Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: March 9, 2007
Liberty Commons Nursing and Rehab - Alamance,	
Petitioner,	Civil Remedies CR1427 App. Div. Docket No. A-06-80
	Decision No. 2070
- v. -	
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Liberty Commons Nursing and Rehab - Alamance (Liberty Commons or Petitioner) appealed the March 20, 2006 decision of Administrative Law Judge (ALJ) Steven T. Kessel. Liberty Commons Nursing and Rehab - Alamance, DAB CR1427 (2006). The ALJ sustained a determination by the Centers for Medicare & Medicaid Services (CMS), based on findings by the State survey agency, that Liberty Commons failed to comply substantially with federal requirements governing the participation of long-term care facilities in Medicare and Medicaid. The State survey agency found that Liberty Commons was not in substantial compliance with a quality of care provision requiring each facility to ensure adequate supervision and assistance devices to prevent accidents. See 42 C.F.R. § 483.25(h)(2). The ALJ upheld CMS's imposition of a civil money penalty (CMP) of $3,500 per day from September 19 through November 17, 2004 and $50 for November 18, 2004.

As we discuss below, the ALJ's conclusion that Liberty Commons was not in substantial compliance with section 483.25(h)(2) is

legally sound and supported by substantial evidence. In addition, substantial evidence supports the ALJ's determination that the CMP amounts are reasonable. We also agree with the ALJ's conclusion that CMS's determination of immediate jeopardy was not clearly erroneous.

Applicable legal provisions

Long-term care facilities participating in the Medicare and Medicaid programs are subject to 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." 42 C.F.R. § 488.301.

A long-term care facility found not to be in substantial compliance is subject to various enforcement remedies, including CMPs. 42 C.F.R. §§ 488.402(c), 488.408. CMS may impose CMPs ranging from $50 - $3,000 per day for one or more deficiencies that do not constitute immediate jeopardy but that either cause actual harm or create the potential for more than minimal harm, and from $3,050 - $10,000 per day for deficiencies constituting immediate jeopardy. 42 C.F.R. § 488.438(a). "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. The regulations set out a number of factors that CMS considers in determining the amount of a CMP. Section 488.438(f).

The participation requirement at issue here falls under the "quality of care" requirements, which share the same regulatory objective that "[e]ach 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." 42 C.F.R. § 483.25. Section 483.25(h) provides in relevant part:

> *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., Golden Age Skilled Nursing & Rehabilitation Center, DAB No. 2026 (2006); Woodstock Care Center, DAB No. 1726, at 28 (2000), aff'd, Woodstock Care Center v. Thompson, 363 F.3d 583 (6th Cir. 2003). Although section 483.25(h)(2) does not make a facility strictly liable for accidents that occur, it does 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 Center v. Thompson, 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. Golden Age at 11, citing Woodstock at 590.

Standard of Review

Our standard of review on a disputed conclusion of law is whether the 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 for Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs, www.hhs.gov/dab/guidelines/prov.html; see also Batavia Nursing and Convalescent Center, DAB No. 1911, at 7 (2004), aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson, No. 04-3687 (6th Cir. Aug. 3, 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[1]

A November 11, 2004 survey of Liberty Commons found that the facility failed to put interventions in place to prevent the elopement of one resident, identified as Resident #2. CMS Ex. 1 (survey report), at 1. Resident #2 was an 87-year-old woman who was diagnosed with Alzheimer's disease and osteoporosis. ALJ

[1] The information in this section is drawn from the ALJ Decision and the record before the ALJ, and is presented to help the reader understand the context of the issues raised on appeal. Nothing in this section is intended to replace or supplement the ALJ's findings of fact or conclusions of law.

Decision at 3. Until May 2003, Resident #2 resided in a locked Alzheimer's unit at Liberty Commons. She was transferred into the general resident population when Liberty Commons closed the Alzheimer's unit. Id. The facility had 15 exit doors. CMS Ex. 1, at 19. Each door had an electronic lock that could be unlocked by entering a code number into a keypad located adjacent to the door. The lock could also be deactivated by operating a switch, resembling an electric light switch, that was located next to each door. With the exception of the front door, none of the exit doors was equipped with an audible alarm. ALJ Decision at 3, citing CMS Ex. 13 (surveyor's declaration), at 5.[2]

Liberty Commons identified Resident #2 as at high risk for elopement on quarterly assessment forms completed in December 2003, March 2004, June 2004, and August 2004. CMS Ex. 2, at 14, 19, 27, 35 (cited in ALJ Decision at 3). Resident #2 eloped from Liberty Commons on six occasions between May 2003 and November 19, 2004. The last three times she eloped were on September 19, November 6 and November 7, 2004. ALJ Decision at 4. Another resident claimed to have seen Resident #2 flip the deactivation switch and exit the facility on September 19. Immediately after the November 6 elopement, facility staff discovered that the deactivation switch had been flipped on the door through which the resident exited. On November 7, Resident #2 was observed by two visitors flipping the deactivation switch for the front door and exiting the facility. CMS Ex. 13, at 11, 14, 16; CMS Ex. 2, at 50 (cited in ALJ Decision at 4).

On November 8, 2004, Liberty Commons ordered a supplemental alarm system that would be triggered by someone who attempted to flip a deactivation switch. ALJ Decision at 6; P. Ex. 43 (written direct testimony of Liberty Commons' Administrator) at 8; P. Ex. 44 (written direct testimony of Liberty Commons' Director of Nursing (DON)) at 6. Installation of this system began on November 16 and was completed the next day. ALJ Decision at 6; CMS Ex. 1, at 19. Liberty Commons then provided in-service training to its staff on its door locking system and elopement policies, which was completed on November 18. CMS Ex. 1, at 19-20. In addition, on November 17, Liberty Commons adopted a care plan for Resident #2 with the goal of preventing further attempts

[2] The ALJ inferred from the fact that an alarm sounded when Resident #2 went out the front door on November 7 that the front door was wired so that an alarm would be triggered when a resident wearing a Wanderguard, such as Resident #2, opened the door. ALJ Decision at 3, n.1.

at elopement. CMS Ex. 2, at 43-44.[3] Liberty Commons also instituted one-to-one supervision of Resident #2 on a 24-hour basis beginning on November 18. CMS Ex. 1, at 20-21; P. Ex. 45, at 6.

By letter dated December 17, 2004, CMS notified Liberty Commons that the survey found that the facility was not in substantial compliance with the requirements for participation in Medicare and Medicaid and that conditions in the facility constituted immediate jeopardy to residents' health and safety from September 19, 2004 through November 17, 2000. CMS Ex. 8. CMS stated that, based on these findings, it was imposing a CMP in the amount of $3,050 per day effective September 19 through November 17, 2004 and a CMP of $50 per day effective November 18, 2004, to continue until substantial compliance was achieved. CMS Ex. 8, at 2. By letter dated January 10, 2005, CMS notified Liberty Commons that a revisit survey on December 30, 2004 found the facility in substantial compliance effective November 19, 2004. CMS Ex. 11.

Liberty Commons requested a hearing before an ALJ pursuant to 42 C.F.R. Part 498. Pursuant to the ALJ's pre-hearing order, each party submitted the written direct testimony of its witnesses prior to an in-person hearing. At the December 15, 2005 in-person hearing, the ALJ heard the cross-examination of two witnesses–the State surveyor and Liberty Commons' MDS (assessment) Coordinator.

On appeal, the ALJ made three numbered findings of fact and conclusions of law (FFCLs):

> 1. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h)(2) during the period that ran from September 19 - November 18, 2004.
> 2. CMS's determination that Petitioner's noncompliance was at the immediate jeopardy level from September 19 through November 17, 2004 was not clearly erroneous.
> 3. Civil money penalties of $3,050 and $50 per day are reasonable.

ALJ Decision at 3, 9, and 10.

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[3] The previous care plan stated "SECURE UNIT DOORS/APPLY WANDERGUARD TO ANKLE." The stated purpose of these measures was to permit the resident to "ambulate with rolling walker w/o [without] injury," not to prevent elopement. P. Ex. 14, at 7-8.

In support of FFCL 1, the ALJ noted that Liberty Commons "made efforts generally to protect its residents from elopement-associated risks and hazards" and "also took several steps that were specifically designed to protect Resident # 2 from such risks and hazards." ALJ Decision at 5. The ALJ nevertheless found that the measures Liberty Commons took to protect Resident #2 from these risks and hazards "were inadequate." Id. Specifically, the ALJ found that the September 19, 2004 incident-

> put Petitioner's staff on notice that there was a flaw in its security system. Beginning on September 19, Petitioner's staff knew that Resident # 2 was capable of defeating the keypad locking mechanism on each of Petitioner's exit doors. That knowledge imposed on Petitioner a burden to take reasonable and effective measures to prevent a recurrence.

Id. at 6 (citation omitted); see also id. at 9 (once Liberty Commons knew that "Resident # 2 was capable of eloping its premises by flipping a deactivation switch . . . Petitioner was under an obligation to do something immediately to rectify the problem"). The ALJ continued:

> However, Petitioner failed to do so. Petitioner did not change its door security system immediately despite knowing that Resident # 2 was capable of defeating it. Nor did it give heightened supervision to the resident that was sufficient to assure that she would not elope while unobserved.

Id. at 6. The ALJ noted that Resident #2 exited the facility twice more by using the deactivation switch before "Petitioner decided to order a supplemental alarm system that would be triggered by someone who attempted to flip a deactivation switch."[4] Id.

In support of FFCL 3, the ALJ stated that the penalty amounts imposed by CMS were "reasonable as a matter of law" because they were "the minimum daily penalty amounts[.]" ALJ Decision at 11.

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[4] The ALJ Decision describes the supplemental alarm system as consisting of "a box with a front cover that is placed over each deactivation switch. A shrill alarm is triggered if someone attempts to access the deactivation switch by opening the cover. CMS Ex. 13, at 18." ALJ Decision at 6, n.2. The boxes are also referred to in the record as "squeal boxes."

Below, we discuss why we uphold FFCLs 1 and 3. We uphold FFCL 2 without any discussion because the ALJ Decision correctly addressed all of the arguments raised by Liberty Commons on appeal with respect to this FFCL.[5]

Analysis[6]

I. Substantial evidence supports the ALJ's conclusion that Liberty Commons was not in substantial compliance with 42 C.F.R. § 483.25(h)(2).

A. Liberty Commons' procedural arguments have no merit.

We note preliminarily that Liberty Commons takes the position that the ALJ erred in refusing to hear certain testimony from Randy Warden, the president of the company that installed the door locking system Liberty Commons had in place when Resident #2 eloped. The ALJ denied, in part, a request made by Liberty Commons prior to the in-person hearing to supplement its case with either oral or written direct testimony by Mr. Warden and later denied Liberty Commons' motion to reopen the decision to admit such testimony. See E-mail from Petitioner to CRD staff dated 11/21/05; Ruling Allowing Limited Testimony of Randy Warren, dated 11/21/05;[7] Petitioner's Motion to Reopen Decision, dated 4/27/06; and Ruling Denying Motion to Reopen Decision, dated 5/19/06.[8] Liberty Commons argued before the ALJ that the

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[5] In the text following FFCL 2, the ALJ required that CMS make a prima facie showing of immediate jeopardy. ALJ Decision at 10. The Board has previously held that such a requirement constitutes legal error. See Daughters of Miriam Center, DAB No. 2067 (2007); Liberty Commons Nursing and Rehab Center – Johnston, DAB No. 2031 (2006). Neither party has raised this legal error as an issue, and the error was harmless in this case.

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

[7] The Ruling incorrectly refers to Mr. Warden as Mr. Warren.

[8] The ALJ stated that he would "allow Mr. Warren to testify concerning the specific features of Petitioner's system

(continued...)

testimony was necessary to respond to a new argument the ALJ had permitted CMS to raise after both parties had filed their written direct testimony: that Liberty Commons "failed to provide adequate assistance devices to protect Resident 2 from elopement-related risks of harm." See CMS's First Amendment to Pre-Hearing Brief, at 1. According to Liberty Commons, Mr. Warden would have testified that: the door security system it used – a locking system with a nearby override switch – is one of only two kinds of locking systems allowed by the State of North Carolina in nursing facilities and is a state-of the-art system; the nearby override switch is required by both North Carolina and Life Safety Codes; the fact that a locked door can be opened by a demented resident is not a "flaw" in a particular system, but is possible with any system; paper covers or squeal boxes over override switches may or may not deter a resident from tampering with the override switch; and North Carolina and Life Safety Codes do not permit mechanical or electronic restrictions that might make the locking system with the override switch more secure. See P. Br. at 25, citing Petitioner's Motion to Reopen at 11.[9] Liberty Commons argues that the proffered testimony would have contradicted the ALJ's findings that Liberty Commons' staff was on notice that "there was a flaw in its security system" and that "Petitioner did not change its door security system immediately despite knowing that Resident #2 was capable of defeating it." P. Br. at 24, quoting ALJ Decision at 6. The ALJ

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[8](...continued)
and to explain how it functioned as of the dates of the survey[.]" Ruling dated 11/21/05, at 1. The ALJ then provided Liberty Commons an opportunity to submit his testimony in writing. However, Liberty Commons did not submit any such testimony.

[9] Liberty Commons gave no indication that Mr. Warden would have testified that a squeal box constitutes a "mechanical or electronic restriction" on the "override" (deactivation) switch which was prohibited by North Carolina law or the Life Safety Code (and it is unlikely that he would have installed the squeal boxes had this been the case). As described in the existing record, a squeal box is not a restriction on the deactivation switch because the squeal box does not make the switch inaccessible but merely gives staff an audible warning if someone tampers with the box to access the switch. We note that since tampering with the squeal box does cause a sound audible to staff, Mr. Warden's proposed testimony (as described by Liberty Commons) that a squeal box might not deter tampering with the switch is immaterial.

found that the proffered testimony was not relevant to the issues in the case.

The ALJ did not err in excluding the proffered testimony. Mr. Warden's proffered testimony is not relevant for the reasons explained by the ALJ in his ruling denying the motion to reopen:

> I made no finding that there was a mechanical or electrical problem with Petitioner's door locking system. I found that the system was inadequate to protect one of Petitioner's residents - assuming even that it worked perfectly - because that resident discovered a way to defeat the system by flipping a deactivation switch. The flaw that I identified in Petitioner's system was a flaw in its *overall supervision* of the resident, which was manifestly inadequate, given that Petitioner knew that the resident had learned how to defeat the door locking mechanism.

Ruling dated 5/19/06, at 1-2 (emphasis in original). Since the ALJ did not find that Liberty Commons' door locking system was itself flawed, it was unnecessary for him to hear testimony concerning those matters.

A related procedural argument made by Liberty Commons on appeal is that the ALJ obviated its "right to offer evidence on disputed issues of fact" by requiring the written direct testimony of all witnesses and permitting no oral testimony except on cross-examination. According to Liberty Commons, this "problem" was "exacerbated" because CMS chose to cross-examine only one of the nine witnesses for whom Liberty Commons had submitted written direct testimony and chose not to cross-examine its Administrator, Jeanne Hutcheson. P. Br. at 3-4. Liberty Commons states that Ms. Hutcheson's written direct testimony described the "specific features of Petitioner's [alarm] system" but suggests that her testimony was inadequate in that it did not address all of the matters involving the alarm system that were identified in the proffer for Mr. Warden. Id. at 23. Liberty Commons further suggests that Ms. Hutcheson would have been able to testify to those matters had she been called for cross-examination at the in-person hearing. Since we agree with the ALJ that the matters proposed to be covered by in-person testimony from Mr. Warden and/or Ms. Hutcheson are irrelevant, Liberty Commons has not shown that it was prejudiced by the procedures allegedly followed by the ALJ. We therefore need not address in this case whether there are any circumstances under which such procedures might infringe on a provider's right to a hearing.

A final procedural issue raised by Liberty Commons is "whether the DAB's iteration of the parties' respective burdens of proof is consistent with the Administrative Procedure Act [APA] and due process of law." P. Br. at 42, n.18.[10] Liberty Commons takes the position that application of the burdens of proof "may be quite pertinent to the outcome" given what the ALJ accepted here as meeting CMS's burden of persuasion. Id. For the reasons discussed in section B. below, we conclude that the evidence in this case is not in equipoise. Thus, it is immaterial where the burden of persuasion lies. See, e.g., Fairfax Nursing Home v. U.S. Dep't of Health & Human Servs., 300 F.3d 835 (7th Cir. 2002), cert. denied, 537 U.S. 1111 (2003) (affirming Fairfax Nursing Home, DAB No. 1794 (2001)). In any event, we reject Liberty Commons' apparent contention that placing the ultimate burden of persuasion on the facility to show substantial compliance violates the APA because this standard was not promulgated pursuant to rulemaking procedures set forth in the APA. As the Board has previously stated, the burden of proof that the Board applies is not a rule under the APA but instead is in the nature of an order setting forth a rationale, based on the statute and regulations, that establishes precedent for ALJ hearings in these cases. See, e.g., Batavia Nursing and Convalescent Center, DAB No. 1904. Furthermore, while Hillman Rehabilitation Center, DAB No. 1611, was the first Board decision addressing burden of proof in cases to which the procedures at 42 C.F.R. Part 498 apply, the rationale in Hillman has not been treated as a binding rule but has been reexamined, in cases such as Batavia, and found appropriate to different types of cases.

B. Liberty Commons' substantive arguments have no merit.

A major theme in Liberty Commons' appeal is that there was no reason to penalize it for not doing more to protect Resident #2 because Resident #2 was never injured. It is well-established, however, that a showing of actual harm is not necessary to support a finding that a facility has failed to substantially comply with a participation requirement. A facility is not in substantial compliance if its acts or omissions either cause actual harm or create the potential for causing more than minimal harm. See, e.g., Livingston Care Center, DAB No. 1871 (2003); 42 C.F.R. § 488.301. As discussed below, Liberty Commons' failure to implement adequate methods of supervising Resident #2 after it learned that she eloped by using the deactivation switch on

[10] The ALJ Decision does not address this issue, which Liberty Commons says it "preserved" in its request for hearing and pre-hearing brief. P. Br. at 42, n.18.

September 19, 2004 certainly created the potential for more than minimal harm.

Liberty Commons appears to argue that there was no potential for more than minimal harm because Resident #2 "quickly was retrieved and suffered no injury" as a result of her elopements. P. Reply Br. at 13. According to Liberty Commons, this case is thus similar to Willow Creek Nursing Center, DAB CR1351 (2005), aff'd, DAB No. 2040 (2006), where ALJ Carolyn Hughes reversed CMS's determination that the facility failed to comply with section 483.25(h)(2), finding that a resident who repeatedly exited the facility "never departed the building undetected or unsupervised" and thus "never entered into harm's way." Willow Creek at 6. However, this case is clearly distinguishable from Willow Creek on its facts.

First, Resident #2's exits were undetected on September 19 and November 6 and were unsupervised on those dates as well as on November 7. The record shows, and Liberty Commons does not dispute, that facility staff became aware of Resident #2's exits from the facility on September 19 and November 6 only after she was outside the facility. See, e.g., CMS Ex. 1, at 6-7, 9-11; CMS Ex. 13, at 11-16. In addition, despite some conflicting evidence, substantial evidence in the record shows that, although staff detected Resident #2's exit from the front door when the Wanderguard alarm was triggered on November 7, the resident exited before staff arrived. Liberty Commons asserts in its appeal brief that on November 7, Resident #2 "promptly was retrieved before she exited[.]" P. Br. at 31. However, the only support for this assertion in the record - the statement in the written direct testimony of Liberty Commons' Assistant DON that on November 7, 2004, the resident "was retrieved before she could get outside" (P. Ex. 45, at 5) - is contradicted by other evidence offered by Liberty Commons, as well as by the survey report and the surveyor's declaration (CMS Ex. 1, at 11-12; CMS Ex. 13, at 16-17). Specifically, Liberty Commons' own incident report states that the resident "walked out front door" and that "the two visitors were bringing Res back in the door as nurses came to answer the alarm." P. Ex. 24, at 1. In addition, one of Liberty Commons' nurses, Diana Deitz, L.P.N., stated in her direct testimony that "the two visitors stopped her just outside the door . . . ." P. Ex. 47, at 2-3. The actions of visitors do not constitute supervision by facility staff.

Second, Liberty Commons has not disputed the ALJ's finding as to the hazards Resident #2 encountered outside the facility, which the ALJ stated included "the terrain surrounding Petitioner's facility, the elements, the hazards of walking unsupervised, and

exposure to motor vehicles." See ALJ Decision at 5, citing CMS Ex. 13, at 13-14. Thus, Resident #2 clearly entered into harm's way on September 19 since Liberty Commons points to no evidence that shows that Resident #2 was quickly retrieved when she exited the facility on that date. In addition, regardless of whether Resident #2 was quickly retrieved when she exited the facility on November 6, it is apparent from the written direct testimony of Ms. Deitz, who retrieved her, that it was simply fortuitous that Ms. Deitz became aware that the resident had eloped and retrieved her. P. Ex. 47, at 1-2.[11] Thus, there was certainly a potential for more than minimal harm to Resident #2 when she exited on that date.[12]

Accordingly, substantial evidence in the record here supports the ALJ's finding that the resident's elopements created a potential for more than minimal harm, unlike Willow Creek, in which substantial evidence supported a contrary finding.

Liberty Commons also argues that the ALJ made an error of fact in concluding that the facility failed to take action immediately after the September 19, 2004 incident to prevent Resident #2 from

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[11] Ms. Deitz alleged that she was in a resident room when she heard knocking at a nearby door at the end of the hallway, and that, upon investigation, she "found Resident #2 standing outside the door knocking to come back in." P. Ex. 47, at 2.

[12] The ALJ stated that "[t]he record is more or less silent as to the amount of time that the resident spent outdoors on the occasions when she eloped." ALJ Decision at 5, citing P. Exs. 19-24. This statement might not be entirely accurate with respect to the November 7 elopement. Despite the absence of specific times (which might be what the ALJ meant by "silent"), the evidence discussed in the text above indicates that Resident #2 had barely stepped outside before she was returned to the facility on November 7. With respect to the November 6 elopement, Ms. Deitz testified that Resident 2 "had been outside for only a matter of seconds." P. Ex. 47, at 2. However, this is mere speculation. The facts asserted by Ms. Deitz to support her conclusion do not show that anyone was even monitoring Resident #2's whereabouts closely enough to know when she left or how long she was outside. The ALJ's statement is entirely accurate with respect to the length of time the resident was outside the facility on September 19.

eloping.[13] According to Liberty Commons, the evidence shows that its staff "*did* act immediately to 'rectify the problem' by immediately placing paper and tape covers over the [deactivation] switches, which the staff thought would be effective to distract the Resident from tampering with the switches." P. Br. at 35 (emphasis in original); see also id. at 29-30 and P. Reply Br. at 15, 17, citing written direct testimony of Liberty Commons' Administrator (P. Ex. 43, at 7-8), DON (P. Ex. 44, at 4-6), and Assistant DON (P. Ex. 45, at 4-5).[14]

Contrary to what Liberty Commons asserts, the ALJ did not conclude that the facility took no action in response to the elopement on September 19, 2004. The ALJ specifically discussed various actions Liberty Commons alleged it had taken both before and after September 19 that were designed to protect residents, and specifically Resident #2, against elopement.[15] However, he concluded that these were not "reasonable and effective" actions after September 19, since Liberty Commons became aware on that date that Resident #2 was eloping by flipping the switch that deactivated the door locking mechanism. ALJ Decision at 6. It is apparent from the ALJ Decision that the ALJ found the protective actions alleged by Liberty Commons unreasonable and ineffective after that date because they did not adequately address Resident #2's ability to defeat the door security system.

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[13] Liberty Commons does not, however, dispute that it knew as of September 19 that Resident #2 had used the deactivation switch to elope.

[14] Ms. Hutcheson testified that "[a]fter it became clear following the September 19, 2004 incident that the Resident was using the override switches to open doors, I ordered that the switches be covered with paper and tape so that she could not see them." Similarly, DON Lineberry testified that based on information about how the resident had eloped on September 19, "we covered all of the override switches with paper and tape to deter Resident #2 from opening them." Finally, Assistant DON Bruner testified that "[w]hen it became clear that the Resident somehow had figured out how to use the override switch, we immediately . . . covered all of the switches with paper and tape so that she could not see them."

[15] It appears that the ALJ accepted these allegations as true for purposes of his decision (at least, he did not indicate otherwise).

> Petitioner did not change its door security system immediately despite knowing that Resident #2 was capable of defeating it. Nor did it give heightened supervision to the resident that was sufficient to assure that she would not elope while unobserved.

Id. The ALJ cited for these findings the surveyor's testimony that Resident #2's care plan was not modified after the September 19 elopement to require increased supervision or monitoring of the resident's whereabouts and evidence that Liberty Commons had not taken any meaningful steps to ensure that the resident did not continue to elope using the deactivation switches. Id., citing CMS Ex. 13, at 15. Liberty Commons does not dispute that it did not adopt a care plan specifically addressing elopement until November 17, 2004. Moreover, the only intervention Liberty Commons claims it implemented in direct response to the September 19 elopement was taping paper covers over the switches.

The ALJ did not specifically discuss Liberty Commons' allegations about taping paper over the deactivation switches. However, when discussing all of the actions Liberty Commons alleged having taken to protect against elopements, the ALJ cited the written direct testimony of Liberty Commons' witnesses addressing this action as well as the other actions. See ALJ Decision at 6. Accordingly, it appears that the ALJ was aware of this particular alleged action and took it into account when concluding with respect to all of the alleged actions:

> All of these actions were appropriate. But, they clearly were inadequate, individually and in sum, to protect the resident from a known risk. Petitioner's staff knew, by September 19, 2004, that Resident #2 could elope the premises without detection by flipping the deactivation switch that was located next to each exit door. Yet, Petitioner did not address that problem with a more secure system until November 16, 2004.

Id. at 7.

Even assuming that the ALJ was not aware of Liberty Commons' alleged action of taping paper over the deactivation switches in an attempt to divert Resident #2 from flipping them, that would not change the result here. As we discuss below, taping paper over the switches was not reasonable or effective. Thus, this alleged action does not undercut the ALJ's finding that Liberty

Commons took no "reasonable and effective" actions after discovering on September 19, 2004 that Resident #2 could defeat the door locking mechanism.

Resident #2's elopement risk stemmed from her ability to walk out the door undetected because she had learned how to flip the switch that deactivated the locking mechanism, an action that did not cause any alarm to sound to alert staff. Taping paper over the switches did not provide a means for alerting staff to any unobserved attempt by Resident #2 to flip the switch. We also note the absence of any evidence indicating that, prior to covering the switches with paper, Liberty Commons considered whether it was a reasonable or effective means of preventing Resident #2 from eloping again. The absence of such evidence is particularly noteworthy in light of Resident #2's demonstrated ability (her Alzheimer's notwithstanding) to locate the switches and figure out how to use them to override the locking mechanism. Since Resident #2 already knew where the switches were, merely covering them with paper would not necessarily "hide" them from her.

Liberty Commons argues that because Resident #2 did not elope again until November 6, 2004, taping paper over the deactivation switches must have been effective. However, there is no evidence that the gap between the September 19 and November 6 elopements can be attributed to this action by the facility. This was not the first time there was a time gap of more than a month between Resident #2's elopements (see ALJ Decision at 4), and there is no evidence that Resident #2 was actually diverted by the paper covers. On the contrary, the paper cover notwithstanding, a nurse observed Resident #2 tampering with a switch two hours before she eloped on November 7. P. Ex. 44, at 7. There also is no evidence of any system for assuring that the paper covers remained intact during this period or that they actually did remain intact. We note in this regard that the paper cover had been removed from the deactivation switch next to the door from which Resident #2 eloped on November 6. P. Ex. 44, at 6. The absence of evidence that the paper covers remained intact is particularly important since Liberty Commons had been aware since at least June 2004 that staff might be using the override switches rather than the keypads, when exiting. See P. Ex. 45, at 3, 5 (written direct testimony of Assistant DON that facility discovered after Resident #2's June 23, 2004 exit "that the key pad override switch had been turned off, and concluded that a staff member must have done so" and that after the September 19 exit, "[a]gain, the Administrator informed staff if they used the override switches, they could be terminated"); CMS Ex. 4 (7/28/04 notice to staff not to turn off override switch).

Liberty Commons argues further that the finding of noncompliance was not warranted since "there is no evidence whatsoever in the record that any additional or different interventions would have been any more effective in deterring the Resident's continuing elopement attempts than the interventions Petitioner actually did implement." P. Br. at 2. This argument has no merit. As discussed above, there is substantial evidence to support the ALJ's conclusion that the actions Liberty Commons alleges it took between September 19 and November 16-18 (when it installed the squeal boxes, provided in-service training on its elopement policy and its door security system, and began one-to-one supervision) were not effective interventions. This is sufficient to establish that Liberty Commons was not in substantial compliance with section 483.25(h)(2). CMS was not required to show, or the ALJ to find, that other interventions would have been more effective. In any event, Liberty Commons does not allege that there were no interventions it could have implemented earlier to prevent Resident #2 from eloping; instead, it merely questions whether its later success in preventing any further elopements (until the resident was discharged to another facility) was due to the installation of the squeal boxes or the one-to-one supervision. P. Br. at 38.

Liberty Commons also takes the position that it would be unreasonable to require that it ensure Resident #2's safety if the cost to do so "was objectively unreasonable" or "when restrictions designed to safeguard Resident #2 . . . impinged on other residents' rights," such as their "free use of the facilities[.]" P. Reply Br. at 8, n.7. In addition, Liberty Commons suggests that the failure of Resident #2's family to accept Liberty Commons' recommendation that she be moved to a more secure facility was relevant in determining the reasonableness of Liberty Commons' actions, contrary to the ALJ's finding that the family's wishes "did not relieve Petitioner from responsibility for protecting the resident so long as she resided on Petitioner's premises" (ALJ Decision at 8). Liberty Commons argues that under Crestview Parke Care Center v. Thompson, 373 F.3d 743 (6th Cir. 2003), "the question is whether, under the 'rule of reason' incorporated into the regulation, the facility provided appropriate supervision to its residents . . . ." P. Reply Br. at 3.

Liberty Commons' argument is based on a misreading of Crestview, however. After discussing the Board's conclusion in Woodstock (affirmed by the Sixth Circuit) that "an element of reasonableness is inherent in [section 483.25(h)(2)'s] requirements," 373 F.3d 743 at 754, the court in Crestview concluded that a reasonableness standard inheres in the general

quality of care requirement in section 483.25 as well. However, contrary to what Liberty Commons suggests, nothing in Crestview indicates that failure to provide care and services required by the regulation can be excused (or found "reasonable") based on alleged external constraints. Once a facility admits a person to its facility, it is obligated to provide care and services to that resident that comply with all federal requirements, including the quality of care requirement in section 483.25. Section 483.25 requires a facility to provide "the necessary care and services" for each resident "to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." As the Board stated in a recent decision, the word "practicable" in section 483.25 "refers to the resident's condition, not to the care and services that the facility must provide." Tri-County Extended Care Center, DAB No. 2060, at 5 (2007). Accord, Ridge Terrace, DAB No. 1834, at 8 (2002) (stating that the meaning of the general quality of care requirement in section 483.25 is "that a facility must provide care and services so that a resident attains the highest level of well-being the resident is capable of attaining, not that a facility is excused from providing such care and services if it is not 'practicable' to monitor its staff to ensure compliance"); Koester Pavilion, DAB No. 1750, at 34 (2000) ("The facility is not simply absolved of responsibility for providing the care needed . . . by the family's wish[es]"). The regulation contains no qualifiers related to cost, to the rights or needs of other residents, or to the wishes of the resident's family. In any event, Liberty Commons did not show that the cost of protecting Resident #2 was "objectively unreasonable" or that protecting Resident #2 would necessarily impinge on other residents' rights.

II. Substantial evidence supports the ALJ's conclusion that the CMP amounts were reasonable.

On appeal, Liberty Commons argues that the CMPs imposed here do not serve a remedial purpose. According to Liberty Commons, the Board has "noted many times that an ALJ must evaluate whether any proposed CMP actually has a 'remedial' purpose" and "has made clear that where such a 'remedial' purpose is absent, the CMP may take on the characteristics of an ultra vires, and therefore improper, penalty." P. Br. at 48, citing Emerald Oaks, DAB No. 1800 (2001) and CarePlex of Silver Spring, DAB No. 1683 (1999).

Contrary to what Liberty Commons suggests, the Board has never held that a CMP may not be imposed as a remedy for noncompliance unless CMS demonstrates that it serves a remedial purpose. The applicable regulations state that "[t]he purpose of remedies is

to ensure prompt compliance with program requirements." 42 C.F.R. § 488.402(a). By including CMPs among the remedies CMS may impose for noncompliance with federal requirements for skilled nursing facilities, the Department has already determined that CMPs serve a remedial purpose, and the Board is bound by that determination. If an ALJ or the Board finds that the amount of a CMP is not reasonable under the factors, they can change the amount. However, they cannot eliminate the CMP remedy or reduce the amount to zero. 42 C.F.R. § 488.438(e)(1); see also CarePlex at 16-17. In Emerald Oaks, the Board merely found that the ALJ had committed no error when she concluded that "the amount [of a CMP] imposed was within the reasonable range of amounts appropriate to achieving the remedial purposes of such sanctions." Emerald Oaks at 13 (emphasis added).

Liberty Commons also argues that no CMP is appropriate since "CMS has not recited, even by rote, that it ever considered the application of the regulatory factors" that CMS may take into account in determining the amount of the CMP. P. Br. at 49. Once again, Liberty Commons is confusing CMS's authority to impose a CMP in some amount whenever it finds noncompliance with participation requirements and CMS's obligations when determining the amount of the CMP. The factors pertain to the latter, not the former. Since the CMP amounts here were the minimum amounts, however, the regulatory factors are irrelevant.[16]

[16] In any event, the Board has previously stated that "[t]here is a presumption that CMS has considered the regulatory factors [in section 488.438(f)] in setting the amount of the CMP," and that CMS has a responsibility to produce evidence as to a particular factor only if the facility contends that the factor does not support the CMP amount. Harmony Court, DAB No. 1968, at 35 (2005), aff'd, Harmony Court v. Leavitt, No. 05-3644, 2006 WL 2188705 (6th Cir. Aug. 1, 2006), quoting Coquina Center, DAB No. 1860, at 32 (2002). Liberty Commons has not alleged that any factor or factors do not support the CMP amount.

Conclusion

Based on the above analysis, we sustain the ALJ Decision in its entirety and affirm FFCLs 1-3.

/s/
Judith A. Ballard

/s/
Leslie A. Sussan

/s/
Sheila Ann Hegy
Presiding Board Member