doctor's notes or other indications before October 19, 2007, the date of R6's first elopement from the facility, that R6 was an elopement risk. At that time, R6 had been a resident at the facility for nine years. As indicated by CMS's decision to impose a CMP effective November 24, 2007, as opposed to October 19, 2007, the effective date recommended by the State Agency, it is reasonable to conclude that it is undisputed that it was not foreseeable that R6 was an elopement risk prior to October 19, 2007.

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[8] Whether R6 was propelling her wheelchair toward the highway or sitting stationary is in dispute. P. Br. at 15.

Petitioner argues that R6's second elopement from the facility was also unforeseeable. P. Br. at 1 ("Neither exit was reasonably foreseeable."); P. Reply Br. at 3 ("Both exits were isolated occurrences."). On October 19, 2007, however, the facility was now on notice that R6 was able to elope from Petitioner's facility undetected. That knowledge placed Petitioner on notice and obligated Petitioner to take steps necessary to adequately supervise R6 to prevent further elopements. *Liberty Commons Nursing & Rehab Ctr. – Alamance v. Leavitt*, 285 F. App'x 37, 42 (2008).

Petitioner argues that it was in substantial compliance with 42 C.F.R. § 483.25(h), because CMS did not make a prima facie case of noncompliance. P. Br. at 13-15. Specifically, Petitioner argues: (1) there was no accident; (2) there was not an elopement; (3) the absence of particular documentation expressly referencing exit-seeking behavior does not demonstrate the facility did not intervene to prevent it, and thus does not demonstrate noncompliance; and (4) CMS's conclusions are not entitled to deference. P. Br. at 15-22. I will discuss each of Petitioner's four arguments in turn below.

First, Petitioner argues that R6's exits were the direct result of her medication, and thus they are not properly considered an "accident" for purposes of determining compliance with section 483.25(h). P. Br. at 16-17. Petitioner relies on Transmittal 27, which states that an "accident" for purposes of section 483.25(h) "does not include adverse outcomes that are a direct consequence of treatment or care that is provided in accordance with current standards of practice (e.g., drug side effects or reaction)." P. Br. at 16. Moreover, Petitioner argues that R6's exiting behavior was a consequence of R6's medication or a possible urinary tract infection, which caused anxiety and confusion. *Id.* Cynthia Brantley, the geriatric nurse practitioner who worked closely with R6's doctor, testified that ordering a urinalysis the day of the October exit was the intervention for the elopement. Tr. at 513.

This argument misses the point that, regardless of what other care R6 needed at this time, the facility also needed to take reasonable steps necessary to prevent future undetected elopements that put R6 at risk of harm and accidents. An elopement is not an "adverse outcome" of the treatment of care; rather, the increased confusion and paranoia was thought to be the adverse outcome from R6's medications. Tr. at 477-78 (testimony of Cynthia Brantley, geriatric nurse practitioner, on whether the increased confusion and paranoia was due to R6's drugs or to a urinary tract infection); Tr. at 624 (testimony of Dr. Holl stating that changes in anxiety medication instigated the November elopement by making R6 more anxious with increased energy). Upon review of R6's plan of care, these symptoms of confusion and paranoia do not appear to be new to R6 such that elopement could be determined to be the direct consequence of these side effects or reactions. P. Ex. 1, at 16 (noting increased confusion and paranoia on April 8, 2007); P. Ex. 1, at 1 (listing admitting diagnoses and updated diagnoses through 2001, which include seizures, depression, panic disorder, paranoid ideation, and dementia); CMS Ex. 4, at 15 (noting diagnosis of Alzheimer's dementia with mild short and long term

memory deficits on August 2, 2006). There is no allegation that the facility did not take proper steps to treat R6's confusion and paranoia. The allegation is that the facility did not perform its affirmative duty to protect R6 from the danger that undetected elopements posed.

Second, Petitioner argues that there was not an elopement. P. Br. at 17. Petitioner relies on a definition of elopement that extends the definition of "premises" to include the facility grounds.[9] P. Br. at 17; P. Ex. 10 (SOM, app. PP, defining elopement). The Petitioner argues that, because R6 never left the grounds of the facility and never left a safe area, no elopement occurred. *Id.*

Petitioner also argues that the "mere fact that [R6] was outside did not make her unsafe or put her at risk." *Id.* Petitioner relies on the fact that R6 was "only [outside] for a few minutes" and the fact that no harm occurred. *Id.* at 17-18. Petitioner maintains that CMS's focus is grounded solely in strict liability, since CMS argues that a violation of section 483.25(h) occurred when the resident exited the facility. *Id.* at 19.

Those arguments also miss the point in that the issue here is that the resident, who is cognitively impaired and not capable of protecting herself, left the facility undetected, without nursing staff supervision. The purpose of the regulation is to keep residents safe, regardless of whether the resident leaves the facility grounds or simply wanders into an unsafe area, such as a kitchen, undetected and unsupervised. An elopement in and of itself is not the reason Petitioner was found out of compliance with section 483.25(h); rather, it was the fact that Petitioner did not plan or implement adequate interventions to address the elopement, and, as a consequence, R6 was not well-supervised and was at risk of accident. *Compare Pinehurst Healthcare & Rehab. Ctr.*, DAB No. 2246, at 25 (2009) (Petitioner was out of compliance with 42 C.F.R. § 483.25(h) because it failed to establish that its monitoring of elopement-prone residents was adequate) *with Willow Creek Nursing Ctr.*, DAB. No. 2040 (2006) (Facility was in compliance with 42 C.F.R. § 483.25(h) despite R4's elopement, because it planned and implemented effective interventions to address the elopement risk, and R4 was found to be well supervised.). Here, Petitioner failed to establish that its monitoring of R6 was adequate, as further addressed in the discussion of Petitioner's third argument below.

Petitioner's third argument is that the absence of particular documentation expressly referencing exit-seeking behavior does not mean that the facility did not intervene to prevent it and, thus, does not demonstrate noncompliance. P. Br. at 19.

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[9] "Elopement," as defined in the SOM, "occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so." SOM, app. PP.

The problem with this argument is that Petitioner has presented no credible evidence that the facility intervened to address R6's elopement risk such that adequate supervision of R6 was provided. The facility did take the step of attempting to transfer R6 to another facility. P. Ex. 1, at 253, 306; CMS Ex. 9, at 38. However, no beds were available at either of the two facilities to which a transfer was attempted. P. Ex. 1, at 306; CMS Ex. 9, at 38. No further attempts to transfer R6 were made, and no documentation exists beyond that of any plans or interventions to address R6's elopement risk, even though R6's elopement risk is in the doctor notes dated November 30, 2007. *Id.* That inaction was despite the fact that those same doctor notes indicate that R6 has "[a]ctive range of motion all extremities. She is propelling her wheelchair in the hallway today." *Id.* Dr. Holl testified that he did not believe R6 was an exit seeker, because he did not believe R6 had the strength to push the front doors to exit the facility. As such, he did not perform an elopement evaluation for R6 after the October exit. Tr. at 606, 636-38, 662. Dr. Holl later clarified that he did believe R6 to be an elopement risk after the second exit, and he attempted to transfer R6 to another facility. Tr. at 639-40. As noted above, however, that attempt failed. Petitioner has not come forward with any evidence sufficient to demonstrate that it planned or implemented effective interventions to address R6's elopement risk prior to February 6, 2008.

As stated in *Liberty Commons*, the two factors used to determine whether Petitioner's response was reasonable are whether: a risk of an "accident" was foreseeable; and the facility's response was adequate under the circumstances. *Liberty Commons,* 285 F. App'x at 44 (citing *Woodstock Care Ctr.,* DAB No. 1726). As noted above, the second elopement on November 24, 2007 was foreseeable, because Petitioner was put on notice of R6's elopement risk after the first elopement on October 19, 2007. Petitioner's response to R6's behavior was not adequate. Petitioner's attempt to transfer R6 to another facility failed. Petitioner has not demonstrated any further action it took to specifically address R6's elopement risk.

Petitioner maintains that "[t]he record is clear that between October 19 and the November 24 exit, the facility placed the resident on acute monitoring for increased paranoia and wandering, wrote progress notes reporting on the resident, evaluated the resident's behavior and documented multiple interactions with the residents' physicians." P. Br. at 26.

Progress notes on the resident, evaluation of the resident's behavior, and documentation of interactions with the resident's physicians are all steps that would be performed regardless of whether the patient was an elopement risk. In other words, these are not additional steps that the facility took to ensure the resident was properly monitored for her wandering and exit seeking behavior. *See* Tr. at 688, 769-72. There is no evidence that these tasks occurred more frequently or in a heightened manner to consider R6's elopement risk.

In regard to the acute monitoring for increased paranoia and wandering, the acute monitoring charts[10] were not presented to the surveyors at the time of the February survey. Tr. at 177. Upon review of the documentation presented during the survey, no documents indicate the monitoring of R6's whereabouts and safety in terms of exit seeking behavior and wandering. Tr. at 194. During the relevant time, there is only documentation of monitoring for adverse reactions to medications, particularly the antibiotics for a urinary tract infection. *Id.*

The acute monitoring charts were found after the survey. Only the first two of the six pages of P. Ex. 4, which set forth the acute monitoring charts, indicate a frequency of "acutely" monitor[11] for, inter alia, "paranoia, wandering behavior." *Id.* at 1-2. The next two pages are for the monitoring of "VS latent injury, (L) shoulder bruising c/o pain" at a frequency of "Q [(every)] shift x 3 days." *Id.* at 3-4. The last two pages are for the monitoring of "Neg. statements, effectiveness" at a frequency of "Q shift x 14 days." *Id.* at 5-6.

The acute monitoring charts list "paranoia, wandering behavior" under the "points to chart" heading; however, "paranoia, wandering behavior" is handwritten on the chart, whereas "refusing meds, anxiety," which is also listed in that same section of the chart, is typed as with most other entries on the relevant pages. P. Ex. 4, at 1-2; Tr. at 702-05. At hearing, Petitioner submitted a replacement copy of this exhibit, because three of the pages were not originally submitted. Tr. at 12. CMS objected to the admission of the additional three pages stating that, although the documents are very relevant in that they go to the monitoring of the resident who had eloped during the relevant time period, the charts were not provided to the surveyor at the time of the survey, and they were not submitted to the state office during the time of IDR. Tr. at 14, 699. In addition, CMS questioned the authenticity of the documents. Tr. at 14. CMS points out that these charts present a lot of inconsistencies, such as: Petitioner indicating that six pages were faxed to the facility's attorney, when the fax information at the top of the page indicates only five pages were faxed; and the Petitioner's pre-hearing brief states that acute monitoring

[10] The staff indicated that the acute monitoring charts are used as an internal communication tool at the facility. Tr. at 802. The nurses refer to these charts, which are located at the nurses' stations, to learn what they should look for with the residents. *Id.* The nurses then document the behaviors they are to look for in their progress notes. If that specific behavior does not occur, the nurse does not have to write anything in the progress report. Tr. at 769; 772.

[11] According to the testimony of Jill Dixon, a L.P.N. at the facility, "acutely" under the "frequency" category of the acute monitoring charts means whenever that patient for whom the entry is written exhibits the behavior indicated, such as paranoia, wandering behavior, then the nurse is to document that in the nurse's notes. Tr. at 456-57.

started on October 20, 2007 and stopped after three days, but, on the substituted exhibit, a page dated October 30, 2007, which is more than three days after when the acute monitoring was alleged to have begun, it states that acute monitoring is still occurring. Tr. at 15, 704-05 (noting that unit managers update acute monitoring charts on a daily basis, or every couple of days).

The direction to monitor R6 for paranoia, wandering behavior is handwritten even on the acute monitoring chart dated October 30, 2007, ten days after the instruction was given. Petitioner had plenty of time to update the chart in the computer system so that the monitoring directions would also be computer generated. I am concerned that the records were not provided to the surveyors, or as part of the exchange process, in these proceedings prior to trial. Furthermore, no corroboration exists in the nurse's notes of any monitoring for paranoia, wandering behavior. The facility states that no documentation means that no wandering behavior is observed, because the nurses do not have to note anything that did not occur. Tr. at 707, 806-07. Because there is no notation regarding wandering behavior during the time period in which acute monitoring took place, there is no way of knowing if in fact the nurses performed such monitoring, and there is no evidence illustrating how this monitoring was actually performed to ensure R6's safety.[12]

Instead, the testimony and Petitioner's brief, which argues no elopement occurred, indicates that staff did not even find R6 to be an elopement risk, much less indicate that they had concern for preventing such behavior. Tr. at 497, 509, 623; P. Br. at 17-19, 23. The director of nursing (DON) at the time of the elopements and the administrator indicated to surveyors that they were not even aware of R6's elopements until their interviews with surveyors.[13] Tr. at 393, 809.
The current DON testified that there are no procedures at the nursing home, or under the parent company, to follow when a resident has left the facility. She indicated that they have a policy on a missing resident, but the DON testified that R6 was never missing. Tr. at 811. None of the systems described to be in place to ensure that communication

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[12] The only corroboration that was indicated was oral communication among the nurses between shifts. Tr. at 448; 688-90.

[13] Contradictory evidence exists that the DON and administrator knew of the elopement. The Resident Council minutes indicate that council members told the administrator about their concern for residents leaving the facility undetected. The nurse's progress notes indicate the DON was notified. CMS Ex. 24, at 34; Tr. at 460; CMS Ex. 9, at 94. In addition, the administrator testified that Asheville ordered a Wanderguard system (an electronic monitoring system) the last week of December, had it installed in January, but it was not yet operational at the February survey because of a computer chip defect. T. at 723.

occurs to prevent accidents indicate R6's safety was adequately monitored to prevent undetected exiting from the facility. *See* Tr. at 688 (listing the following systems to facilitate communication to prevent accidents: lots of oral communication during shift changes; handwritten shift reports by nurses; progress notes that can be flagged to attach to a resident's medical record; and acute monitoring sheets).

Petitioner argues that "[t]here is no requirement that a resident be within eye view at all times." P. Br. at 26. Although this is true, two doors of the facility were not locked, or alarmed, and were not monitored at all times. There was systematic failure to supervise or alarm the doors. Petitioner lists as systematic measures and safeguards to ensure safety the following: its closed unit staffing model; and the structural elements of the facility and premises, such as the large windows on the front of the facility and the design of the parking lot and doors. P. Reply Br. at 2. Petitioner also points to the fact that it had ordered and installed an electronic monitoring system and hired a staff person to monitor the front door on weekends. P. Reply Br. at 4. But, the electronic monitoring system was not operational at the time of the survey, and there were still times when the front door was unlocked and not monitored. T. at 94, 723.

To provide adequate supervision of R6 under these circumstances, a plan for monitoring R6 or for some type of successful and effective intervention is required. While a facility has discretion to determine the specific manner by which to achieve adequate supervision, it must implement some form of supervision to meet the regulatory requirement of adequate supervision. Petitioner points to no reason why I should assume that its level of supervision provided to R6 increased after her elopement. Petitioner has not identified any such measures that were in fact adopted to specifically address R6's elopement risk. Instead, Petitioner lost an opportunity to analyze and correct the problem that led to the elopement by failing to have an effective system for staff to even report and investigate such episodes.[14] This is illustrated in Petitioner's presentation of different events at hearing than were presented to the state, as well as Petitioner's presentation of new evidence, the acute monitoring charts, in the course of litigation.

Petitioner's fourth argument is that CMS is not entitled to deference. P. Br. at 20-22. However, CMS has presented a prima facie case that Petitioner is out of compliance with 42 C.F.R. § 483.25(h). As stated above, Petitioner was on notice that R6 was an

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[14] No incident report was given to the surveyors or produced as evidence at the hearing. The testimony regarding whether one was filled out was ambiguous. Tr. at 457-59. However, Ms. Dixon, R6's nurse, concluded in her testimony that she does not recall if one was filled out but that she would have recalled this fact at the time of the survey in February 2008. Tr. at 458-60. The administrator also indicated that no incident report was filled out for the elopements. Tr. at 694.

elopement risk after successfully exiting the facility undetected, and the facility's response was insufficient to ensure R6's safety. It is now Petitioner's burden to prove beyond a preponderance of the evidence that it was in substantial compliance. *Hillman Rehab. Ctr.*, DAB No. For the reasons set forth above, Petitioner has not met this burden.

2. Petitioner was out of compliance with the participation requirement at 42 C.F.R. § 483.15(e)(1) (F Tag 246, SS D).

Pursuant to 42 C.F.R. § 483.15, which reads, in pertinent part:

> A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.
>
> * * * *
>
> (e) *Accommodation of needs.* A resident has the right to—
>
> (1) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered;

The February 7, 2008 SOD reflects that Petitioner:

> [F]ailed to ensure a call bell was within reach for one (1) of twenty (20) sampled residents who use a call bell to request assistance. (Resident # 7)

CMS Ex. 1, at 1. Petitioner's care plan for resident 7 (R7) reads, "[c]all bell within reach." CMS Ex. 11, at 19. That intervention is listed to address R7's history of falls, dizziness, psychotropic medications, and bilateral knee osteoarthritis. *Id.*

Petitioner argues CMS presented insufficient evidence to establish that the facility failed to provide a resident with reasonable accommodations. P. Br. at 34. Specifically, Petitioner argues that R7 could always access assistance: "(i) when she was in bed, she could access a call bell that allowed her to call staff for assistance; and (ii) when the resident was in her wheelchair, she could maneuver her chair to the hallway and ask for assistance." *Id.*

The surveyor testified:

> I had observations on each day of the survey when the Resident was out of bed, in her wheelchair that the call bell was not within her reach. It was attached to the top side rail of her bed. She was in bed B, which is the bed closest to the window. And the call bell was wrapped around the left side rail which would have put it on the side rail that is closest to the other bed.

> And there was not enough room for her to move her wheelchair to reach the call bell.
>
> * * * *
>
> [W]hat my assessment was and what the [survey] team talked about is the fact that [R7] had a history of falls and that she did have some injury from that -- from at least one of those falls. And that the facility had assessed and care planned for her to have a call bell within reach. And I had consistent observations throughout the survey of when she was in her wheelchair the call bell was not within her reach. So because she had a history of falls if she attempted to get that call bell when it was not in reach, there's a potential for her to have another fall. And therefore, other . . . injury. So there's potential for more than minimal harm, the D level that we placed the deficiency at.

T. at 338, 346-47. During the surveyor's interview with the resident, R7 stated that she could not reach the call bell, unless she gets up and walks to get it. T. at 341; CMS Ex. 1, at 3. I find the surveyors observations and interview findings are sufficient evidence to constitute a deficiency under the applicable regulation. R7 was care planned to have a call bell within reach, and it was not.

3. Petitioner was out of compliance with the participation requirements at 42 C.F.R. §§ 483.25(a)(3) (F Tag 312, SS D) and 483.25(k) (F Tag 328, SS D).

Pursuant to 42 C.F.R. § 483.25(a)(3), (k),

> (a) *Activities of daily living.* Based on the comprehensive assessment of a resident, the facility must ensure that—
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> * * * *
>
> (3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.
>
> * * * *
>
> (k) *Special needs.* The facility must ensure that residents receive proper treatment and care for the following special services:
>
> * * * *
>
> (7) Foot care

The February 7, 2008 SOD reflects that Petitioner:

> [F]ailed to provide toe nail care to three (3) of twenty (20) sampled residents in need of extensive assistance with personal hygiene. (Resident # 14, 15, & 19)
>
> * * * *

> [F]ailed to provide toe nail care to two (2) of two (2) sampled diabetic residents who required nail and foot care by a podiatrist. (Resident # 7 and # 22)

CMS Ex. 1, at 3, 29.

Petitioner has not adduced evidence or presented argument to rebut the allegations. Petitioner's only argument with regard to these deficiencies is that "Surveyor Robinson admitted that at least one resident, Resident 19, suffered no actual harm from any alleged deficiencies." P. Br. at 35. Regardless of whether actual harm occurred, the regulation requires that the facility ensure the residents receive proper treatment and care. Petitioner neglected to provide this care for five residents. The allegations in the SOD in this case are sufficient to establish a prima facie case, unless disproved or rebutted. Accordingly, I sustain these deficiencies.

4. Petitioner's noncompliance with the participation requirement at 42 C.F.R. § 483.25(h) (F Tag 323, SS J) constituted immediate jeopardy to its residents.

The regulations define "immediate jeopardy" as "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination about the level of noncompliance must be upheld, unless it is clearly erroneous. 42 C.F.R. § 498.60(c).

The surveyors concluded:

> Immediate Jeopardy began on 10/19/07 when Resident # 6 exited the building unsupervised and was removed 2/7/08 at 11:45 AM. The facility remained out of compliance at a lower scope/severity of (D), isolated with potential for more that [sic] minimum harm while monitoring the implementation of their corrective actions stated on the credible allegation.

CMS Ex. 1, at 9. As noted above, CMS instead determined that an immediate jeopardy situation existed on November 24, 2007 through February 7, 2008, as a result of Petitioner's noncompliance with section 483.25(h) (Tag F 323). CMS Ex. 2, at 2. Petitioner argues that immediate jeopardy is reserved for "crisis situations in which the health and safety of individuals are at risk," relying on the language in the State Operations Manual (SOM), Appendix Q, Guidelines for Determining Immediate Jeopardy (Rev. 1, May 21, 2004). P. Br. at 28.

The SOM also lists immediate jeopardy triggers, which are situations that most likely create jeopardy to an individual's psychological and/or physical health and safety, and describe situations that will cause the surveyor to consider if further investigation is needed to determine the presence of immediate jeopardy. SOM, app. Q, at 4. The

following is listed as a trigger, "[l]ack of supervision of cognitively impaired individuals with known elopement risk." *Id.* at 5. Upon observing or identifying a trigger, the surveyors are instructed to investigate the situation further to determine whether immediate jeopardy is present, which is a very fact-specific analysis. SOM, app. Q.

In this case, the surveyors determined that R6's ability to elope undetected resulting in unsupervised exposure to areas beyond the confines of the facility walls constituted immediate jeopardy. CMS agreed with the surveyors' finding, as do I. R6 is of advanced age, has a history of falls and seizures, is being care-planned for confusion and dementia, which includes paranoia and delusions, and is on psychotropic medication with noted interventions for side affects that include behavior problems requiring a psych consult. P. Ex. 1, at 10-19. Thus the finding of immediate jeopardy is not clearly erroneous, because patients suffering from conditions similar to R6's have wandered from their facility and been involved in accidents. *Liberty Commons*, 285 Fed. App'x at 43 (including cases cited therein). In this case, the crisis situation is R6's undetected elopement outside of the facility walls for an unknown period of time during which she was unsupervised and at risk of accident.

Petitioner argues that "the fact that the resident was quickly seen [and] brought back inside each time was evidence that the facility systems, including its emphasis on staff training, worked." P. Br. at 28. Petitioner further argues that there was not a "risk of [R6] being hit by a car or anything like that in the parking lot" and focuses on the fact that R6 was not injured. P. Br. at 28-29.

According to the plain language of the regulation, a finding of immediate jeopardy only requires that a nursing facility's noncompliance is <u>likely</u> to cause harm to a resident. 42 C.F.R. § 488.301 (emphasis added). The purpose of the regulation, 42 C.F.R. § 483.25(h)(2), is to prevent not only actual harm, but also likely harm to a resident. *Liberty Commons*, 258 Fed. App'x at 44 (citing *Woodstock*, 363 F.3d at 589). Thus, it is irrelevant that R6 was not injured. Here, R6 exited the facility undetected on two occasions, and the staff was uncertain as to how long R6 had been outside the facility. Tr. at 453. The fact that R6 eloped on more than one occasion increased the possibility that she would suffer an injury, especially given her medical condition.

Petitioner's assertion that R6 was quickly seen and brought back inside is speculative. As noted above, the staff was unsure how long R6 had been outside the facility. Further, it is not evidence that the facility had an effective system in place to prevent elopements, but instead merely a fortuitous sequence of events. No one at Asheville claimed to have been aware of R6's absence or to have been looking for her before the receptionist luckily spotted R6 outside the front door after the first elopement, or an off-duty staff member luckily spotted R6 in the parking lot as he was leaving work after the second

elopement.[15] R6's recovery from outside, if prompt (which, is hard to prove, because no one knows the point at which R6 left the facility), was merely fortuitous and lends no confidence that eloping residents would generally be promptly rescued.

The likelihood of serious harm is weighed not merely by the fortuitous sequence of events that actually resulted from lack of supervision in the instances discovered by the surveyor, but by considering what the episode reveals about dangers to which residents in the facility were exposed by the identified problems and how likely such dangers were to result in serious harm. The fact that a resident, who was care planned for maintaining a safe environment (CMS Ex. 9, at 70) and who had a history of seizures, falls, and dementia, could wander off entirely unnoticed and not be sought until off-duty staff members spotted her, presents significant likelihood that vulnerable residents might encounter the dangers involved with wandering away, such as falls, traffic, and so forth.[16] *See* P. Ex. 2, at 10-19.

Petitioner maintains that "[b]alanced against the resident's need for protection is the right to be maintained in the least restrictive manner." P. Br. at 29. Petitioner provides no authority to support a conclusion that safeguarding a resident's dignity or independence is preferred to protecting a resident from accidents. Accordingly, I find no merit in Petitioner's position.

Petitioner argues that the resident's family requested that R6 be permitted to stay at Asheville and that it is reasonable to conclude that the resident's family would have moved her to another facility "had they believed that continued stay at Asheville posed a danger." P. Br. at 30. The facility is not simply absolved of responsibility for providing the care needed by the family's wishes. *Koester Pavilion*, DAB No. 1750, at 34.

5. The remedies imposed are reasonable.

a. The imposed CMP of $3,550 per day from November 24, 2007 through February 6, 2008 is reasonable.

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

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[15] The parties are not in agreement as to who in fact spotted R6 in the parking lot first after the second elopement. *See* P. Br. at 10 n.9.

[16] Although Asheville screens residents before admitting them to ensure they are not elopement risks, residents do change over time, as occurred with R6. Upon assessment of all residents, Asheville identified other elopement-risk residents. Tr. at 736-37.

deficiencies as set forth at 42 C.F.R. § 488.404; and (4) the facility's degree of culpability.

The upper range of CMP, from $3,050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents, and, in some circumstances, for repeated deficiencies. 42 C.F.R. § 488.438(a)(1)(i), (d)(2).

CMS seeks to impose an upper-range CMP of $3,550 per day from November 24, 2007 through February 6, 2008, for a total upper-range CMP of $262,700.

With respect to the facility history, CMS asserts that Petitioner was repeatedly out of compliance with Tag F 323, a total of six times since 2003, one of which was an immediate jeopardy level deficiency cited at the January 18, 2007 complaint survey. CMS Br. at 29.

Petitioner explains that the other Tag F 323 citations had nothing to do with elopement. P. Br. at 31. The immediate jeopardy citation that occurred in 2007 was related to a motor vehicle accident. *Id.*; P. Ex. 35. Two citations in 2004 and 2005 were related to the hot water heater and water being too hot. *Id.*

With respect to the facility's financial condition, Petitioner asserts that "the facility itself is not making a profit and lost money in 2008." P. Br. at 32. Petitioner also asserts that "[a]ccording to the administrator, the facility would have closed, but for its parent [company]." *Id.* However, Petitioner has not provided any evidence to show that this would preclude it from paying the proposed CMP.

With regard to the seriousness of the deficiency, Petitioner argues: this was an isolated deficiency; no elopement occurred; and there has never been an elopement at the facility. P. Br. at 32. As to culpability, Petitioner argues that the two exits were unforeseeable, and no evidence exists that the facility was neglectful, indifferent, or disregarded the resident's comfort or safety. P. Br. at 33.

CMS asserts that given the absence of any security system or methodical monitoring in the facility to protect elopement-risk residents, the CMP is reasonable. I agree. As established above, the second exit was foreseeable, and the fact that the facility does not view R6 as an elopement risk further illustrates their culpability and disregard for resident's safety. Ms. Brantley testified that, even if they had a Wanderguard system in place, she would not have ordered a bracelet for R6, which would trigger an alarm when R6 attempted to exit the facility. Tr. at 497. Petitioner presented no evidence that any methodical monitoring or intervention of any type was put into place for R6's safety in regard to R6's elopement risk. Thus, I find Petitioner culpable.

At $3,550 per day, the imposed penalty is at the low end of the range for an immediate jeopardy level penalty. The seriousness of Petitioner's noncompliance and Petitioner's

culpability for failing to provide R6 with adequate supervision to mitigate foreseeable risks of harm from accidents justify the penalty imposed.

b. The imposed CMP of $100 per day from February 7, 2008 through March 17, 2008 is reasonable.

The lower range of CMP, from $50 per day to $3,000 per day, is reserved for deficiencies that do not constitute immediate jeopardy but either cause actual harm to residents or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii).

CMS seeks to impose a lower-range CMP of $100 per day from February 7, 2008 through March 17, 2008, for a total lower-range CMP of $3,900.

Petitioner does not argue that the duration of the penalty is incorrect. *Id.* Petitioner does not discuss the non-immediate jeopardy deficiencies in its assertion that the CMP was unreasonable but instead limits its discussion to the immediate jeopardy finding. P. Br. at 31-33. All of Petitioner's arguments relate to the Tag F 323 and whether an elopement occurred. *Id.*

The Tag F 323 continued after the immediate jeopardy was abated, as a lower level deficiency. For the same reasons stated for the immediate jeopardy penalty, I find that deficiency alone is sufficient to uphold a CMP of $100 per day.

As noted above in my discussion of three of the five lower level deficiencies, I also find Petitioner culpable for these deficiencies, which are also sufficient to uphold the CMP. At $100 per day, this imposed penalty is at the low end of the range for a non-immediate jeopardy level penalty. I find it to be reasonable.

V. Conclusion

Based on my review of all of the evidence in this case, I find Petitioner out of substantial compliance with the participation requirements of 42 C.F.R. § 483.25(h) at a level of immediate jeopardy. I also find Petitioner out of compliance with participation requirements at a non-immediate jeopardy level. I further sustain, and I find reasonable the remedies that CMS imposed, including CMPs totaling $266,600, and the loss of NATCEP.

/s/

Alfonso J. Montaño
Administrative Law Judge