Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: February 25, 2008
Hotel Reed Nursing Center,	
Petitioner,	Civil Remedies CR1494 App. Div. Docket No. A-07-13
- v. -	Decision No. 2154
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF
ADMINISTRATIVE LAW JUDGE DECISION

Hotel Reed Nursing Center (Hotel Reed or Petitioner) appeals the January 23, 2007, decision of Administrative Law Judge (ALJ) Jose A. Anglada. Hotel Reed Nursing Center, CR1494 (2006) (ALJ Decision). Following an evidentiary hearing and post-hearing briefing, the ALJ sustained a determination by CMS that from February 11 through April 16, 2002, Hotel Reed failed to comply substantially with four federal requirements governing the participation of long-term care facilities in the Medicare and Medicaid programs: 42 C.F.R. §§ 483.13(b); 483.13(c); 483.25(h)(2); and 483.75.[1] CMS based its determination on survey findings by the Mississippi State Department of Health (MSDH), the State survey agency. The ALJ also upheld CMS's determination that the noncompliance with 42 C.F.R. §§ 483.25(h)(2) and 483.75 constituted immediate jeopardy from February 11, 2002 through March 12, 2002, concluding that Hotel Reed had not shown that determination to be clearly erroneous. The ALJ reduced the CMP imposed by CMS for the immediate jeopardy period of noncompliance

[1] CMS also found noncompliance with 42 C.F.R. § 483.30(a), but the ALJ concluded in finding of fact and conclusion of law (FFCL) E that CMS had not made a prima facie case with respect to that finding. ALJ Decision at 20-21. CMS did not appeal FFCL E.

to $3,050 per day and the CMP for the period of noncompliance following abatement of the immediate jeopardy to $200 per day.[2] On appeal, Hotel Reed argues that a CMP in any amount is unwarranted because, Hotel Reed insists, it was not out of substantial compliance at any level. P. RR at 23.

For the reasons discussed below, we affirm the ALJ's conclusions that Hotel Reed was not in substantial compliance with the participation requirement at 42 C.F.R. § 483.25(h)(2) during the stated period and that CMS's finding of immediate jeopardy with respect to that requirement was not clearly erroneous. We also affirm the ALJ's determinations that $3,050 per day for the immediate jeopardy period and $200 per day for the remaining period of noncompliance at less than the immediate jeopardy level are reasonable CMP amounts.[3]

Applicable Legal Provisions

Long-term care facilities participating in the Medicare and Medicaid programs are subject to the survey and enforcement procedures set out in 42 C.F.R. Part 488, subpart E, to determine if they are in substantial compliance with applicable program requirements which appear at 42 C.F.R. Part 483, subpart B. "Substantial compliance" means a level of compliance 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. "Noncompliance," in turn, is defined as "any deficiency that causes a facility to not be in substantial compliance." Id.

A long-term care facility found not to be in substantial compliance is subject to various enforcement remedies, including

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[2] Hotel Reed asserts that CMS cannot collect a judgment from Hotel Reed or its provider number because Hotel Reed ceased operating as a skilled nursing facility (SNF) several years ago, and its provider number is no longer being used. P. Request for Review (RR) at 2. Hotel Reed further asserts that its previous owners continue to operate other SNFs. These matters, whether true or not, are not material to the Board's decision. However, we note that neither Hotel Reed nor CMS has argued that these circumstances render the appeal moot.

[3] The ALJ reduced the CMP from the $4,000 per day and $250 per day CMP amounts imposed by CMS for the immediate jeopardy and non-immediate jeopardy periods respectively. CMS did not appeal the ALJ's decision to reduce the amount of the CMPs and, in fact, asserts that the reduced amounts are reasonable. CMS Response to RR at 28-29.

per day CMPs. 42 C.F.R. §§ 488.402(c), 488.408. CMS may impose CMPs ranging from $3,050 - $10,000 per day for one or more deficiencies constituting immediate jeopardy and from $50 - $3,000 per day for deficiencies that do not constitute immediate jeopardy but that either cause actual harm or create the potential for more than minimal harm. 42 C.F.R. § 488.438(a). The regulations set out a number of factors that CMS considers in determining the amount of a CMP. 42 C.F.R. § 488.438(f).

"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." 42 C.F.R. § 488.301. CMS's determination that a deficiency constitutes immediate jeopardy is a determination of the level of noncompliance which "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2); Woodstock Care Center, DAB No. 1726, at 9 (2000), aff'd, Woodstock Care Center v. Thompson, 363 F.3d 583 (6th Cir. 2003). The provider bears the burden of proving that CMS's immediate jeopardy determination is clearly erroneous. E.g., Liberty Commons Nursing & Rehab Center v. Johnston, DAB No. 2031 at 18-19 (2006), aff'd, Liberty Commons Nursing and Rehab Center - Johnston v. Leavitt, 241 Fed. Appx. 76 (4th Cir. 2007).

Standard of Review

Our standard of review on a disputed conclusion of law is whether ths ALJ decision is erroneous. 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. Guidelines - Appellate Review of Decisions of Administrative Law Judges Affecting A Provider's Participation In the Medicare and Medicaid Programs; Batavia Nursing and Convalescent Inn, DAB No. 1911, at 7 (2004), aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson, 143 Fed.Appx. 664 (6th Cir. 2005); Hillman Rehabilitation Center, DAB No. 1611, at 6 (1997), aff'd, Hillman Rehabilitation Ctr. v. U.S. Dep't of Health and Human Servs., No. 98-3789 (GEB) at 21-38 (D.N.J. May 13, 1999).

Case Background

By letter dated February 25, 2002, CMS notified Hotel Reed that it was imposing selected remedies due to noncompliance with federal requirements identified during an on-site survey by MSDH that ended on February 15, 2002. ALJ Decision at 1. The survey cited numerous deficiencies, three of which were determined to pose immediate jeopardy to resident health and safety. Id.; P. Exhibit (Ex.) 1. MSDH conducted a revisit survey that ended on March 13, 2002 and found that the immediate jeopardy had been abated effective March 13, 2002 but that noncompliance continued

at a scope and severity Level E (a pattern of noncompliance that is not immediate jeopardy but has the potential for more than minimal harm). ALJ Decision at 2; P. Exs. 4, 6. By letter dated March 26, 2002, CMS notified Hotel Reed that it was revising the remedies based on the results of the March 13, 2002 revisit. ALJ Decision at 2; P. Ex. 8.[4] Hotel Reed filed a hearing request on May 25, 2002, and the ALJ held a hearing on January 11-12, 2006. ALJ Decision at 1, 2. The ALJ issued a decision containing the following findings of fact and conclusions of law (FFCLs):

> A. Petitioner was not in substantial compliance with federal participation requirements on the dates CMS determined to impose a CMP.
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> B. Petitioner failed to provide an environment free from verbal and mental abuse, as provided by 42 C.F.R. § 483.13(b) (Tag F-223).
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> C. Petitioner failed to investigate and report all violations involving mistreatment, neglect or abuse, including injuries of unknown source as required by 42 C.F.R. § 483.13(c) (Tag F-225).
>
> D. The facility failed to ensure that residents receive adequate supervision and assistance devices to prevent accidents, as required by 42 C.F.R. §483.24(h)(2) (Tag F-324).
>
> E. CMS failed to establish a prima facie case that Petitioner did not have sufficient nursing staff to provide nursing and related services, as required by 42 C.F.R. § 483.30(a) (Tag F-353).
>
> F. Petitioner failed to administer its facility in a manner that enabled it to use its resources effectively and efficiently to attain the highest practicable physical, mental, and psychosocial well-being of its residents, as required by 42 C.F.R. § 483.75 (Tag F-490).
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> G. CMS's finding of immediate jeopardy was not clearly erroneous.
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> H. The amount of the CMP originally imposed was unreasonable.

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[4] MSDH conducted another revisit survey in April 2002 which determined that Hotel Reed had achieved substantial compliance on April 17, 2002.

Hotel Reed appealed all of the FFCLs.

For the reasons discussed in our decision, we affirm the ALJ's finding of noncompliance with the participation requirement at 42 C.F.R. § 483.25(h)(2) (FFCL D) and, accordingly, his finding that Hotel Reed was not in substantial compliance with federal participation requirements (FFCL A). Noncompliance with even a single participation requirement provides a basis for imposing an available remedy. Section 1819(h)(2)(A) of the Social Security Act (Act); 42 C.F.R. § 488.402(b),(c). Accordingly, we need not reach FFCLs B, C, and F, findings of noncompliance with additional participation requirements, to conclude that CMS had a basis for imposing a CMP, and other remedies. FFCLs B, C, and F also are not material to our summary affirmance of the ALJ's finding that $3,050 per day for the period of immediate jeopardy and $200 per day until the facility achieved substantial compliance are reasonable amounts since we conclude that those amounts are reasonable for the noncompliance that we uphold under 42 C.F.R. § 483.25(h)(2), without regard to the additional findings of noncompliance that we do not reach.[5] CMS did not appeal FFCL E. We modify FFCL H, as stated at the end of our decision so that it more accurately reflects the ALJ's determination regarding the reasonable CMP amounts.

Discussion

A. The ALJ's finding that Hotel Reed was not in substantial compliance with federal participation requirements from February 11 through April 16, 2002 because it failed to ensure that residents received adequate supervision to prevent accidents, as required by 42 C.F.R. § 483.25(h)(2), is supported by substantial evidence and free from legal error.

The ALJ's finding of noncompliance with 42 C.F.R. § 483.25(h)(2) was based on evidence regarding four of the five Hotel Reed residents cited on the Statement of Deficiencies (SOD) in

[5] The amount of $3,050 is the minimum CMP that may be imposed for immediate jeopardy. 42 C.F.R. § 488.438(a)(1)(i). The amount of $200 per day is at the lower end of the per day range for non-immediate jeopardy. See 42 C.F.R. § 488.408(d)(iii)(requiring that a per day CMP imposed for noncompliance that is not immediate jeopardy be in the range of $50-$3000 per day). Moreover, following abatement of the immediate jeopardy, Hotel Reed's noncompliance with 42 C.F.R. § 483.25(h)(2) continued at scope and severity Level E until the facility achieved substantial compliance on April 17, 2002. ALJ Decision at 2 and n.1; P. Ex. 6. That is sufficiently serious to justify a CMP in the amount of $200 per day.

connection with this noncompliance: Residents #3, #9, #10 and #14.[6] The regulation provides:

> *Accidents*. The facility must ensure that –
>
> * * *
>
> (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

The requirements of this regulation have been explained in numerous Board decisions. See, e.g., Liberty Commons Nursing and Rehab - Alamance, DAB No. 2070, at 3 (2007), citing Golden Age Skilled Nursing & Rehabilitation Center, DAB No. 2026 (2006); Woodstock, DAB No. 1726, at 28. Although section 483.25(h)(2) does not make a facility strictly liable for accidents that occur, it does require that the facility 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, 363 F.3d at 590 (a SNF 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 are adequate in light of the resident's needs and ability to protect himself or herself from a risk." Liberty Commons Nursing and Rehab - Alamance at 3, citing Golden Age at 11 and Woodstock, 363 F.3d at 590.

Hotel Reed does not dispute these requirements and, in fact, quotes passages from Board decisions (including Woodstock) that articulate them. P. RR at 15. Nonetheless Hotel Reed argues on appeal that substantial evidence does not support the ALJ's

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[6] The ALJ found that CMS did not make a prima facie case of noncompliance under 42 C.F.R. § 483.25(h)(2) with respect to Resident #12. In its brief responding to Hotel Reed's appeal, CMS asks us to reverse that finding. CMS Response to RR at 22-24. We decline to address CMS's request since CMS did not file a written request for review of this ALJ finding within 60 days after receiving the ALJ decision, as required by 42 C.F.R. § 498.82(a)(2). See also John J. Kane Regional Center – Glen Hazel, DAB No. 2068, at 20 (2007) (declining to entertain CMS's request to reinstate the CMP amount imposed by CMS when CMS made the request in its response to Petitioner's request for review rather than timely filing its own request to review the ALJ's reduction of the CMP amount).

findings of noncompliance with respect to Residents #3, #9, #10 and #14.[7] We disagree for the reasons stated in our discussion.

1. Resident #10

Although our decision addresses incidents involving all four residents for whom the ALJ found Hotel Reed's supervision inadequate, we regard Hotel Reed's failure to provide adequate supervision to Resident #10, without more, as sufficiently egregious to support the ALJ's finding of noncompliance with 42 C.F.R. § 483.25(h)(2). See, e.g., Ridge Terrace, DAB No. 1834, at 7 (2002) ("[E]ven one isolated instance of non-compliance having a potential for more than minimal harm may be the basis for a finding that the petitioner is not substantially complying with the applicable participation requirement.") The ALJ found that Hotel Reed did not adequately monitor Resident #10's whereabouts despite her diagnoses of mental disease (depression, psychosis and paranoid schizophrenia); deteriorating mental status; documented multiple episodes of wandering behavior; and, two vivid psychotic episodes, at least one of which the facility considered sufficiently alarming to warrant hospitalization for a psychiatric evaluation. ALJ Decision at 17, citing CMS Ex. 9, at 1, 6, 21, 43-46, 59-63; CMS Ex. 7, at 18-20. One of the psychotic episodes, documented in nurses' notes on January 11, 2002, occurred when the resident went to a 1700 foot pier across North Beach Boulevard from the facility that juts out into a body of water that Hotel Reed refers to as "the Mississippi Sound".[8] CMS Ex. 9, at 20, 59-60; P. RR at 18, n.6. The resident told nursing staff that she witnessed a murder on the pier, with a woman going over the railing, a dog eating the murder victim's remains and a bloody towel in the trash. Id. Hotel Reed acknowledges that it routinely allowed Resident #10 to go to the pier to smoke, claiming that this was an appropriate intervention to control her smoking obsession. P. RR at 18; Tr. at 260-61. Relying on a map the surveyor drew, the ALJ found that the pier did not have railings in certain locations to protect individuals

[7] Hotel Reed also argues that CMS did not make its prima facie case of noncompliance with 42 C.F.R. § 483.25(h)(2) with respect to Residents #3, #9, #10 and #14 or, alternatively, that Hotel Reed rebutted that case. P. RR at 5. Our determinations that the ALJ's findings of fact are supported by substantial evidence and his legal conclusions are free of error make it unnecessary to address this argument further.

[8] We note that a map submitted by Hotel Reed identifies the body of water as "Saint Louis Bay." P. Ex. 42, at 1.

from falling into the water.[9] ALJ Decision at 17. He concluded that it was "fortuitous that Resident 10 was not injured on these occasions." Id.

On appeal, Hotel Reed argues, as it did below, that Resident #10 was not a wanderer and that allowing her to smoke near the pier was an appropriate intervention to control her smoking obsession. The ALJ rejected those arguments, and we conclude, for reasons explained below, that the ALJ's reasons for doing so are supported by substantial evidence and contain no legal error. However, even if we agreed with Hotel Reed on these arguments, which we do not, we would uphold the ALJ's finding of noncompliance because the record contains substantial evidence, consisting mainly of copies of Hotel Reed's own records, supporting the ALJ's principal basis for upholding the finding of noncompliance – that allowing Resident #10 to go to the pier unsupervised put her in danger because of her multiple mental illnesses and deteriorating cognitive and mental status, which included experiencing two vivid psychotic episodes a month apart.

The nurses' notes documenting Resident #10's psychotic episode while standing on the pier on January 11, 2002 constitute particularly compelling evidence. The details of the story the resident told the nurse – witnessing a murder, the victim going over a railing and being eaten by a dog, a bloody towel in the trash – show that the resident's delusion was vivid and deeply disturbing to her. Indeed, the notes state that 15 minutes after relating this story, the resident was still "very nervous" and "scared". CMS Ex. 9, at 60. Hotel Reed does not directly address this episode on appeal, and we find no support in the record for any conclusion other than that reached by the ALJ, that the resident was unsupervised in a dangerous environment during this episode, and it was fortuitous that she was not injured. Apart from the danger posed by the water, we note that the resident had to cross a public road with no traffic light to get to the pier. Tr. at 123. The nurses' notes suggest that the psychotic episode was already in progress as Resident #10 crossed the street because the resident told the nurse that she "felt like something was going to happen [and] that's why she went [to the pier]." CMS Ex. 9, at 60. Hotel Reed asserts that the street was "not a major thoroughfare." P. RR at 18, n.6.

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[9] Hotel Reed does not dispute that finding. Hotel Reed claims that the body of water is "very shallow." P. RR at 18, n.6. The map drawn by the surveyor, however, indicates that people were fishing off the pier, and Hotel Reed does not dispute that fishing took place there. CMS Ex. 9, at 20. Presumably if the bay was deep enough for fishing, it was deep enough to create a hazard.

However, the surveyor testified that during the survey she observed Resident #10 leave the facility and cross the road with "cars whizzing by . . . ." Tr. at 99-101. Regardless of whose description is accepted, Hotel Reed does not deny that the street was a public thoroughfare leading into the town of Bay St. Louis and had no traffic lights. The absence of a light, on its face, poses a risk of harm to any person crossing the road, much less a nursing home resident with the serious mental illnesses and cognitive deficits suffered by Resident #10.

Despite the psychotic episode on January 11, 2002, and further evidence of mental status deterioration following that incident, Hotel Reed continued to allow Resident #10 to leave the building and go to the pier unsupervised.[10] The facility did not stop Resident #10 from doing this until February 2002, and then it revoked this "privilege" because of her noncompliance with smoking rules, not because of any assessment that going to the pier unsupervised posed a danger to her because of her generally deteriorating mental status or the specific psychotic episodes. CMS Ex. 7, at 20.

Petitioner cites testimony of Dr. Barnes, a psychiatrist, that he felt it was acceptable to allow Resident #10 to go to the pier to smoke because he considered her competent and not a danger to herself or others. P. RR at 18-19. However, in his testimony, Dr. Barnes stated only that she was competent "most of the time," which is an implicit admission that she was not competent all of the time. Tr. at 200. Dr. Barnes continued, "[W]hen she'd have these little episodes of paranoia or whatever, she would – for a few moments or a short period of time, day or two, she might be not as with it." Id. Neither Dr. Barnes nor Hotel Reed explained how going unsupervised to an unfenced pier jutting out into a bay and crossing a public road with no traffic light to get there could be safe during these paranoid periods of up to two days when the resident "might be not as with it."

The ALJ also found that the response of Hotel Reed's staff to Resident #10's second psychotic episode in February (sending her to the hospital for a psychiatric evaluation) as well as staff's attempt during the survey to coax Resident #10 back into the facility when they saw her outside near the road "call into question the DON's testimony that Petitioner was not worried

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[10] As the ALJ discussed, nurses' notes dated January 16, 2002 indicated that she exhibited "increasingly odd behaviors," and doctor's notes from February 7, 2002 noted that she experienced "episodes of euphoria and delusions." ALJ Decision at 17, citing CMS Ex. 9, at 21, 61.

about the Resident crossing the street."[11] ALJ Decision at 17, citing Tr. at 261. Hotel Reed objects that the ALJ adopted "CMS's version of events" instead of the DON's "explanation" at the hearing that the staff members who went out to retrieve the resident (the administrator and an activity assistant) did so because they wanted the resident to participate in an activity, not because she could not be outside. P. RR at 19. The ALJ made a credibility determination. He credited the testimony of the surveyor, who observed the event and testified that the two staff members talked to the resident for ten or fifteen minutes to "coax" her back in (Tr. at 21-23), over the testimony of the DON, who did not observe the incident but only heard about it later (Tr. at 262, 264). The Board generally defers to an ALJ's credibility determinations and does not disturb them unless they are clearly erroneous. E.g., Madison Health Care, Inc., DAB No. 2049, at 7-8 (2006). We find no clear error here. Furthermore, Hotel Reed has not accurately characterized the DON's testimony. The DON testified that the administrator was "maybe getting [the resident] back in for the party" and "I don't know if she went out there to get her for the party." Tr. at 265, 266. This is not a conclusive statement that the reason staff went to retrieve Resident #10 was, in fact, to take her to a party.[12]

The record as a whole supports the ALJ's conclusion that Resident #10's deteriorating mental and cognitive status and her delusional episodes, without more, were sufficient to put the facility on notice that allowing her to cross the road and go to the pier unsupervised put her at risk for an accident and that Hotel Reed's failure to mitigate this foreseeable risk constituted noncompliance with 42 C.F.R. § 483.25(h)(2).

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[11] "DON" is used here, as it was in the ALJ decision, as an acronym for "Director of Nursing."

[12] Hotel Reed also cites testimony by the surveyor to the effect that she must not have feared for Resident #10's safety during this event since she "didn't stop it or anything." P. RR at 19, citing Tr. at 101. However, Hotel Reed ignores the surveyor's subsequent statement that the "administrator was right there, and she was going out the door to get her." Tr. at 102. In context, the surveyor's statements indicate that she was not concerned for the resident's safety because she saw facility staff go out to assist the resident. In any event, the issue being addressed by the ALJ was not whether the surveyor feared for the resident's safety during this event but, rather, whether the conduct of Hotel Reed staff suggested that they feared for her safety.

As for Hotel Reed's assertion that Resident #10 was not a wanderer, the ALJ found this assertion "unpersuasive," and we find no basis in the record for rejecting that finding. ALJ Decision at 18. The ALJ relied, in part, on the facility's January 11, 2002 Minimum Data Set (MDS) assessment, which coded this resident as a wanderer.[13] ALJ Decision at 17-18. He also relied on multiple nurses' notes describing her wandering behavior.[14] Id. Relying on testimony by its DON, Hotel Reed reiterates here its argument below that the MDS was miscoded by a new MDS nurse and subsequently corrected to indicate no wandering behavior. P. RR at 18. Hotel Reed also relies on testimony by psychiatrist Roy Barnes, M.D., that he did not consider the resident to be a wanderer in the sense of moving without purpose

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[13] Federal rules require SNFs like Hotel Reed to do a comprehensive assessment of each resident's functional capacity within 14 calendar days after admission, 14 calendar days after any significant change in condition and not less than once a year, using the resident assessment instrument specified by the State. SNFs also are required to do quarterly reviews using instruments specified by the State and approved by CMS. 42 C.F.R. § 483.20(b),(c). The January 11, 2002 MDS contains the information gathered by Hotel Reed during one of these assessments or reviews. See CMS Ex. 9, at 5-17. Hotel Reed points out that there are other MDS forms in the record that do not code Resident #10 as a wanderer. P. RR at 18. That is true; however, the January 2002 MDS is the MDS closest to the February 2002 survey.

[14] Wandering behavior in a nursing home context, according to the MDS, is moving with no rational purpose, seemingly oblivious to needs or safety. CMS Ex. 9, at 7. The MDS indicated that Resident #10's wandering behavior occurred one to three days during the last seven days, without any change in behavior over the past 90 days, and was not easily altered. Id. The MDS also indicated that Resident #10 had long-term memory problems and "moderately impaired cognitive skills" for daily decision making, meaning that her decisions were poor and she needed cues and supervision. Id. at 6. The MDS also said that Resident #10 had symptoms of socially inappropriate/disruptive behavior. Id. at 7. Nurses' notes documented numerous wandering episodes for Resident #10 between September 2001 and February 2002: "up and about wandering up and down the hall . . . ;" "continues to wander around;" "resident with increasingly odd behaviors . . . wandering;" "up and about all night wandering;" "wandering aimlessly about the 2nd floor;" and "ambulating aimlessly about the facility." CMS Ex. 7, at 17-18.

and, therefore, that she did not need to be care planned or monitored for wandering. Id., citing Tr. at 194.[15]

Hotel Reed put into evidence a copy of the January 11, 2002 MDS showing the alleged "correction" (changing a "1" to a "0"). P. Ex. 79, at 17. However, as the ALJ noted, the date of that change is not indicated on the document. ALJ Decision at 18, citing P. Ex. 79, at 16-20. The DON testified that she made the alleged "correction" sometime in January 2002. Tr. at 271-72. However, the ALJ noted that this testimony was inconsistent with her testimony in another proceeding that she corrected the MDS after the survey, which was in February 2002. ALJ Decision at 18, citing P. Ex. 64, at 77-79. The ALJ also rejected Hotel Reed's claim, which relied on Dr. Barnes' testimony, that its staff misused the term "wandering" with respect to Resident #10. "I must attribute knowledge to the facility regarding this term. Petitioner's nursing staff, in particular, can be expected to know the appropriate definition of 'wandering' and to appropriately identify 'wandering' behavior." Id., citing Tr. at 194-95.

After weighing the evidence, the ALJ essentially found the contemporaneous documentary evidence (the original January 11, 2002 MDS and the nurses' notes) more credible than the after-the-fact testimony of the DON and Dr. Barnes. As stated earlier in our decision, the Board generally defers to an ALJ's credibility determinations and does not disturb them unless they are clearly erroneous. Once again, we find no clear error.

The evidence discussed is substantial and supports the ALJ's conclusion that Hotel Reed failed to provide adequate supervision to prevent accidents, as required by 42 C.F.R. § 483.25(h)(2), when it allowed Resident #10 to leave the facility, cross the road and go to the pier unsupervised despite evidence of her deteriorating cognitive and mental status, diagnoses of multiple mental illnesses and recent delusional episodes. The ALJ's conclusion also is free of legal error.

2. Resident #9

The ALJ concluded that Hotel Reed failed to provide Resident #9 with supervision adequate to prevent accidents based on November 19 and December 14, 2001 incidents involving the resident's

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[15] However, two of the nurses' notes describing the resident's wandering behavior use terms such as "wandering aimlessly" and "ambulating aimlessly," terms consistent with Dr. Barnes' definition of "wandering."

hoarding behavior that are documented in nurses' notes. In the first incident, Resident #9 was found in Hotel Reed's medication room with a pack of cigarettes. CMS Ex. 29, at 22. In the second, a nurse found in Resident #9's room three pills of Darvocet-N 100 (one on top of a candy cup and two on top of a night stand wrapped in aluminum foil); dressing scissors; and an entire box of disposable razors. CMS Ex. 29, at 20. The ALJ found that Hotel Reed had not adequately addressed how the resident obtained a Schedule IV Narcotic controlled substance and stored it in her room. ALJ Decision at 15. Absent any explanation to the contrary, the ALJ inferred that the staff did not adequately supervise Resident #9 to assure that she ingested the narcotic when it was given to her. Id.

Although Hotel Reed objects to this inference on appeal, it does not argue that the inference is unreasonable. In fact, Hotel Reed says that "it is possible R9 did not swallow the Darvocet when given to her" but further states, "A one time occurrence of a resident not swallowing prescribed medicine does not demonstrate non-compliance with this regulation, especially at the immediate jeopardy level." P. RR at 17. The reference to a "one time occurrence" does not take into account that three, not one, Darvocet tablets were found in the resident's room, suggesting that the resident might not have swallowed her Darvocet on more than one occasion. Hotel Reed's statement also minimizes the mishandling of a controlled substance in a way that is inconsistent with its own policies, which strictly control access to such drugs and impose strict requirements on staff with respect to accounting for their administration. ALJ Decision at 15, citing CMS Ex. 3, at 7-8. The ALJ's inference that Hotel Reed did not adequately monitor the resident's ingestion of her prescribed narcotic is reasonable.[16]

In any event, the ALJ's finding that Hotel Reed was not adequately supervising Resident #9's access to controlled substances was not based only on the presence of the three Darvocet pills in her room. The ALJ also cited the undisputed fact that on November 19, 2001, Resident #9 was found inside the medication room, and staff could not explain how she got in. CMS Ex. 7, at 23; CMS Ex. 29, at 22. The ALJ also found that Hotel Reed had not responded effectively to Resident #9's hoarding behavior, even after the December 14, 2001 incident. Hotel Reed argues on appeal that it identified the hoarding behavior and

[16] It would have been reasonable for the ALJ to infer, in the alternative, that the resident got the narcotics from the medication room since, as discussed later, she was found in that room, without any explanation as to how she got in.

care planned and counseled for it. The care plan of record indicates that Hotel Reed identified the resident's propensity to hoard food, and other documents indicate a problem with stealing from staff and other residents. CMS Ex. 29, at 25-26, 56. However, none of these documents addresses her hoarding of drugs or other items of the type found in her room on December 14, 2001. Id. Furthermore, the only intervention listed is "Educate resident when you see her taking food to her room." Id. at 26. As the ALJ noted, staff did counsel the resident after the December 14, 2001 incident, instructing her to not go behind the nurses' station, to stay away from the medicine cart and to not take items that did not belong to her. ALJ Decision at 14-15. However, as the ALJ also noted, despite this intervention, the resident continued to roam, "pilfer" and hoard items. Id. at 15, citing CMS Ex. 29, at 15, 91, 93-94, 97, 99-100. Much of this continuing behavior was documented on Nurses' Progress Notes which, as the ALJ noted, do not indicate any reassessment or use of new interventions.[17] Id.

The evidence discussed is substantial and supports the ALJ's conclusion that Hotel Reed failed to provide adequate supervision to prevent accidents, as required by 42 C.F.R. § 483.25(h)(2), when it did not adequately address Resident #9's hoarding behavior which included hoarding a Schedule IV narcotic. The ALJ's conclusion also is free of legal error.

3. Resident #14

Petitioner #14 was admitted to Hotel Reed with a diagnosis of alcohol abuse. An incident report of an incident on January 5, 2002 and nurses' notes from that date document an activity aide's observation of Resident #14 drinking from a liquor bottle while he was returning from being out on a pass and the resident's becoming verbally abusive when questioned. CMS Ex. 12, at 5, 9; CMS Ex. 7, at 22. The nurses' notes also indicate that while staff were searching for the bottle, the resident was seen staggering down the sidewalk and continuing down the street, again drinking from a bottle. CMS Ex. 12, at 9; CMS Ex. 7, at 22. Since he had not signed out on a pass, he was "AWOL" according to the notes. Id. When brought back to the facility (in an employee's car) and counseled, the resident was staggering and had slurred speech and alcohol on his breath. Id.

[17] In fact, on the progress notes, after the line for denoting the "Problem behavior," there is a line that states "Effective intervention." On many of the notes, the symbol for "none" appears next to the latter statement. See, e.g., CMS Ex. 29, at 91, 93, 97.

Hotel Reed argues on appeal, as below, that there was only one documented incident of Resident #14 returning to the facility after drinking and that one occurrence was not sufficient to establish a failure to supervise. P. RR at 20-21, citing Tr. at 167, 286. The ALJ rejected that argument, finding that sign-out sheets indicated a loosely enforced supervision system where Hotel Reed did not always know when residents left the facility or even if they returned. He found such a loosely enforced system inadequate, especially for a resident with a known history of alcohol abuse. ALJ Decision at 20. He also noted the facility's failure to supervise Resident #14 right after he returned to the facility intoxicated on January 5, with the result that he was able to leave the facility again, without signing out, and once again stagger down a sidewalk and street while intoxicated. Id.

Hotel Reed does not dispute the essential facts regarding the January 5, 2002 incident, and, as indicated above, the facility's own records document those facts. However, Hotel Reed asserts that Resident #14 was competent to sign himself out and always returned to the facility. P. RR at 20, citing Tr. at 285. This misses the point, which is that Hotel Reed's own "Release of Responsibility for Leave of Absence" forms indicate that Resident #14, and other residents, did not always fully comply with the sign-out process. See generally P. Ex. 51 (showing incomplete information after many entries, including no date or time of return or verifying signature of nurse). With respect to Resident #14, the surveyor reviewed these forms and determined that such information was missing for 35 of the 44 days that the resident signed out from January 1 to February 13, 2002. CMS Ex. 12, at 4; see also P. Ex. 51. Hotel Reed does not dispute this evidence but argues that no regulation requires residents to sign in and out. P. RR at 20. This argument also misses the point. It is true that the regulation requiring SNFs to provide adequate supervision to prevent accidents does not tell them precisely what they must do to accomplish that goal. However, whatever system a facility chooses, it must be adequate. Hotel Reed chose to implement a sign-out process as a way of supervising the whereabouts of its residents yet did not enforce it consistently. The ALJ reasonably inferred from the evidence of Hotel Reed's lax enforcement of its sign-out process that it was not adequately supervising residents like Resident #14.

The evidence discussed is substantial and supports the ALJ's conclusion that Hotel Reed failed to provide adequate supervision to prevent accidents, as required by 42 C.F.R. § 483.25(h)(2), when it allowed Resident #14, an abuser of alcohol, to leave the facility without complying with sign-out procedures, even after

he was observed returning to the facility drinking and visibly intoxicated. The ALJ's conclusion also is free of legal error.

4. Resident #3

The ALJ found that Hotel Reed failed to comply with 42 C.F.R. § 483.25(h)(2) because it failed to adequately investigate two incidents involving injury to Resident #3.[18] On August 1, 2001, a member of Hotel Reed's staff discovered bruising under Resident #3's left arm, and the resident complained of pain when breathing; the resident was transferred to the hospital where she was diagnosed with two broken ribs. ALJ Decision at 10, citing CMS Ex. 27, at 9 (nurses' notes), 63 (x-ray report). On August 10, 2001, a Hotel Reed staff member discovered dark purple bruises on Resident #3's left buttock, right leg and left leg. Id., citing CMS Ex. 27, at 10 (nurses' notes). The ALJ concluded that Hotel Reed had not adequately investigated the cause of these injuries and that "[w]ithout an adequate investigation ... the facility could not make appropriate adjustments in its care of Resident 3 to prevent future incidents." ALJ Decision at 13. Hotel Reed argues that these incidents do not provide a basis for finding noncompliance with 42 C.F.R. § 483.25(h)(2) because the facility "recognized and correctly noted the resident's bruises and took the appropriate step of sending the resident to the hospital when R3 complained of pain." P. RR at 16. Hotel Reed also argues that the record shows that all of the bruises emanated from the resident's fall on July 30, 2001, and, therefore, there was no need for further investigation.

We agree with the ALJ that "adequate supervision to prevent accidents" encompasses a duty to adequately investigate why an accident occurred in order to prevent future accidents. This conclusion is consistent with the duty imposed by the regulation, discussed in Woodstock, to mitigate foreseeable risks of harm or threats of harm. We also conclude that substantial evidence supports the ALJ's finding that Hotel Reed did not adequately investigate the source of Resident #3's bruises and broken ribs. Nurses' notes from July 30, 2001 do establish that Resident #3 fell on July 30, 2001. CMS Ex. 27, at 6. However, contrary to

[18] The same incidents were at issue in the ALJ's finding of noncompliance with 42 C.F.R. § 483.13(c) (which requires investigation of injuries of "unknown source"), a finding that we do not reach in this decision. In his discussion of the incidents under 42 C.F.R. § 483.25(h)(2), the ALJ incorporated by reference his discussion of the incidents in connection with section §483.13(c). ALJ Decision at 13 (citing pages 8-9 of his Decision).

what Hotel Reed asserts, the record does not establish that the bruises discovered on August 1 and August 10, 2001 all emanated from that fall, thus obviating the need for further investigation.

We look first at the bruises discovered on August 1, 2001. Hotel Reed's DON testified that these injuries, which were under the resident's left arm, resulted from the resident's fall on July 30, 2001. Tr. at 235-36. The DON based her testimony, in part, on a nurses' note from August 1, 2001 that addresses the bruises discovered on that date as well as the subsequent diagnosis of broken ribs. P. Ex. 56, at 663; CMS Ex. 27, at 9. However, the August 1, 2001 nurses' note (in contrast to the July 30 nurses' note) does not mention a fall and does not attribute the bruises or broken ribs to a fall or, for that matter, to any other cause. The DON also based her testimony on an incident/accident report dated July 31, 2001 that she identified as reporting the fall on July 30, 2001.[19] Tr. at 237 (testifying about CMS Ex. 27, at 5). However, the injuries described in the incident/accident report (and in the July 30, 2001 nurses' notes) documenting the fall are not bruises but, rather, "3 small skin tears to left elbow." CMS Ex. 27, at 5, 6. Thus, contrary to the DON's testimony, Hotel Reed's records from July 30 and 31 and August 1, 2001 do not establish that the bruises (and fractured ribs) discovered on August 1, 2001, resulted from Resident #3's fall on July 30, 2001.

In any event, the ALJ's finding that Hotel Reed failed to adequately investigate an injury of unknown source also related to the multiple bruises discovered on Resident #3 on August 10, 2001. P. Ex. 56, at 664; CMS Ex. 27, at 10. Hotel Reed argues that these bruises also emanated from the resident's fall on July 30, 2001 and, therefore, that further investigation into their source was not necessary. However, the evidence Hotel Reed relies upon does not show that Hotel Reed reasonably considered the fall on July 30, 2001 to be the "known source" of the bruises (on the resident's buttock, arms and legs) discovered eleven days later.

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[19] That report, unlike the nurses' notes from July 30, 2001, does not actually state that the resident fell, only that she was startled as she "was getting up from w/c" and "hit her elbow." CMS Ex. 27, at 5. However, as the ALJ noted, the parties agree that the July 31, 2001 report and the July 30, 2001 nurses' note refer to the same incident. See ALJ Decision at 10, n.6. For purposes of this decision, we assume that both documents refer to Resident #3's fall from her wheelchair on July 30, 2001.

Hotel Reed relies on testimony by its DON that the bruises discovered on August 10, 2001 emanated from the same July 30, 2001 fall to which she attributed the bruises (and broken ribs) discovered on August 1, 2001. P. RR at 10, citing Tr. at 238-39. The DON's conclusion is based on an incident/accident report completed by the facility on August 10, 2001. Tr. at 239, citing P. Ex. 18, at 2. However, the only mention of a fall in that report is the following statement: "When asked resident denies being hit. States got bruises when she fell." P. Ex. 18, at 2. The DON concluded that this statement attributed to Resident #3 established that the July 30, 2001 fall caused the bruises discovered on August 10, 2001 and, therefore, that no further investigation was necessary. Tr. at 239-40.

The ALJ disagreed. He found that relying on the statement attributed to Resident #3 in the incident/accident report was not an adequate investigation in light of Resident #3's cognitive deficits. The ALJ also noted a lack of clarity in the record about the resident's statements that rendered the statement attributed to her in the incident/accident report inconclusive. ALJ Decision at 10-11. In particular, the ALJ noted that while the August 10, 2001 incident/accident report indicates that the resident said she received the bruises when she fell, the nurses' notes for August 10 state that the resident did not know how she received the bruises.[20] Id., citing CMS Ex. 27, at 8, 10.

Substantial evidence supports the ALJ's rejection of Hotel Reed's reliance on Resident #3's statement as establishing the known cause of her injuries. The record establishes that Resident #3 suffered from confusion and long and short-term memory loss. CMS Ex. 27, at 11, 61, 62. In Britthaven, Inc., d/b/a Britthaven of Smithfield, DAB No. 2018, at 14 (2006), we found that the ALJ "could reasonably conclude that an investigation limited to asking a memory-impaired person why her eye is bruised is inadequate." We make the same finding here. Furthermore, the ALJ's conclusion in the instant case was based not only on the resident's cognitive deficits but also on a lack of clarity about her statements that is supported by the record. The documents cited by the ALJ indeed show that a statement attributed to Resident #3 in the nurses' notes from August 10, 2001 contradicts the statement attributed to her in the August 10, 2001 incident/accident report and, thus, undercuts Hotel Reed's reliance on the latter statement. Such contradictory statements

[20] We also note that the records which document that a fall occurred on July 30, 2001 – the July 30 nurses' notes and the July 31, 2001 incident/accident report – do not cite any statement by Resident #3. See CMS Ex. 27, at 5, 6.

from any resident, and certainly one with Resident #3's cognitive deficits, should have put Hotel Reed on notice of the need for further investigation.[21]

The ALJ noted that even the DON testified that under its protocol, Hotel Reed would have compiled additional information regarding the incidents, including an accident log, which the DON described as a "report of the investigation." ALJ Decision at 10-11; Tr. at 248-50. The ALJ concluded from this testimony that under the facility's own protocol, it should not have relied solely on Resident #3's inconclusive statements. The ALJ also noted that Hotel Reed did not provide any of the additional documentation described by the DON. ALJ Decision at 11. Hotel Reed has not addressed this particular ALJ finding on appeal.

Hotel Reed also points to testimony by its DON that it is "usual" for bruises in elderly residents to not appear for some period of time after a fall.[22] P. RR at 10, citing Tr. at 258. The ALJ rejected this assertion because Hotel Reed did not present any clinical evidence to support the DON's testimony. He also found the assertion inadequate in light of the Board's statement in Britthaven that "'assumptions based solely on a resident's characteristics . . . do not constitute knowledge of the cause of an injury that justifies a failure to investigate.'" ALJ Decision at 11, quoting DAB No. 2018. Presumably, the "characteristic" the ALJ was referring to in this case was "elderly people". We need not decide whether this was a type of "characteristic" contemplated by our statement in Britthaven or whether the ALJ should have rejected the DON's testimony on this issue based on a lack of clinical evidence because the testimony is not material to our decision. Even if true, this testimony would not establish that Hotel Reed reasonably found that the bruises discovered on August 10, 2001 had a known source – the resident's fall eleven days earlier. At best, this testimony, if true, would show that it was possible that the bruises emanated

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[21] We also note that the statement attributed to Resident #3 in the August 10, 2001 incident/accident report merely states that she fell; it does not state when she fell. Hotel Reed asks us to assume that the reference was to the fall that occurred on July 30, 2001. However, it is possible that Resident #3 was referring to another fall that is not documented in the record, perhaps because of this very assumption.

[22] We note that Hotel Reed in its request for review substituted the word "common" for the word "usual" that the DON used. The term "usual" suggests that delayed appearance of bruises in the elderly is standard; the word "common" does not.

from the fall, that is, it attempts to explain the eleven-day gap between the fall and the bruising. It does not establish a causal link between the fall and the bruising sufficient to obviate any need to investigate. Hotel Reed's position in this appeal, as below, is based on an assumption that is not supported by substantial evidence in the record as a whole.

For the reasons discussed above, we conclude that substantial evidence supports the ALJ's conclusion that Hotel Reed failed to provide adequate supervision to prevent accidents, as required by 42 C.F.R. § 483.25(h)(2), when it did not conduct an adequate investigation into the cause of Resident #3's bruises. The ALJ's conclusion also is free of legal error.

B. The ALJ did not err in concluding that CMS's finding of immediate jeopardy was not clearly erroneous.

The ALJ concluded that Hotel Reed had not met its burden of proving that CMS's finding of immediate jeopardy was clearly erroneous. "Immediate jeopardy" is "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 that a deficiency constitutes immediate jeopardy is a determination of the level of noncompliance which "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2); Woodstock, DAB No. 1726, at 9.

Hotel Reed challenges the ALJ's immediate jeopardy determination by asserting, "CMS did not demonstrate that Hotel Reed's actions or inactions 'caused, or were likely to cause, serious injury, harm, impairment, or death to a resident.'"[23] P. RR at 23. This assertion reflects a misunderstanding of the burden of proof on the immediate jeopardy issue. It is not CMS's burden to prove that noncompliance constitutes immediate jeopardy. Rather, once CMS has made a determination about the level of noncompliance, including a determination that the noncompliance constitutes immediate jeopardy, the provider bears the burden of proving that CMS's determination is clearly erroneous. E.g., Liberty Commons

[23] Hotel Reed also asserts, "None of the findings cited [rise] to the level of immediate jeopardy or a level less than immediate jeopardy." P. RR at 23. In essence, Hotel Reed is arguing that the deficiencies cannot constitute immediate jeopardy because, in Hotel Reed's view, they do not even constitute noncompliance. We have already concluded that Hotel Reed's deficiencies under 42 C.F.R. § 483.25(h)(2) do constitute noncompliance.

Nursing & Rehab Center – Johnston, DAB No. 2031, at 18-19. Hotel Reed makes no argument and cites no evidence specific to this burden but merely refers in general terms to the evidence on which it relied to support its assertion that it was in substantial compliance with 42 C.F.R. § 483.25(h)(2): "As discussed, Hotel Reed presented evidence, which when the record is reviewed as a whole, demonstrates that the Facility ensured all of its residents received adequate supervision to prevent accidents." P. RR at 23. This vague assertion, that does not even address the level of noncompliance, falls far short of proving that CMS's determination of immediate jeopardy was clearly erroneous.[24] Accordingly, we conclude that the ALJ did not err in concluding that CMS's finding of immediate jeopardy was not clearly erroneous.

Conclusion

Based on the above analysis, we uphold the ALJ's Decision. We specifically affirm FFCLs A, D, and G. We modify FFCL H to specify that the reduced CMP amounts imposed by the ALJ are reasonable. The modified FFCL reads: "The amount of the CMP originally imposed was unreasonable, but a CMP of $3,050 per day from February 11, 2002 through March 12, 2002 and $200 per day from March 13, 2002 through April 16, 2002 is reasonable." We need not and do not affirm, modify or reverse FFCLs B, C, E or F since our affirmance of FFCL D alone is sufficient, as a matter

[24] In any event, the substantial evidence that we have concluded supports the finding of noncompliance with 42 C.F.R. § 483.25(h)(2), especially the evidence regarding Resident #10, clearly shows the type of situations that present a likelihood of serious injury or harm if uncorrected, as they were at the time the noncompliance was cited. See, e.g., Liberty Commons Nursing and Rehab Center – Johnston, DAB No. 2031 at 19-20 (stating that immediate jeopardy exists if a SNF's noncompliance is the type of noncompliance that would likely cause serious injury, harm, impairment, or death if not corrected, even if surveyors did not observe or identify a particular resident who was actually threatened with harm during the survey).

of law, to support our affirmance of FFCLs A and G and FFCL H, as modified, and CMS did not appeal FFCL E.

/s/
Judith A. Ballard

/s/
Constance B. Tobias

/s/
Sheila Ann Hegy
Presiding Board Member