Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Owensboro Place and Rehabilitation Center
(CCN: 18-5236),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-09-573

Decision No. CR2286

Date: November 22, 2010

DECISION

Petitioner, Owensboro Place Care and Rehabilitation Center (Petitioner or facility), is a long-term care facility located in Owensboro, Kentucky, that participates in the Medicare program. The Centers for Medicare and Medicaid Services (CMS) determined that the facility was not in substantial compliance with Medicare requirements and that its deficiencies posed immediate jeopardy to resident health and safety. Based on this, CMS imposed civil money penalties (CMPs) of $3,050 per day for fifty days of immediate jeopardy (December 25, 2008 through February 12, 2009). Petitioner timely appealed CMS's determination.

For the reasons set forth below, I find that the facility was not in substantial compliance with Medicare program requirements, its deficiencies posed immediate jeopardy to resident health and safety, and, because $3,050 is the minimum per day penalty for periods of immediate jeopardy, the penalty imposed is reasonable as a matter of law.

I. Background

The Social Security Act (Act) sets forth requirements for nursing facility participation in the Medicare program and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act §1819. The

Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. The regulations require that each facility be surveyed once every twelve months and more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a); 488.308.

Here, responding to a complaint, the Kentucky Cabinet for Health and Family Services (State Agency) initially surveyed the facility from January 26 - February 3, 2009. CMS Ex.16; P. Ex. 2. State surveyors returned to the facility for follow-up on April 3, 2009. CMS Ex. 18; P. Ex. 1.[1] Based on their findings, CMS determined that, from December 25, 2008 through February 12, 2009, the facility was not in substantial compliance with Medicare participation requirements, including 42 C.F.R. § 483.25(h) (Tag F323 – supervision/accident prevention) and 42 C.F.R. §§ 483.10(d)(3) and 483.20(k)(2) (Tag F 280 – comprehensive care plans).[2] CMS also determined that the deficiencies cited under these regulations posed immediate jeopardy to resident health and safety. CMS Exs. 1, 18. CMS has imposed against the facility CMPs of $3,050 per day for fifty days of immediate jeopardy (December 25, 2008 through February 12, 2009), for a total penalty

[1] In the interim, the surveyors revisited the facility on February 16, 2009, and cited an additional deficiency at the immediate jeopardy level (42 C.F.R. § 483.25). The parties agree that the February 16 survey findings are not before me here, although they disagree about the reasons for that. According to CMS, the facility did not appeal the February 16 survey findings, which are therefore final. CMS Ex. 17; CMS Br. at 2 n.1; 42 C.F.R. § 498.22(b). Petitioner claims that no survey was completed on that date, an assertion that seems incompatible with the existence of a survey report form that cites February 16, 2009 as the "date survey completed." CMS Ex. 2. On the other hand, CMS presents no evidence that it imposed any remedies as a result of the survey or even sent Petitioner a copy of the survey report, much less notice of any appeal rights.

[2] Other deficiencies were cited at lower levels of scope and severity: 42 C.F.R. §§ 483.20(b)(2)(i), 483.25, and 483.20(c). CMS Exs. 16, 17, 18. Because I find that the deficiencies cited under 42 C.F.R. § 483.25(h) are, by themselves, sufficient to support the remedy imposed, I decline to review these additional citations. For the same reason, I need not review the deficiencies cited under sections 483.10(d)(3) and 483.20(k)(2). *See Claiborne-Hughes Health Ctr.*, 609 F.3d 839, 847 (6th Cir. 2010); *Carrington Place of Muscatine*, DAB No. 2321 at 20-21 (2010).

of $152,500. CMS Ex. 1.[3]

Petitioner timely requested a hearing.

The case was initially assigned to Administrative Law Judge (ALJ) Alfonso J. Montano, who convened a hearing in Louisville, Kentucky on April 14, 2010. Ms. Erica Matos appeared on behalf of CMS, and Ms. Donna Holshouser Stinson appeared on behalf of Petitioner. Transcript (Tr.) at 4-5.

At the hearing, Judge Montano admitted into evidence CMS Exhibits (Exs.) 1-20, although he acknowledged, and the parties agreed, that CMS Exs. 9, 11, 12, 13, 14, and 15 are not relevant to the issues in this case. Tr. at 8-9. Therefore, although those exhibits have been made part of this record, in deciding this matter, I will not consider them. *See* 42 C.F.R. § 498.60(b)(1) (providing that the ALJ receives in evidence "any documents that are relevant and material"). Judge Montano also admitted P. Exs. 1-25. Tr. at 10.

When Judge Montano left the Civil Remedies Division, the matter was reassigned to me. In an order dated August 20, 2010, I noted that the case had been heard and fully briefed and advised the parties that, unless they objected, I would close the record and decide the case. Neither party objected.

II. Issues

The issues before me are: 1) from December 25, 2008 through February 12, 2009, was the facility in substantial compliance with Medicare requirements; and 2) if the facility was not in substantial compliance, did its deficiencies pose immediate jeopardy to resident health and safety.

Because CMS has imposed the minimum per-day penalty for situations involving immediate jeopardy, the reasonableness of the penalty is not before me. 42 C.F.R. § 488.438(a)(i).

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[3] CMS initially imposed an additional CMP of $100 per day, effective February 13, 2009, but, based on the facility's plan of correction, it rescinded that penalty, determining that the facility returned to substantial compliance on February 13. CMS Ex. 1; CMS Post-Hearing Br. at 2.

III. Discussion

A. The facility was not in substantial compliance with 42 C.F.R. § 483.25(h), because staff ignored facility policy regarding elopements when they failed to respond to a door alarm, allowing a vulnerable, unsupervised resident to leave the facility.[4]

Under the statute and the "quality of care" regulation, each resident must receive, and the facility must provide, the necessary care and services to allow a resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. Act § 1819(b); 42 C.F.R. § 483.25. To achieve this, the facility must, among other requirements, "ensure" that each resident's environment remains as free of accident hazards as possible. 42 C.F.R. § 483.25(h)(1). It must "take reasonable steps to ensure that a resident receives supervision and assistance devices designed to meet his assessed needs and to mitigate foreseeable risks of harm from accidents." *Briarwood Nursing Ctr.*, DAB No. 2115 at 5 (2007); *Guardian Health Care Ctr.*, DAB No. 1943 at 18 (2004) (*citing* 42 C.F.R. § 483.25(h)(2)). The facility must anticipate what accidents might befall a resident and take steps to prevent them. A facility is permitted the flexibility to choose the methods it uses to prevent accidents, but the chosen methods must constitute an "adequate" level of supervision under all the circumstances. *Briarwood* DAB No 2115 at 5; *Windsor Health Care Ctr.*, DAB No. 1902 at 5 (2003); *see Burton Health Care Ctr.*, DAB No. 2051 at 9 (2006) (holding that determining whether supervision/assistive devices are adequate for a particular resident "depends on the resident's ability to protect himself from harm").

Resident 1 (R1) was an 81-year-old woman, admitted to the facility on August 1, 2008. CMS Ex. 8 at 2, 61, 88, 111; P. Ex. 4 at 1. She suffered from a variety of ailments, including vascular dementia, peripheral vascular disease, and Alzheimer's disease. CMS Ex. 8 at 13; P. Ex. 4 at 1, 2. According to her initial assessment, she engaged in wandering behavior, defined as "moving with no rational purpose, seemingly oblivious to needs or safety," and her behavior was not easily altered. CMS Ex. 8 at 19, 26, 65, 90; P. Ex. 4 at 3; Tr. at 27.

Because of her wandering, the facility identified R1 as an elopement risk, and her care plan directed staff to attach a WanderGuard bracelet to her. If the WanderGuard alarm sounded or if she attempted to leave the unit or the building, staff were to redirect her. CMS Ex. 8 at 75; P. Ex. 4 at 32, 80. A physician's order instructed staff to check the WanderGuard for placement and function every shift. CMS Ex. 8 at 83, 85. Her records confirm that staff put a WanderGuard in place on her ankle, and checked it periodically. CMS Ex. 8 at 8, 26, 57, 89; P. Ex. 4 at 74; Tr. at 28.

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[4] My findings of fact/conclusions of law are set forth, in italics and bold, in the discussion captions of this decision.

When an individual wearing a WanderGuard bracelet approaches a door that is linked into the system, an alarm sounds, alerting staff of a potential elopement before the resident can even open the door. Some systems also provide for automatic door locking – the linked-in door will lock when approached by someone wearing the bracelet, although others can pass through freely. Tr. at 64-65.

R1 was one of approximately 15 residents equipped with a WanderGuard bracelet. CMS Ex. 3; P. Ex. 12 at 5; P. Ex. 13; Tr. at 34. But only three of the facility's exit doors were linked into the WanderGuard system. R1 lived on the facility's E wing, which was located at the far back end of the building. None of the E wing exit doors were linked into the WanderGuard system. P. Ex. 18; Tr. at 32-33, 102. The unlinked doors would open if pushed for 15 seconds, and an alarm would sound. Tr. at 33, 66. At the same time, another alarm would sound at a nursing station panel. Tr. at 67. It appears that the E wing door alarms sounded at a panel located in the D wing. When the alarm sounded at the panel on the D wing, the nurse there was supposed to announce to staff that one of their alarms was sounding. Tr. at 138.

Facility policy dictated that, upon hearing a door alarm, "all staff must secure the resident that they are working with and go to visually check the door that is sounding." In checking the door, staff were required to open it, go outside, and look around the vicinity to make sure that a resident had not left. "You must check that door and the surrounding areas outside as well." CMS Ex. 6 at 15; P. Ex. 11 at 8; Tr. at 129-30. But, as the following incident illustrates, facility staff were either unaware of their obligations or chose to ignore them.

On December 25, 2008, seven employees were assigned to the E wing. Tr. at 130. They acknowledge hearing a door alarm sound. Yet, they did not respond, which allowed R1 to leave the facility. Fortunately, a staff member happened to spot R1 in the facility parking lot and returned her to the facility before any harm came to her.

The record before me suggests that the facility's investigation of this incident was less than thorough. Written statements are vague, incomplete, and inconsistent, and no apparent effort was made to reconcile those inconsistencies.[5]

A nursing note says that R1 was "found in [the] parking lot." She was carrying blankets and a purse, wore a sweatshirt, sweatpants, and socks, no shoes. The temperature outside was 32 degrees Fahrenheit. CMS Ex. 8 at 74; P. Ex. 4 at 25.

In an undated note, Registered Nurse (RN) Randy Sickels writes that, while he was transporting a resident to the dining room, he looked out the window and saw R1 in the

[5] Director of Nursing (DON) Carolyn Lynn (nee Davis) testified that she put together a time line of the events of December 25, but the record includes no such document. Tr. at 129.

parking lot between the garage and the building.[6] She was carrying her blankets and walking toward the main parking area. He escorted her back to the building and reported the incident to the resident's "responsible nurse," apparently Licensed Practical Nurse (LPN) Kristina Johnson, who was the only other nurse on duty in the E wing. CMS Ex. 5 at 2; P. Ex. 5 at 4. In his note, RN Sickels does not mention what time he found R1, nor does he mention hearing a door alarm, factors that would have been important in assessing where and why the facility's anti-elopement systems broke down.

RN Sickels later told the state surveyor, Carol McIntosh, that on December 25 he was in another resident's room on the E wing with the door closed when he "vaguely" heard an alarm go off. He did not respond to it. Later, while taking residents to the dining room, he happened to see saw R1 in the parking lot. CMS Ex. 7 at 9; Tr. at 48.

Notwithstanding RN Sickels' statement to Surveyor McIntosh, DON Lynn testified that "[i]n my investigation, [RN Sickels] did not hear the alarm." Tr. at 139-40. She does not explain how she reached this conclusion, and I find no support for it in the record. Petitioner did not produce RN Sickels as a witness. No investigative report suggests that the alarm was not audible. *See, e.g*., P. Ex. 14. Moreover, the facility's anti-elopement policy was predicated on the assumption that staff in the unit could hear door alarms and respond immediately. If DON Lynn legitimately concluded that RN Sickels did not hear the alarm, I would expect to see evidence that she investigated further and that the facility re-visited the efficacy of its policy.

In her statement regarding the incident, LPN Johnson wrote that she saw R1 in the dining room at 11:45 a.m. The resident was wearing a sweatshirt, sweatpants, and socks, and was carrying blankets and a purse. The temperature outside was 32 degrees. At 12:20 p.m., Randy Sickles told her that he had found R1 in the parking lot and brought her inside. LPN Johnson's note does not mention a door alarm, but says that, while in the dining room, she heard a page directing the East Wing South to lock its door. CMS Ex. 5 at 4; P. Ex. 5 at 1.

LPN Johnson told Surveyor McIntosh that she had been assigned to the E wing on December 25, and was involved with R1's care; she heard the alarm go off but was not able to respond, because she had to stay in the dining room to help feed the residents. Tr. at 50-51, 116. At the hearing, LPN Johnson added that she was unable to respond to the alarm because a nurse had to be in the dining room in case of a choking incident. Tr. at 116-17. During her testimony, LPN Johnson admitted that, while she remained in the dining room, she twice heard the page asking staff of E South to check their door. Tr. at 117.

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[6] Another employee statement challenges RN Sickel's claims. Nurse Aide Crystal Howard writes: "Randy Sickels was not transporting residents. I saw him get a cigarette and leave the floor alone." CMS Ex. 5 at 9. The record contains no evidence that facility administrators followed up on these charges.

LPN Johnson also testified that four to five nurse aides were with her in the dining room. It apparently "did not cross [her] mind" to send one of them out in response to the alarm. *See* Tr. at 122-23. In any event, not one of them responded to the door alarm.

Some of these staff apparently suggested to Surveyor McIntosh that they were not supposed to leave the dining room. Tr. at 53. If so, the facility's elopement policy itself was probably unworkable, and, at the least, should have been reconsidered. At mealtime, almost all of the E wing employees were in the dining room, which left virtually no one available to respond to a door alarm.

I could not tell from LPN Johnson's statements whether she saw R1 in the dining room before or after the elopement. Some statements from staff support my concluding that the resident eloped between 11:00 and 11:30 a.m. According to Nurse Aide Angie Calloway, the door alarm was sounding on the south hall of the E wing at 11:00 to 11:30 a.m.; LPN Nayla Dunn paged the unit three times, asking that the door be checked and cleared. According to Nurse Aide Calloway's note, LPN Dunn sent at least two people to check the door, and a third person also said she would check because of the "excessive sounding of the alarm." CMS Ex. 5 at 18. Consistent with this statement, LPN Dunn wrote that, at 11:30 a.m., she was working on the D wing, and, for approximately 15 minutes, she heard the alarm sounding for E wing south. She "announced" three times for E Wing to check the door, and then sent three people to check on the alarm. Eventually, someone named Mary Roberts went to check "as [the] door alarm [was] still sounding," and she locked the door and reset the alarm. CMS Ex. 5 at 7; P. Ex. 5 at 9.

Without specifying any times, Nurse Aide Amanda Calloway wrote that she heard LPN Dunn page E South to reset the door. About 20-30 minutes later, she saw Randy Sickels bring R1 back into the wing's front door. CMS Ex. 5 at 8; P. Ex. 5 at 7.[7] This statement suggests that 20 to 30 minutes elapsed between R1's setting off the alarm and her return to the facility.

Based on this evidence, it seems that R1 exited the facility, setting off the alarm, some time between 11:00 and 11:30 a.m. No one from that unit responded to LPN Dunn's repeated pages asking that someone check the door. After about fifteen minutes, LPN Dunn sent someone from another unit to lock the door and reset the alarm. In the meantime, RN Sickels saw the resident and returned her to the facility.

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[7] In a subsequent clarification, dated December 26, Nurse Aide Calloway wrote that the alarm was not going off for 30 minutes. Rather, the alarm went off and LPN Dunn called for a reset; after a minute or so, it was reset. But then the alarm went off again, and LPN Dunn paged for it to be reset, and the door was reset in a couple of minutes. CMS Ex. 5 at 13; P. Ex. 5 at 8. Nurse Aide Calloway does not explain how she knew that the door was so quickly reset, an assertion that is inconsistent with the statements of others, including LPN Dunn.

But other employees wrote that LPN Dunn's announcements to the E unit occurred later, between 12:15 and 12:30 p.m. Nurse Aide Talna Laughery wrote that she was on the B/C wing at about 12:15 to 12:20, when she twice heard LPN Dunn page E Wing South to check its south door. P. Ex. 5 at 3. According to Nurse Aide Crystal Howard, she was in the dining room at 12:20 p.m., feeding a resident, when she heard the page for East Wing South staff to lock their door. After the second page, someone re-set the door. CMS Ex. 5 at 9. Nurse Aide Sarah Chilafoe wrote that, at 12:17 p.m., she saw "Randy . . . coming in the door from C wing with R1." P. Ex. 5 at 6.

Just one employee wrote that she responded to the alarm. Medication Aide Karen Lewis was assigned to the E wing, charged with passing medications. Tr. at 51. She wrote that "at approximately 12:15 p.m.," she saw R1 standing in the E wing lobby, holding a blanket. The aide then left the unit to go to the bathroom. She did not indicate how long she was gone but wrote that, when she returned, the alarm on the south end door was going off. She went to check and reset the door. She went outside to look for any resident who might have gone out, but, seeing no one, returned to the facility and reset the door. Someone told her that R1 had set off the alarm but was back in the facility. CMS Ex. 5 at 5; P. Ex. 5 at 2. I am not able to reconcile her time table with those offered by Nurse Aide Angie Calloway and LPN Dunn. Assuming that Medication Aide Lewis was away for as long as 20 to 30 minutes, her statement would be consistent with that of Nurse Aide Amanda Calloway.

Ultimately, I need not resolve these conflicts. The undisputed evidence establishes that the nurses and most of the nurse aides on the E unit failed to respond to the sound of a door alarm, in contravention of the facility policy, which allowed R1 to elope. This alone means that facility staff failed to take reasonable steps to ensure that the resident received the supervision necessary to mitigate foreseeable risks of harm from accidents. The facility was therefore not in substantial compliance with 42 C.F.R. § 483.25(h).

B. CMS's determination that the facility's deficiencies posed immediate jeopardy to resident health and safety is not clearly erroneous.

Immediate jeopardy exists if a facility's noncompliance has caused or is likely to cause "serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination as to the level of a facility's noncompliance (which would include an immediate jeopardy finding) must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Departmental Appeals Board (Board) has observed repeatedly that the "clearly erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy, and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1931 at 27-28 (2004) (*citing Koester Pavilion*, DAB No. 1750 (2000)); *Daughters of Miriam Ctr.*, DAB No. 2067 at 7, 9 (2007). The facility must come forward "with evidence and argument showing that the

harm or threatened harm did not meet any reasonable standard of serious." *Daughters of Miriam Ctr.* DAB No. 2067 at 9.[8]

Fortuitously, no harm befell R1. However, the regulation does not require actual harm, and as the Board has determined:

> The likelihood of serious harm is weighed not merely by the fortuitous sequence of events . . . 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 . . . . [T]he fact that someone who was severely mentally impaired and unable to care for her own safety could wander off entirely unnoticed and not be sought until strangers rescued her presents significant likelihood that vulnerable residents might encounter the very dangers which [the facility] calls the "usual hazards of wandering away," such as falls, traffic, etc.

Century Care of Crystal Coast, DAB 2076 at 24 (2007); *accord, Kenton Healthcare, LLC*, DAB No. 2186 at 23-26 (2008).

Here, a vulnerable resident was able to leave the facility without staff intervention and remain outside in a parking lot for an unknown period of time. She was inappropriately dressed for the freezing temperature, having no shoes and no coat. Moreover, at least 15 residents were at risk for elopement, and, to protect them, the facility's policy required that *all* staff respond *immediately* to door alarms. Yet, at last six of the seven staff assigned to the E wing did not respond to the sounding alarm. They were either unaware of the facility's policy, indifferent to it, or unable to follow it because it conflicted with other policies, which required them to remain with residents in the dining room. That staff would not or could not follow the policy in place to prevent elopements created a "significant likelihood" that vulnerable residents could encounter the significant dangers related to elopement. CMS's immediate jeopardy determination is therefore not clearly erroneous.

C. CMS's determinations as to the duration of the periods of noncompliance and immediate jeopardy are consistent with statutory and regulatory requirements.

Substantial compliance means not only that the facility corrected the specific cited instances of substantial noncompliance, but also that it implemented a plan of correction *designed to assure that no additional incidents would occur* in the future. Once a facility has been found to be out of substantial compliance (as Petitioner was here), it remains so

[8] In error, Petitioner cites the ALJ decision in *Daughters of Miriam Ctr.*, DAB CR1357 (2005), but that decision was reversed by the Departmental Appeals Board.

until it affirmatively demonstrates that it has achieved substantial compliance once again. *Premier Living and Rehab Ctr.*, DAB No. 2146 at 23 (2008); *Lake City Extended Care*, DAB 1658 at 12-15 (1998). The burden is on the facility to prove that it has resumed complying with program requirements, not on CMS to prove that deficiencies continued to exist after they were discovered. *Asbury Ctr. at Johnson City*, DAB No. 1815 at 19-20 (2002). A facility's return to substantial compliance usually must be established through a resurvey. 42 C.F.R. § 488.454(a). To be found in substantial compliance earlier than the date of the resurvey, the facility must supply documentation "acceptable to CMS" showing that it "was in substantial compliance and *was capable of remaining in substantial compliance*" on an earlier date. 42 C.F.R. § 488.456(e) (emphasis added); *Hermina Traeye Mem'l Nursing Home*, DAB No. 1810 at 12 (*citing* 42 C.F.R. §488.456(a) and (e)); *Cross Creek Care Ctr.*, DAB No. 1665 (1998).

Here, CMS determined that the facility returned to substantial compliance after its April 3, 2009 follow-up survey. Instead of setting April 3 as the date the facility achieved substantial compliance, however, CMS accepted the facility's representation that its corrective actions were completed on February 13, 2009. P. Exs. 2, 3; CMS Ex. 18.

Petitioner nevertheless complains that it corrected its deficiencies, particularly the immediate jeopardy "immediately, within a matter of hours. . . ." P. Post-Hearing Br. at 17. The evidence does not support Petitioner's position.

DON Lynn, who was not in the facility at the time of the elopement, testified that, when LPN Johnson called to tell her about the December 25 elopement, she instructed the LPN to assess the resident, notify the physician and the family, "start educating the staff," and to take statements from the staff. Tr. at 128-29. As instructed by DON Lynn, LPN Johnson conducted a staff in-service on responding to alarms. Tr. at 118. By itself, one in-service training session does not establish that the facility has corrected its problems and assured that they will not recur. After all, according to LPN Johnson, the employees were already aware of their duties regarding elopement or possible elopement (Tr. at 118), yet a serious error occurred, involving multiple staff members. The facility must not only make sure that its staff is trained adequately, it must thereafter monitor to make sure that the training resolved the problem.

Moreover, the "evidence" of in-service training seems inadequate to address the problem. A December 25 statement signed by staff reads: "when door alarms staff is to exit building to look for possible elopement." P. Ex. 6. But this single statement does not even address, much less resolve, the problems of December 25. The problem was not that staff inadequately responded to the door alarms; the problem was that they did not respond at all. If, in fact, they were also directed to remain with their residents in the dining room, this training did nothing to resolve that conflict.

Finally, the facility's "investigation" of the December 25 elopement raises additional questions about the speed with which the facility corrected its deficiency. By not investigating properly, a facility loses the opportunity to analyze and correct its problems.

Century Care of Crystal Coast, DAB No. 2017 at 21 (2007), *aff'd* No. 07-1491, 2008 WL 2385505 (4th Cir. 2008). I have already discussed problems with witness statements. In addition, Petitioner submits only one document purporting to be a report of the incident: a December 26, 2008 document titled "Allegations of Violation of Policy," signed by Facility Administrator Bruce Roberson. The report says that the resident was a "wander risk" and a WanderGuard bracelet was in place. This intervention was "effective" because she was "brought back into [the] facility [in] less than 5 minutes by [a] staff member." He therefore declared the "investigation complete." P. Ex. 14 at 2 (emphasis in original).

This report is most charitably described as inaccurate. All of the evidence establishes that the WanderGuard intervention was simply irrelevant to the incident. No evidence suggests that staff returned the resident within five minutes. And the report completely ignores the overarching problem that staff did not follow the facility policy by responding to the door alarm. Such inaccuracies belie the facility's assertion that it immediately corrected its deficiencies. In fact, it had not even acknowledged them.

Because Petitioner has not established that an effective plan of correction was implemented any earlier than that determined by CMS, I sustain CMS's determinations as to the duration of the periods of substantial noncompliance and immediate jeopardy.

IV. Conclusion

From December 25, 2008 through February 12, 2009, the facility was not in substantial compliance with Medicare requirements, and its deficiencies posed immediate jeopardy to resident health and safety. CMS has imposed the minimum per-day penalty for situations involving immediate jeopardy, so the penalty is reasonable as a matter of law.

/s/
Carolyn Cozad Hughes
Administrative Law Judge