Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Pinecrest Nursing and Rehabilitation Center
Docket No. A-12-8
Decision No. 2446
March 20, 2012

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Pinecrest Nursing & Rehabilitation Center (Pinecrest), a Texas skilled nursing facility (SNF), appeals the August 17, 2011 decision by Administrative Law Judge (ALJ) Steven T. Kessel, *Pinecrest Nursing and Rehabilitation Center*, DAB CR2417 (2011) (ALJ Decision). The ALJ concluded that Pinecrest was noncompliant with Medicare participation requirements in 42 C.F.R. §§ 483.13(c), 483.25(h), and 483.75 from May 11, 2010 through June 1, 2010. The ALJ also upheld a finding by the Centers for Medicare & Medicaid Services (CMS) that Pinecrest's noncompliance was at the immediate jeopardy level from May 11 through May 14, 2010. Finally, the ALJ sustained civil money penalties (CMPs) imposed by CMS based on its determinations of noncompliance. We affirm the ALJ Decision.

Legal Background

In order to participate in Medicare, a SNF must comply with the participation requirements in 42 C.F.R. §§ 483.1-483.75. Compliance with these requirements is verified by nursing home surveys conducted by state health agencies. 42 C.F.R. Part 488, subpart E. Survey findings are reported in a document called a Statement of Deficiencies. *See, e.g.,* CMS Ex. 1. A "deficiency" is "any failure to meet a participation requirement." 42 C.F.R. § 488.301.

CMS may impose CMPs and other enforcement "remedies" on a SNF if CMS determines, on the basis of survey findings, that the SNF's deficiencies constitute lack of "substantial compliance" with one or more Medicare participation requirements. 42 C.F.R. §§ 488.400, 488.402(b), (c). The term "noncompliance" is defined in CMS's regulations to mean the condition of not being in substantial compliance. *Id.* § 488.301. A SNF is not in substantial compliance when it has a deficiency that creates the potential for more than minimal harm to one or more residents. *Id.* § 488.301 (defining "substantial compliance" to mean the "level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm").

In choosing an appropriate remedy for a SNF's noncompliance, CMS considers the "seriousness" of the noncompliance and may consider other factors specified in the regulations. 42 C.F.R. § 488.404(a), (c). "Seriousness" is a function of "severity" (whether the noncompliance has created a "potential" for "more than minimal" harm, resulted in "actual harm," or placed residents in "immediate jeopardy") and "scope" (whether the noncompliance is "isolated," constitutes a "pattern," or is "widespread"). *Id.* § 488.404(b); State Operations Manual (SOM), App. P – *Survey Protocol for Long Term Care Facilities,* sec. IV (available at http://www.cms.gov/Manuals/IOM/list.asp). "Immediate jeopardy" is the highest level of severity. *See* 42 C.F.R. §§ 488.404 (setting out the levels of severity and scope that CMS considers when selecting remedies) and 488.438(a) (authorizing the highest CMPs for immediate jeopardy-level noncompliance); 59 Fed. Reg. 56,116, 56,183 (Nov. 10, 1994) (scope-and-severity grid). When CMS imposes a per-day CMP for noncompliance at the immediate jeopardy level, as it did here, the CMP must be set within the "upper range" of $3,050 to $10,000 per day. 42 C.F.R. §§ 488.408(d)(3)(ii), 488.438(a)(1)(i).

A SNF may challenge a finding of noncompliance that has resulted in the imposition of a CMP or other enforcement remedy by requesting a hearing before an ALJ. *See* 42 C.F.R. §§ 488.408(g)(l), 498.3(b)(13), 498.5(b).

Case Background

On May 14, 2010, the Texas Department of Aging and Disability Services (state survey agency) completed a Medicare compliance survey of Pinecrest. CMS Ex. 1, at 1; CMS Ex. 12, at 2. Based on its investigation, which included a review of facility records and employee interviews, the state survey agency issued a Statement of Deficiencies (SOD) containing 23 separate citations of noncompliance, each identified with a unique survey F-tag number. *Id.*

The most serious deficiency citations concerned Pinecrest's care of three residents, identified here and in the SOD as Resident 14, Resident 8, and Resident 3. Residents 14 and 8, who had multiple physical or cognitive impairments, had a propensity to "elope" – leave the facility without supervision. CMS Ex. 1, at 7-15. The state survey agency found, and Pinecrest does not deny, that Resident 14 and Resident 8 eloped on April 1, 2010 and May 8, 2010 (respectively) and attempted to do so on other occasions. *Id.* at 7-18. Surveyors also found that Residents 14 and 3 engaged in physically or verbally abusive or disruptive behavior that posed a risk of harm to other residents. *Id.* at 79-88, 91-97. In evaluating how Pinecrest handled these problems, the surveyors found that its nursing staff failed to devise or implement resident care policies, and to take other necessary or adequate measures, to ensure that Residents 14, 8, and 3 were adequately supervised and did not harm themselves or other residents. *Id.* at 5-6, 26-28, 43-45, 78-79, 99-100, 155-157.

Based on its findings concerning the care of Residents 14, 8, and 3, the state survey agency cited Pinecrest (under the designated F-tags) for noncompliance with the following six requirements:

- ***42 C.F.R. § 483.13(c)***, which requires a SNF to "develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents" **(tags F224 and F226)**;

- ***42 C.F.R. § 483.13(c)(2)***, which requires a SNF to "ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, . . . are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency)" **(tag F225)** [1];

- ***42 C.F.R. § 483.25(f)(1)***, which requires a SNF to ensure that a resident who displays "mental or psychosocial adjustment difficulty" receives "appropriate treatment and services to address" that problem **(tag F319)**;

- ***42 C.F.R. § 483.25(h)***, which requires a SNF to ensure that each resident receives "adequate supervision" to prevent accidents **(tag F323)**; and

- ***42 C.F.R. § 483.75***, which requires a SNF to "use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident" **(tag F390).**

CMS Ex. 1, at 5, 26, 43, 78, 99, 155. The state survey agency determined that Pinecrest's noncompliance with each of these requirements was at the immediate jeopardy level beginning on May 11, 2010. *Id.* In addition, the state survey agency determined that Pinecrest did not abate the immediate jeopardy until May 15, 2010 and that Pinecrest remained noncompliant with Medicare requirements at a lower level of severity on and after May 15, 2010. *Id.* The state survey agency later determined, based on a revisit survey, that Pinecrest was back in substantial compliance with all Medicare participation requirements on June 2, 2010. *See* CMS Ex. 2, at 9-10.

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[1] Tag F225 also cited section 483.13(c)(1)(ii)-(iii), which prohibits a SNF from employing persons determined or found to have abused, neglected, or mistreated residents, and which requires the SNF to report to state authorities its knowledge of legal actions against any employee that would indicate the employee's unfitness to work in the facility. CMS Ex. 1, at 26. However, none of the factual allegations under tag F225 involves those subsections, and they were not germane to the ALJ Decision. *Id.* at 26-43.

CMS concurred with the state survey agency's noncompliance findings – including the finding that the noncompliance had placed residents in immediate jeopardy – and imposed the following CMPs on Pinecrest: $6,150 per day from May 11 through May 14, 2010; and $150 per day from May 15 through June 1, 2010. CMS Ex. 2, at 9-10.

Pinecrest then requested an ALJ hearing to challenge the imposition of the CMPs. The parties later submitted proposed documentary evidence and written direct testimony. Pinecrest submitted written testimony from two witnesses who were not its employees and who indicated that they were providing "expert" opinions: Joleann Beene, R.N., and C. Lynne Morgan, R.N. P. Exs. 1 and 2.

After the submission of evidence, Pinecrest made an unopposed request, which the ALJ granted, that the dispute be resolved based on the parties' documentary evidence, written direct testimony, and legal argument. Pinecrest's arguments to the ALJ were confined to the six immediate jeopardy-level citations mentioned above – tags F224, F225, F226, F319, F323, and F490.

ALJ Decision

As a preliminary matter, the ALJ found it "unnecessary" to adjudicate the merits of deficiency citations F225 and F319, stating that the survey findings he did address "amply support CMS's remedy determinations." ALJ Decision at 3. In addition, the ALJ did not discuss any of the evidence concerning Resident 3.[2]

The ALJ made the following findings of fact regarding Resident 14:

> Resident # 14 . . ., a relatively young individual, suffered from multiple problems that included: short and long-term memory loss and impaired decision making as a consequence of a brain injury; mood disturbances that were not easily altered; and frequent (at least daily) episodes of abusive, socially inappropriate, and disruptive behavior problems. The resident suffered from a lack of coordination. The resident was assessed by Petitioner's staff as being a high risk for elopement.

[2] Pinecrest does not contend that the ALJ erred in not discussing the evidence relating to Resident 3. Request for Review at 7. Nor does Pinecrest take issue with the ALJ's decision not to address the noncompliance findings under tags F225 and F319. The Board has held that an ALJ need not address noncompliance findings that are not material to the outcome of the appeal. *Plott Nursing Home*, DAB No. 2426, at 24 (2011); *see also Residence at Salem Woods*, DAB No. 2052, at 11 (2006) (stating that an ALJ "may . . . find the CMP amount to be reasonable based on fewer deficiencies than those upon which CMS relied to impose the penalty"). Pinecrest does not claim that a review of the findings under tags F225 and F319 is material to the outcome of this appeal.

> On April 1, 2010, Resident # 14 eloped Petitioner's premises. She disappeared from the facility, after being left during a smoking break without one-on-one supervision. She was absent from the facility for about an hour before returning. . . .

ALJ Decision at 5. Regarding Resident 8, the ALJ found:

> Resident # 8 was, at the time of the [May 2010] survey, an elderly individual who had been admitted to the facility about a month previously. Her impairments included Alzheimer's disease with dementia, anxiety, lack of coordination, and muscular wasting and disuse atrophy. The resident showed confusion as to time and place, and her cognitive skills and ability to make decisions were impaired. The resident was ambulatory but required support.
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> Almost from the moment of her arrival at the facility [on April 13, 2010], Resident # 8 was recognized to be a high risk for elopement. She exhibited wandering behavior and was determined to be aggressive and resistant to care. She was issued a Wanderguard bracelet on the orders of her physician.[3]
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> . . . On May 1, 2010, the resident walked through a facility fire door and was retrieved by facility staff. There is no evidence that the staff reviewed facility security measures in the wake of that attempt, nor is there evidence that the staff intensified supervision of Resident # 8. The resident made a second elopement attempt on May 4, 2010. Aside from entering a cryptic comment about the attempt in the resident's record, the staff made no documentation of this second attempt. . . . Nor did management or staff review the facility security measures or intensify supervision of the resident after this second elopement attempt.
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> On May 8, 2010, Resident # 8 walked through the same fire door, as she had escaped through on May 1, and eloped Petitioner's premises. Her Wanderguard sounded the alarm, but no staff member responded immediately. Only after the alarm had sounded for about a minute did a staff member respond to the alarm. By then, the resident had vanished. The staff could not find Resident # 8. After an absence of about 30-45

[3] A Wanderguard bracelet is designed to trigger an exit door alarm when the bracelet wearer approaches that door. ALJ Decision at 4.

> minutes, she was returned to the facility by an unidentified individual who found the resident walking along a road in a housing development about four tenths of a mile from the facility.

Id. at 4-5. According to the ALJ, the evidence relating to the April 1st elopement of Resident 14 and the May 8th elopement of Resident 8 revealed that Pinecrest had:

- "neglected the needs of its residents" by failing to "take necessary action to prevent" the elopements by Residents 14 and 8, whom it knew were prone to elope and had "actively sought" to do so;

- violated its own policy when it failed to investigate the elopements or attempted elopements by Residents 14 and 8 on April 1, May 1, May 4, and May 8, 2010;

- failed – in the wake of the attempted or successful elopements – to review or reassess existing security procedures and determine "[w]hat extra measures were needed to make as certain as possible that determined residents, like Resident #8 and Resident #14, could not breach the facility's security";

- failed to intensify – or to adequately intensify – the supervision of Residents 14 and 8 in response to the incidents on April 1, May 1, and May 4, 2010; and

- failed to report the April 1, May 1, and May 8 incidents to the "appropriate authorities" in accordance with facility policy.

Id. at 3-8. The ALJ characterized Pinecrest as "indifferent to the dangers of elopement and [its] potential consequences," stating that the facility's management and staff "were manifestly incurious as to the facility's security vulnerabilities and to the reasons why residents were able to elope successfully and stay away from the premises for relatively lengthy periods of time." *Id.* at 3-4.

Based on these findings, the ALJ concluded that as of May 11, 2010, Pinecrest was noncompliant with sections 483.13(c), 483.25(h), and 483.75. ALJ Decision at 3. He also sustained CMS's finding that Pinecrest's noncompliance had placed residents in immediate jeopardy from May 10 through May 14, 2010. *Id.* at 8. Finally, the ALJ upheld the CMPs imposed by CMS, concluding that the "seriousness of Petitioner's immediate jeopardy noncompliance amply supports" a $6,150 per-day CMP for the

period of immediate jeopardy identified by CMS, and noting that Pinecrest had not challenged the reasonableness of the $150 per-day CMP for the residual period of noncompliance (May 11 through June 1, 2010). *Id.* at 8-9.

Standard of Review

The Board's standard of review on a disputed finding of fact is whether the decision is supported by substantial evidence on the record as a whole. *Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs,* http://www.hhs.gov/dab/divisions/appellate/guidelines/index.html. The Board's standard of review on a disputed conclusion of law is whether the ALJ's decision is erroneous. *Id.*

Substantial evidence is "more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales,* 402 U.S. 389, 401 (1971), *quoting Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938). Under the substantial evidence standard, the reviewer must examine the record as a whole and take into account whatever in the record fairly detracts from the weight of the evidence relied on in the decision below. *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 488 (1951).

Discussion

In this appeal, Pinecrest challenges the ALJ's conclusion that it was noncompliant with sections 483.13(c), 483.25(h), and 483.75 at the immediate jeopardy level from May 11 through May 14, 2010.[4] *See* Request for Review (RR) at 3-9. Assuming that these noncompliance findings are upheld, Pinecrest maintains that a $6,150 per-day CMP for the period of immediate jeopardy is not reasonable.[5] RR at 9-10. We address these issues in the sections below.

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[4] Pinecrest does not contend that it abated the residents' immediate jeopardy any earlier than May 15, 2010, nor does it raise any issue concerning the residual period of noncompliance (May 15 through June 1, 2010). *See* Request for Review at 3, 7-9. As noted in the background, the May 2010 survey found that Pinecrest was noncompliant, at a level lower than immediate jeopardy, with multiple participation requirements in addition to the ones at issue in this appeal. Pinecrest did not challenge those other noncompliance findings before the ALJ, nor did it contend that it achieved substantial compliance with all requirements earlier than June 1, 2010. Accordingly, the ALJ's conclusion concerning the length of the immediate jeopardy period, and CMS's determination that Pinecrest's noncompliance continued at a level lower than immediate jeopardy through June 1, 2010, are final.

[5] The ALJ found that Pinecrest had not challenged the $150 per-day CMP as unreasonable, and Pinecrest takes no issue with that finding in this appeal. *See* RR at 3, 9.

1. *Substantial evidence supports the ALJ's conclusion that Pinecrest was noncompliant with 42 C.F.R. § 483.13(c).*

Section 483.13(c) states that a SNF "must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property." The term "neglect" is defined in CMS's regulations as a "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 42 C.F.R. § 488.301 (emphasis added). CMS's interpretive guidelines indicate that the policies and procedures required by section 483.13(c) have certain key elements, including "prevention" (a goal that requires timely assessment and care planning), "reporting" (which involves, among other things, analyzing problematic incidents "to determine what changes are needed, if any, to policies and procedures to prevent further occurrences"), and "investigation" (having procedures to investigate various types of incidents). *See* SOM, Appendix PP (guidelines for tag F226).

The Board has repeatedly held that "multiple or sufficient examples of neglect may support a reasonable inference that a facility has failed to develop or implement policies and procedures that prohibit neglect." *Dumas Nursing and Rehabilitation, L.P.*, DAB No. 2347, at 15 (2010). "The focus, thus, is not simply on the number or nature of the instances of neglect (i.e., failure to provide necessary care or services) but on whether the facts found by the ALJ surrounding such instance(s) demonstrate an underlying breakdown in the facility's implementation of the provisions of an anti-neglect policy." *Oceanside Nursing and Rehabilitation Center*, DAB No. 2382, at 11 (2011); *see also Columbus Nursing & Rehabilitation Center*, DAB No. 2247, at 27 (2009) (cited in *Oceanside* and holding that an issue under section 483.13(c) is "whether the circumstances presented, viewed as a whole, demonstrate a systemic problem in implementing policies and procedures" to prevent neglect).

The evidence concerning Pinecrest's care of Residents 14 and 8 adequately supports the ALJ's conclusion that Pinecrest was noncompliant with section 483.13(c). There is no dispute that those residents were, for various reasons, a danger to themselves (and to others) and needed services, including close supervision to prevent elopement, in order to protect them from physical harm. CMS Ex. 1, at 7, 15 (indicating that both residents were assessed to have cognitive and behavioral impairments and were "high" risks for elopement). CMS submitted evidence of three written policies designed to ensure that Residents 14 and 8 received those necessary services – in other words, to ensure that the residents were not neglected. The first policy, dated May 2005, is described in the SOD (neither party submitted a copy of the policy). CMS Ex. 1, at 22. The May 2005 policy defined neglect to mean any failure to provide a resident with services, treatment, or care that causes or may cause physical injury, harm, or death. *Id.* The policy required Pinecrest to investigate thoroughly all "violations" (that is, incidents involving neglect or

suspected neglect) and to report the results of any such investigation within five days to the facility's administrator and to other officials in accordance with state law. *Id.* at 22-23.

Pinecrest also had an "Elopement/Missing Residents" policy (dated November 2004), which called on Pinecrest "[t]o formulate an assessment of a resident's potential to elope from the facility and [to] have a plan in place to assure appropriate steps are taken to protect the resident from eloping." CMS Ex. 5, at 15. That policy also required "ALL facility staff" to respond "immediately" when a door alarm sounded by "[i]mmediately go[ing] to the [alarmed] door to determine how the alarm was activated and assess the situation[.]" *Id.* In addition, the policy instructed staff to complete an "Incident/Accident Report" for missing residents and to revise a resident's plan of care "as needed." *Id.* at 16.

Finally, Pinecrest had a December 1997 policy entitled "Behavior Management." CMS Ex. 4, at 17-18. In relevant part, that policy required the "social service" staff to "gather information" about any "problem behavior" exhibited by a resident including "details surrounding the onset of the behavior as well as historical information that may have bearing on the behavior." *Id.* at 17. To help Pinecrest evaluate and reduce or eliminate a problem behavior, the policy also required the nursing staff to have a "system" to monitor and report on the nature, frequency, and cause of, and measures taken by the staff in response to, the behavior. *Id.*

Pinecrest failed to implement one or more elements of each of these policies. We first consider the requirement in its May 2005 policy to investigate incidents of neglect or suspected neglect. As discussed in the next section, the April 1st and May 8th elopements resulted from inadequate supervision of Residents 14 and 8 by Pinecrest's nursing staff. Inadequate supervision plainly meets the definition of "neglect" in the May 2005 policy; it was a failure to provide services (namely, supervision) that caused or may have caused harm to the resident. *See Liberty Health & Rehab of Indianola, LLC,* DAB No. 2434, at 11-12 (2011) (upholding the ALJ's conclusion that the SNF was noncompliant with section 483.13(c) based on its failure to implement significant parts of its elopement prevention policy for multiple residents over multiple days). Because the elopements occurred under circumstances that would cause any reasonable person to question the adequacy of the nursing staff's supervision, Pinecrest was obligated by its May 2005 policy (and by section 483.25(h), as we discuss later) to investigate the April 1st and May 8th elopements thoroughly.

The state survey agency and the ALJ found – and Pinecrest does not dispute – that it failed to investigate those incidents thoroughly. *See* ALJ Decision at 3; CMS Ex. 1, at 14, 18. The only documentation of a post-incident investigation was an incident report for the May 8th elopement. CMS Ex. 5, at 13. This report contains only the barest of

details about what occurred, does not indicate that the employees involved had been interviewed, and does not reflect any inquiry about the factors that may have led to the apparent breakdown in supervision. *See also* CMS Ex. 1, at 18 (noting that Pinecrest furnished "no additional documentation or statements from any other residents or staff members"). Pinecrest's Director of Nursing admitted during the survey that she had not yet investigated the May 8th incident. *Id.* at 16. Neither she nor Pinecrest's administrator provided a reason for this omission other than stating that the May 8th elopement was "isolated." (Clearly, that incident was not isolated given that Resident 8 had attempted to elope on May 1st and May 4th.) Having failed to investigate the April 1 and May 8th incidents, Pinecrest was in no position to comply with its additional obligation under the May 2005 policy to report investigative findings to its administrator and to appropriate state authorities within five days.

The record also shows a failure to comply with the requirement in the Behavior Management policy that "social services" staff "gather information" about any "problem behavior." An attempted or successful elopement is obviously a problem behavior for a cognitively and physically impaired resident, such as Resident 8. Although Pinecrest submitted progress notes written by its social services staff, P. Ex. 18, none make any mention of Resident 8's attempted or successful elopements on May 1, May 4, or May 8, 2010. Nothing else in the record shows that the social services staff knew about or tracked those elopements. In addition, Pinecrest's nursing staff failed to comply with its obligation under the Behavior Management policy to monitor and evaluate Resident 8's problem behavior. Daily nursing notes contain only a brief entry concerning the May 1st elopement attempt. CMS Ex. 5, at 45. The entry contains no information about the conditions that might have led to the attempt; such information may have helped the staff understand and modify Resident 8's behavior, prevent future elopement attempts, and judge the effectiveness of its supervision. The same is true of the May 4th elopement attempt: the ALJ found, and Pinecrest does not dispute, that its staff "made no documentation" of the May 4th attempt other than a single "cryptic" entry in a daily nursing record. ALJ Decision at 4 (citing CMS Ex. 5, at 59).[6]

Finally, the record shows multiple failures by Pinecrest to comply with the Elopement/Missing Residents policy. The most conspicuous of these was that Pinecrest did not have a "plan in place to assure appropriate steps are taken to protect [Resident 8] from eloping." CMS Ex. 5, at 15 (emphasis added). Despite classifying Resident 8 as a high elopement risk, Pinecrest had no written plan of supervision for her on May 8, 2010, the date of her successful elopement. CMS Ex. 1, at 15. There is also no evidence that Pinecrest completed a timely "Incident/Accident" report concerning Resident 14's elopement on April 1st, as the policy required. *Id.* at 14. Finally, as we discuss in the

[6] The nursing note for 6:00 p.m. on May 4, 2010 states in full: "elopement attempt. cont. [with] 15 min." CMS Ex. 5, at 59.

next section, the record supports the ALJ's finding that Pinecrest's staff did not comply with the policy's instruction to respond "immediately" to the door alarm triggered by Resident 8 on May 8th.

In short, Pinecrest neglected two different residents within the space of five weeks by failing to supervise them adequately, and then by failing to inquire about, or take appropriate action in response to, the apparent lapses in supervision on April 1 and May 8, 2010. We agree with the ALJ that these (and other related) failures show that Pinecrest was inattentive to the safety of its residents, and these failures further demonstrate an "underlying breakdown in the facility's implementation" of policies and procedures to prevent resident neglect. *Oceanside* at 11.

2. *Substantial evidence supports the ALJ's conclusion that Pinecrest was noncompliant with 42 C.F.R. § 483.25(h)(2) .*

Section 483.25(h)(2) requires a SNF to "ensure" that each resident "receives adequate supervision and assistance devices to prevent accidents" (emphasis added). We have held that section 483.25(h)(2) "obligates the facility to provide supervision and assistance devices designed to meet the resident's assessed needs and to mitigate foreseeable risks of harm from accidents" and to "provide supervision and assistance devices that reduce known or foreseeable accident risks to the highest practicable degree, consistent with accepted standards of nursing practice." *Century Care of Crystal Coast,* DAB No. 2076, at 6-7 (2007) (citations omitted), *aff'd, Century Care of Crystal Coast* v. *Leavitt,* 281 F. App'x 180 (4th Cir. 2008); *see also* W*oodstock Care Ctr. v. Thompson*, 363 F.3d 583, 590 (6th Cir. 2003) (a SNF must take "all reasonable precautions against residents' accidents").

Substantial evidence supports the ALJ's finding that Pinecrest was noncompliant with section 483.25(h)(2). The elopements by Residents 14 and 8 on April 1 and May 8, 2010 reflect obvious breakdowns in supervision. Pinecrest does not dispute the surveyors' account of what happened on those days. The surveyors found that on the morning of April 1st, Resident 14 – whom Pinecrest had identified as a high risk for elopement in June 2009 and again in February 2010, and who during March 2010 had threatened to elope – walked out of the facility, followed by staff, after expressing a desire to buy a gun to protect herself and her belongings. CMS Ex. 1, at 7-9; *see also* CMS Ex. 13, at 3-4. Later that day, at 7:40 p.m., Resident 14 eloped through the back gate of Pinecrest's property even though she had been smoking outside in the presence of staff just minutes

before.[7] *See* CMS Ex. 1, at 9; *see also* CMS Ex. 13, at 3-4; P. Ex. 6, at 3. There is no evidence that prior to this event, Pinecrest had a plan for monitoring elopement-prone residents who went outdoors to smoke, or that the employees who were monitoring the smoking break on April 1st were aware that Resident 14 was an elopement risk. *See* CMS Ex. 6, at 31-32. The plan of care for Resident 14 that was in effect prior to her elopement (and dated August 1, 2009) did not instruct managers to notify employees that she was an elopement risk,[8] and there is no documentation that such notification was given prior to April 1st. *Id.* In addition, the pre-elopement plan of care did not indicate precisely how the staff planned to track Resident 14 (for example, visually or through the use of a door alarm system) to ensure that she did not attempt to leave the facility undetected. *Id.* at 32.

On May 8th, only five weeks after the incident involving Resident 14, Resident 8, who was then 79 years old, managed to elope despite having triggered the alarm on the door through which she exited, and despite the staff's knowledge of previous elopement attempts that began only days after her April 13, 2010 admission to the facility. CMS Ex. 1, at 14, 16. A private citizen found Resident 8 "walking on the road" in a nearby neighborhood and returned her to the facility. *Id.* at 17. Pinecrest's "corporate nurse" admitted to surveyors that on the date of Resident 8's elopement, which was more than three weeks after the nursing staff identified her as a high risk for elopement (*see* CMS Ex. 1, at 15), Pinecrest did not have a plan of care to minimize that risk.

In general, these facts and circumstances show that Pinecrest failed to have adequate plans of supervision for Residents 14 and 8 and, to the extent it did have such plans, failed to execute them or execute them effectively, allowing the residents to wander off the property totally unsupervised. Pinecrest compounded those failures by not investigating the elopements in order to pinpoint why the residents successfully circumvented the facility's security precautions and to reassess the adequacy of those precautions. For example, Pinecrest never sought to understand why its staff failed to prevent Resident 8's disappearance, given that the door alarm she triggered was supposed to prompt an "immediate" response from "all" employees. These are sufficient reasons to conclude that Pinecrest was noncompliant with its obligation under section 483.25(h)(2) to adequately supervise its elopement-prone residents. *St. Catherine's Care Center of*

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[7] The SOD recounted the April 1st elopement as follows: "On 4/1/10 at 7:40 p.m., Resident #14 was outside with staff during a smoke break and upon finding her cigarettes misplaced, the resident stood up and yelled that she was going to go to a store and buy some cigarettes. Resident #14 walked out the back gate. The staff member who was monitoring the smoke break called for another staff member to follow Resident #14. . . . [A]t 7:45 p.m. staff were unable to locate Resident #14 and the administrator was notified at 8:05 p.m." CMS Ex. 1, at 9-10.

[8] The record contains two written plans of care that address Resident 14's elopement risk. One is dated August 1, 2009, the second April 1, 2010. CMS Ex. 6, at 31-32. The April 1st plan called on staff to perform, among other things, 15-minute checks of Resident 14's whereabouts. *Id.* at 32. Other nursing records, and Pinecrest's own witnesses, indicate that 15-minute checks were instituted in response to Resident 14's April 1st elopement. P. Ex. 1, at 13; P. Ex. 2, at 4-5. Hence, it is apparent that the August 1, 2009 plan was the one in effect when Resident 14 eloped, and that the April 1, 2010 plan was adopted in response to that event.

Findlay, Inc., DAB No. 1964, at 13 n.9 (2005) (holding that a finding of noncompliance with section 483.25(h) is warranted if a facility identifies a risk of harm but fails to plan for it); *Owensboro Place and Rehabilitation Center,* DAB No. 2397, at 14-15 (2011) (holding that failure to investigate an elopement is, in itself, evidence of noncompliance with section 483.25(h)); *Residence at Kensington Place,* DAB No. 1963, at 9 (2005) (holding that if a SNF knows or has reason to know that its supervision is substantially ineffective, it must "determine the reasons for the ineffectiveness and . . . and consider – and, if practicable, implement – more effective measures").

The elopement by Resident 14 in the early evening of April 1st was entirely foreseeable, not only because the resident had been assessed to be at "high" risk for elopement, but because she had verbally expressed a desire to elope earlier that day. Yet, there is no evidence that before she was allowed outdoors to smoke, the nursing staff assessed its method or procedure for monitoring smoking breaks (assuming Pinecrest had one, and we see no evidence that it did) to determine whether it was adequate to prevent Resident 14 from leaving the grounds.

Pinecrest asserts that Resident 14 "outran" the staff, vaguely implying that the elopement was unpreventable for that reason. RR at 6. But there is no evidence that close and continuous visual monitoring of Resident 14 while she was outdoors could not have prevented her from "running" away. And there is no evidence that Resident 14 was, in fact, fleet of foot or that employees actually gave chase. According to a nursing note, an employee "went to follow [Resident 14] but found her to be gone." CMS Ex. 6, at 78-79. The note does not say why the staff failed to keep track of her, *id.*, but the words "found her to be gone" imply that the employees who were supposed to be monitoring the smoking break (and it is unclear how many employees were supposed to perform that function) simply took their eyes or attention off her long enough for her disappear from their view. One of Pinecrest's witnesses suggests that Resident 14 escaped because an employee became distracted with another resident. P. Ex. 2, at 4. If that is so, then one could reasonably infer that there were too few employees monitoring the smoking break.

Pinecrest also emphasizes that it instituted 15-minute checks of Resident 14 immediately after her elopement. RR at 6. However, instituting that measure did not change the fact that Resident 14 received inadequate supervision on April 1st or prove that reasonable measures could not have prevented the elopement. Moreover, 15-minute checks "failed to get at the root of the problem," as the ALJ found. ALJ Decision at 7. That problem was how to monitor effectively an elopement-prone resident who was allowed outdoors near an unlocked gate through which she could easily escape. Checking on Resident 14 every 15 minutes would not have prevented her from walking out the gate in between those checks.

Concerning Resident 8, Pinecrest does not deny that her elopement might well have been prevented with better supervision or a more effective response to the door alarm she triggered. Pinecrest's Elopement/Missing Residents policy required all staff to respond "immediately" to a door alarm by "[i]mmediately go[ing] to the [alarmed] door to determine how the alarm was activated and assess the situation[.]" CMS Ex. 5, at 15. The ALJ found that staff did not respond "immediately" to the door alarm on May 8th. ALJ Decision at 6. Pinecrest contends that this finding is not supported by substantial evidence. RR at 6. We disagree. According to the SOD, "LVN G," a vocational nurse, told surveyors that she did not respond to the alarm for about one minute because she thought another employee on the hall would check the exit door. CMS Ex. 1, at 17. Pinecrest concedes that LVN G's response was not immediate but alleges that LVN G was transferring another resident when the alarm sounded. RR at 6. However, we could find no evidence for that assertion. According to the SOD, LVN G told the surveyors that she was feeding another resident when the alarm sounded. CMS Ex. 1, at 17.

Pinecrest also contends that another nurse, LVN X, did respond immediately and cites the words "less than one minute" in notes of this nurse's survey interview. RR at 6 (citing CMS Ex. 8, at 5). Those notes, while somewhat difficult to read, indicate that the words "less than one minute," in context, describe the amount of time LVN X took to search the outside of the building because they state that she "went to left toward front parking lot to scan (took less than 1 min)." CMS Ex. 8, at 5.

Even if LVN X's response had been immediate, that fact would be insufficient to prove that Pinecrest complied with its Elopement/Missing Resident policy. The policy required an immediate response from all staff, implying that a prompt search by multiple employees was necessary (given the size of the facility, the number of exit doors, and other factors) to ensure that a resident bent on eloping was located quickly, before leaving the facility's property. Joleann Beene, R.N., one of Pinecrest's witnesses, testified that "[n]o staff failed to respond or failed to respond promptly." The ALJ gave no weight to that testimony (ALJ Decision at 6 n.5), and we see no reason to disturb that finding. Nurse Beene did not point to any nursing records (and we see none) to support her statement, and, as the ALJ noted, she had no personal knowledge of the May 8th incident (she was not a Pinecrest employee). Pinecrest did not submit the testimony of any employee (much less one who had knowledge of the incident), and we see nothing in the nursing records or the survey interview notes indicating that any Pinecrest employee reacted properly to the door alarm. Moreover, it is reasonable to infer that the nursing staff's collective response to the alarm was not immediate – or, at minimum, was ineffective – from the undisputed fact that Resident 8 had already left Pinecrest's property (despite her advanced age and physical infirmity) by the time staff went outside to look for her. For all these reasons, the evidence concerning LVN X's reaction to the door alarm does not materially detract from the ALJ's finding that Pinecrest's staff did not respond immediately to the door alarm.

Finally, Pinecrest contends that the ALJ erred in finding it noncompliant with section 483.25(h)(2) because he "disregarded the significant and repeated steps [it took] to mitigate Resident #14['s] and Resident #8's elopement risk before and after the incidents at issue." Reply Br. at 5 (emphasis in original). This contention is unpersuasive. The issue here is not whether Pinecrest took some steps to mitigate elopement but whether the steps it took were "adequate" – that is, sufficient to meet the residents' assessed needs and reduce risks of accidental harm to the "highest practicable degree." *Century Care of Crystal Coast; Northeastern Ohio Alzheimer's Research Center*, DAB No. 1935, at 9 (2004). Pinecrest's supervision of Residents 14 and 8 was plainly inadequate. Despite its awareness that these residents posed high risks of elopement and needed close supervision, Pinecrest did not (as discussed):

- properly monitor Resident 14 while she was outdoors smoking (or have a plan for doing so prior to her elopement);

- respond effectively to a door alarm triggered by Resident 8;

- have a plan of care to deal with Resident 8's elopement risk;

- investigate why its supervision of Residents 14 and 8 failed on April 1 and May 8, 2010; or

- reassess the adequacy of its procedure for responding to door alarms or conduct additional training on that subject.

Because the April 1st and May 8th elopements, and the circumstances surrounding them, demonstrate that Pinecrest did not adequately supervise its residents to prevent accidents, we affirm the ALJ's conclusion that Pinecreast was not in substantial compliance with section 483.25(h).

3. *Substantial evidence supports the ALJ's conclusion that Pinecrest was noncompliant with 42 C.F.R. § 483.75.*

Section 483.75 states in its prefatory paragraph that a SNF "must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident." In appropriate circumstances, a finding that a SNF was noncompliant with section 483.75

may be derived from findings of noncompliance with other participation requirements. *Stone County Nursing and Rehabilitation Center*, DAB No. 2276, at 15-16 (2009).

The record contains substantial evidence of ineffective administration. CMS submitted evidence that although Pinecrest identified Resident 8 on April 13, 2010 as a high risk for elopement, and she made repeated attempts to elope, its nursing staff did not develop a plan of care to mitigate that risk prior to her elopement more than three weeks later on May 8, 2010. CMS Ex. 1, at 165-66. Pinecrest did not explain why its nursing supervisors or Resident 8's interdisciplinary care team failed to notice or rectify that omission prior to May 8th. In addition, there is no evidence that supervisors took other measures (in lieu of writing a plan of care) to notify nurses and nurse aides about the elopement risk posed by Resident 8 and how to reduce that risk. *See* CMS Ex. 12 (Aff. of Surveyor Evelyn Meredith, L.B.S.W.), at 3-4 (stating that Pinecrest's Administrator and Director of Nursing failed to develop adequate methods to prevent the elopements by Residents 14 and 8). At minimum, these facts suggest ineffective oversight and communication by the employees in charge of administering the delivery of nursing care to Pinecrest's residents.

Additional evidence of ineffective administration is Pinecrest's inexplicable failure to investigate the supervisory failures that occurred on April 1 and May 8, 2010. Adequate investigations would likely have pinpointed the factors that contributed to those failures. Without such information, Pinecrest's managers could not effectively deploy personnel, training, or other resources to ensure that elopements did not recur.

Finally, the evidence relating to Pinecrest's noncompliance with section 483.13(c) supports an inference that Pinecrest's managers – who were ultimately responsible for quality of care and residents' safety– were not carrying out their critical administrative responsibility to ensure that staff followed policies and procedures designed to promote resident well-being. *See Illinois Knights Templar*, DAB No. 2369, at 14 (2011) (upholding a finding of noncompliance with section 483.75 based on multiple failures to comply with a SNF's anti-neglect policy and with parallel requirements in section 483.13(c)).

4. *CMS's immediate jeopardy findings are not clearly erroneous.*

"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. Actual harm is not a prerequisite for an immediate jeopardy finding; immediate jeopardy may exist when the noncompliance is "likely to cause" serious injury, harm, impairment, or death. 42 C.F.R. § 488.301; *Life Care Center of Tullahoma,* DAB No. 2304, at 58 (2010), *aff'd,*

Life Care Center of Tullahoma v. Sebelius, No. 10-3465 (6th Cir. Dec. 16, 2011), *available at* http://www.ca6.uscourts.gov/opinions.pdf/11a0852n-06.pdf.

CMS's immediate jeopardy finding "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2); *Maysville Nursing & Rehabilitation Facility,* DAB No. 2317, at 11 (2010). "The 'clearly erroneous' standard . . . is highly deferential and places a heavy burden on the facility to upset CMS's finding regarding the level of noncompliance." *Yakima Valley School*, DAB No. 2422, at 8 (2011) (citing cases).

Here, the ALJ concluded that CMS's immediate jeopardy finding was not clearly erroneous for the following reasons:

> . . . [T]he likelihood that either [Resident 8 or Resident 14] would suffer harm from her elopement was very high. As I have discussed, Resident # 8 and Resident # 14 each suffers from physical and mental impairments that put them at great risk if let out in the community unsupervised.
>
> Moreover, Petitioner conceded the likely harm that would result from either of these residents eloping, when it designated these residents as elopement risks. In doing so, the staff concluded that these residents were *not* safe or trustworthy if unsupervised. That is the whole point of designating a resident as an elopement risk and of subjecting the resident to special security measures, such as putting a Wanderguard on that resident.

ALJ Decision at 8.

We find no fault with this reasoning. Pinecrest's noncompliance, particularly the unexplained lapses in supervision on April 1 and May 8, 2010, allowed Residents 8 and 14 to wander off its property unsupervised. (Pinecrest does not deny a causal link between its noncompliance and the residents' elopements.) Once beyond the facility's (relatively) safe confines – and the record indicates that Residents 14 and 8 both walked on or alongside public roads – their documented cognitive, physical, and behavioral deficits made them vulnerable to serious accidental harm from vehicles, uneven terrain, and other persons. *See* CMS Ex. 1, at 7, 8, 12, 14 (describing Resident 14's impaired decision-making, socially disruptive or abusive behavior, and diagnoses of anxiety and psychosis, and further stating that Pinecrest faced a four-lane highway with a posted speed of 45 miles per hour, and that Resident 14 walked to a nearby six-lane highway with a posted speed limit of 50 miles per hour); *id.* at 14-15 (indicating that Resident 8 had senile dementia and impaired decision-making, that she was confused and disoriented at times, and that she was also prone to socially inappropriate or abusive behavior).

Pinecrest's social worker told surveyors that Resident 14's elopement was quite serious given her "sporadic threatening behaviors." CMS Ex. 1, at 12. Those behaviors, it is reasonable to assume, had the potential to provoke a harmful response by someone on the receiving end of them. Resident 8, on the other hand, appeared to be especially vulnerable to injury from physical hazards. In addition to her dementia, periodic confusion and disorientation, and other cognitive deficits, she lacked "coordination," had diagnoses of "muscular wasting" and "disuse atrophy," and was unsteady on her feet (according to a nursing assessment). CMS Ex. 1, at 14-15; CMS Ex. 5, at 7 ("Test for Balance"), 20 (indicating that her problem conditions included "unsteady gait"), and 37 (listing "diagnoses"). With all these impairments, she wandered four-tenths of a mile along a narrow two-lane road that, according to a surveyor's notes, had a 30 mile-per-hour speed limit and no sidewalks, and was bordered by ditches and woods. CMS Ex. 6, at 22. Pinecrest does not dispute these facts. Resident 8 was found and returned to the facility by an obviously well-intentioned stranger (whom the facility did not even interview), but that was merely fortuitious.

In view of the hazards encountered by Residents 14 and 8 outside Pinecrest's property and their cognitive or physical impairments, the ALJ did not err in concluding that CMS's immediate jeopardy finding was not clearly erroneous. *See, e.g., Liberty Health & Rehab of Indianola* at 13-14 (upholding an immediate jeopardy finding in light of various gaps in the SNF's supervision and building security and the fact that an elopement-prone resident with dementia and poor safety awareness "faced immediate serious danger if he or she ventured to the highway fronting the facility"); *Azalea Court*, DAB No. 2352, at 16-18 (2010) (upholding an immediate jeopardy finding concerning a resident with Alzheimer's disease, delirium, and visual problems found wandering alone on a four-lane highway, and citing other Board decisions "upholding determinations of immediate jeopardy in cases of mentally or physically compromised residents who made their way to public roads").

Pinecrest lodges several unpersuasive objections to the immediate jeopardy finding, relying on Appendix Q of the State Operations Manual (SOM).[9] Appendix Q "provide[s] a detailed analysis of the steps surveyors should follow to assist them in accurately identifying those circumstances which constitute Immediate Jeopardy[.]" SOM, App. Q, Preamble. Surveyors are instructed to be alert for immediate jeopardy "triggers," which are "circumstances that may have the potential to be identified as Immediate Jeopardy situations and therefore require further investigation before any determination is made." *Id.* Assuming a trigger is present, then Appendix Q instructs surveyors to evaluate the information gathered by the survey to address what the appendix identifies as the "three components of Immediate Jeopardy": (1) "harm" (is there actual, or a potential for,

[9] Appendix Q, entitled "Guidelines for Determining Immediate Jeopardy," is available at https://cms.gov/manuals/Downloads/som107apqimmedjeopardy.pdf.

"serious" harm?); (2) "immediacy" (is resident harm "likely to occur in the very near future" if immediate action is not taken?); and (3) "culpability." *Id.* § V.(C). Pinecrest suggests that CMS and the ALJ erred by not "address[ing] whether there was sufficient evidence to support" the presence of each component. *Id.*; Reply Br. at 6; *see also* RR at 8 (asserting that the ALJ upheld the immediate jeopardy finding "based on pure speculation" and not substantial evidence).

As the previous paragraph shows, Appendix Q's purpose is to guide surveyors in applying a regulatory standard, not to define that standard. The immediate jeopardy standard is defined by regulation in 42 C.F.R. § 488.301, and the regulatory definition, not the SOM instructions, binds the Board. *Agape Rehabilitation of Rock Hill*, DAB No. 2411, at 19 (2011) (holding that Appendix Q, while "instructive" on the issue of immediate jeopardy, "is not controlling authority"); *see also Foxwood Springs Living Center*, DAB No. 2294, at 9 (2009) ("While the SOM may reflect CMS's interpretations of the applicable statutes and regulations, the SOM provisions are not substantive rules themselves.").

Even if Appendix Q's "three components" had the force and effect of a regulation (which they do not), Pinecrest did not demonstrate that any component was lacking in this case. For example, Appendix Q instructs surveyors to assess "immediacy," that is, whether harm is "likely to occur in the very near future . . . if immediate action is not taken."[10] SOM, App. Q, § V.(C). Petitioner does not explain how or why the evidence it cites tends to show that the threat of harm was not immediate, and the circumstances strongly indicate that it was. Outside the facility's property, the residents were entirely unsupervised; the threat of serious, accidental harm arose – became "immediate" – the moment they left the supervision that Pinecrest's assessments said they needed to avoid such harm. The fact that both residents returned safely is merely fortuitous; it does not obviate the very real threat that existed while they were outside the facility's protection.

Moreover, Pinecrest's suggestion that CMS or the ALJ erred by failing to identify sufficient evidence of each component is at odds with Pinecrest's evidentiary burden under the applicable standard of review. Under the clearly erroneous standard, CMS's determination of immediate jeopardy is presumed to be supported. *Columbus Nursing and Rehabilitation Center*, DAB No. 2398, at 8 (2011) (holding that when an ALJ upholds a determination of noncompliance based on facts asserted by CMS, "CMS's determination that those facts give rise to immediate jeopardy is 'presumed to be correct'" (citation omitted)). To overcome this presumption, Pinecrest had the burden to demonstrate that immediate jeopardy did not exist. Thus, the Board has held that the harm or threatened harm caused by the noncompliance is presumed to be serious, and the

[10] In *Agape Rehabilitation of Rock Hill*, while discussing why the SOM is not binding, the Board noted that the term "immediacy" does not appear in the applicable regulations and that those regulations also do not define the term "likelihood" or "set[ ] any parameters as to the timing of potential harm." DAB No. 2411, at 19.

facility "has the burden to rebut the presumption with evidence and argument showing that the harm or threatened harm did not meet any reasonable definition of 'serious.'" *Daughters of Miriam Center*, DAB No. 2067, at 9 (2007).

Pinecrest contends that the "evidence clearly provides that it was not likely or probable that Residents #14 or #8 would experience serious harm, injury or death." RR at 8. However, Pinecrest does not say what facts support that contention. It merely cites the affidavits of its two witnesses, Joleann Beene, R.N. and C. Lynne Morgan, R.N. However, their professional opinions are either unsupported or fail to account for critical facts. For example, Nurse Beene asserted that when Resident 14 eloped on April 1, 2010, she was "coherent and oriented to person, place, time and date" and that "[s]he was capable of assessing danger and had the capacity to protect herself." P. Ex. 1, at 13. Nurse Beene did not point to clinical or other evidence supporting those assertions, however. She also did not support her statement that Resident 8 was not likely to experience harm while outside the facility. *Id.* at 14.

Nurse Morgan, meanwhile, stated that there "were no circumstances that placed [Resident 14's] health, safety or welfare at risk" while she was outside the facility because "[s]he had no medications due," there was "no extreme weather," and she "was also capable of assessing potential danger as evidenced by her interview with surveyors where she described assessing the danger posed by crossing the highway." P. Ex. 2, at 4. This opinion takes no account of Resident 14's well-documented behavior problems or the nursing assessments of her cognitive functioning. *See, e.g.,* CMS Ex. 6, at 4 (items B4 and B5), 72, 88. Also, we do not agree with Nurse Morgan that Resident 14's survey interview showed that she was able to keep herself safe. According to the SOD,

> Resident #14 stated the road in front of the facility, at the traffic light had a continuous right turn lane, leading on to the six lane highway. She said cars in the continuous right turn lane did not stop, not even for the lights, so she stepped out into the right turn lane, with her knees slightly bent, both arms extended in front of her with her palms up, causing traffic to stop. She said she crossed the highway, across the six lanes of traffic.

CMS Ex. 1, at 13. In the first place, the reliability of this statement is questionable given Resident 14's mental impairments. But even if the statement is reliable, stepping into a turn lane in which drivers do not obey a traffic light, then walking across six lanes of traffic (without an indication that the crossing was aided by a traffic light), is hardly evidence that Resident 14 had good judgment and safety awareness. On the contrary, it supports the nursing staff's own assessment that Resident 14's judgment or decision-making was moderately impaired (meaning that her decisions were "poor"). CMS Ex. 6, at 4 (item B4).

While the line between a "likelihood" of harm, and the mere "possibility" of or "potential" for that outcome, may be difficult to discern in a particular case (*Daughters of Miriam Center* at 10), the Board has emphasized repeatedly that CMS's survey, certification, and enforcement regulations contemplate that "distinctions between different levels of noncompliance . . . do not represent mathematical judgments for which there are clear or objectively measured boundaries." 59 Fed. Reg. at 56,179. "This inherent imprecision is precisely why CMS's immediate jeopardy determination, a matter of professional judgment and expertise, is entitled to deference" and ought not be overturned absent a persuasive contrary showing, which Pinecrest has not made in this proceeding. *Daughters of Miriam Center* at 15.

Finally, Petitioner contends that there is no evidence of its culpability. Although culpability is a factor in setting or reviewing the reasonableness of a CMP, as we address in the next section, it is not a part of the regulatory definition of immediate jeopardy. *See* 42 C.F.R. § 488.301; *North Carolina State Veterans Nursing Home, Salisbury,* DAB No. 2256, at 17 (2009). We also conclude in the next section that there is ample evidence of Petitioner's culpability for the noncompliance.

5. *The ALJ's conclusion that a $6,150 per-day CMP for the period of immediate jeopardy is reasonable is supported by substantial evidence and free of legal error.*

When appealing a finding of noncompliance, a SNF may contend that the amount of the CMP imposed for that noncompliance is unreasonable. *See, e.g., Lutheran Home at Trinity Oaks*, DAB No. 2111, at 21 (2007); *Capitol Hill Community Rehabilitation and Specialty Care Center*, DAB No. 1629, at 5 (1997). CMS imposed a $6,150 per-day CMP for the period of Pinecrest's immediate jeopardy-level noncompliance, and a $150 per-day CMP for the period of noncompliance following abatement of the immediate jeopardy. On appeal to the Board, Pinecrest challenges only the reasonableness of the CMP for the period of immediate jeopardy.

An ALJ (or the Board) determines de novo whether a CMP is reasonable based on facts and evidence in the appeal record concerning the factors specified in section 488.438. *See* 42 C.F.R. § 488.438(e), (f); *Senior Rehabilitation and Skilled Nursing Center*, DAB No. 2300, at 19-20 (2010); *Lakeridge Villa Healthcare Center*, DAB No. 2396, at 14 (2011). Those factors are: (1) the SNF's history of noncompliance; (2) the SNF's financial condition – that is, its ability to pay a CMP; (3) the severity and scope of the noncompliance, and "the relationship of the one deficiency to other deficiencies resulting in noncompliance"; and (4) the SNF's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. 42 C.F.R. §§ 488.438(f), 488.404(b), (c)(1). With respect to the culpability factor, however, "[t]he absence of culpability is not a mitigating circumstance in reducing the amount of the penalty." *Id.*

§ 488.438(f)(4). Once an ALJ has determined that CMS had a valid legal basis (namely, the existence of noncompliance) to impose a CMP, the ALJ (or the Board on appeal) may not reduce that CMP to zero or below the regulatory minimum amount. *Id.* § 488.438(e)(1); *Somerset Nursing & Rehabilitation Facility*, DAB No. 2353, at 26-27 (2010).

The ALJ concluded that the $6,150 per-day CMP for the period of immediate jeopardy was reasonable. The ALJ recited the regulatory factors discussed above but based his conclusion primarily on the third regulatory factor, stating that "[t]he seriousness of the noncompliance is more than sufficient to justify the penalty amount." ALJ Decision at 9. The ALJ explained:

> Petitioner's noncompliance transcends its failure to protect Residents #s 8 and 14. The failure by Petitioner's management and staff to recognize that there were serious problems with Petitioner's security system, their failure to investigate the nature of the problems, their failure to notify appropriate authorities, and, above all else, their failure to develop ways to better protect the residents put not only Residents #s 8 and 14 at risk, but all residents of Petitioner's facility who were at risk of elopement.

Id. The ALJ also noted, correctly, that $6,150 per day "f[e]ll at about the midpoint of the immediate jeopardy range." *Id.*

Pinecrest does not challenge, or even mention, the ALJ's finding regarding the seriousness of its deficiencies or make any specific argument that the amount itself is unreasonable based on that factor. Moreover, CMS determined (and the record shows) that Pinecrest's care of elopement-prone residents showed a "pattern" of noncompliance.[11] We agree with the ALJ that the noncompliance's seriousness justified a CMP above the regulatory minimum of $3,050 per day.

Pinecrest contends that CMS and the ALJ failed to consider, or present evidence of, the facility's history of noncompliance or its financial condition, that CMS's citation of six separate immediate-jeopardy-level deficiencies was "redundant" and "resulted in an inaccurate perception of the relationship of cited deficiencies," and, with respect to culpability, that CMS and the ALJ did not consider "actions taken by Petitioner with regard to the incidents in question prior to surveyors entering the facility for the survey." RR at 9. These arguments illustrate a misunderstanding of the burden of proof regarding

[11] A deficiency's scope "is a pattern when more than a very limited number of residents are affected, and/or more than a very limited number of staff are involved, and/or the situation has occurred in several locations, and/or the same resident(s) have been affected by repeated occurrences of the same deficient practice." SOM, App. P – *Survey Protocol for Long Term Care Facilities*, sec. IV.C.

the factors. The Board has repeatedly held that in a proceeding to challenge CMS's determination of noncompliance and imposition of a CMP, an ALJ or the Board properly presumes that CMS considered the regulatory factors and that those factors support the amount imposed. *Elgin Nursing and Rehabilitation Center,* DAB No. 2425, at 12 (2011); *Coquina Center*, DAB No. 1860, at 32 (2002). Hence, "the burden is not on CMS to present evidence bearing on each regulatory factor" – or to explain its decision-making process and how it weighed each regulatory factor (though CMS is not prohibited from doing so if it wishes) – "but on the SNF to demonstrate, through argument and the submission of evidence addressing the regulatory factors, that a reduction is necessary to make the CMP amount reasonable." [12] *Oaks of Mid City Nursing and Rehabilitation Center*, DAB No. 2375, at 26-27 (2011).

Pinecrest made no significant effort to show that the regulatory factors, either individually or collectively, warranted a reduction in the CMP chosen by CMS. Pinecrest presented no evidence about its compliance history or any argument as to why that history would support a lower CMP amount. It simply states that "the erroneous citation of deficiencies results in an inaccurate statement of the facility's compliance history." RR at 9. The "history" factor does not address noncompliance findings on the surveys on which the CMP is based but, rather, prior surveys. In any event, we have already rejected Pinecrest's arguments that the citations on the survey at issue here were erroneous.

As for Pinecrest's financial condition, the ALJ stated that CMS "was under no obligation to prove a negative [that is, CMS] . . . does not have to offer proof that a facility is financially capable of paying a civil money penalty." ALJ Decision at 9. This statement is legally correct, as shown by our discussion of the burden of proof above. *See Azalea Court* at 23 (no error for ALJ to not consider financial condition when facility put on no evidence on that issue – "The ALJ properly considered all of the factors on which he had evidence."). If Pinecrest was not financially able to pay a CMP of $6,150 per day, it needed to put on evidence to that effect for the ALJ to consider, but it did not do so.

There is no merit to Pinecrest's statement that citing the deficiencies under three different regulations was "redundant" and "resulted in an inaccurate perception of the relationship of cited deficiencies." RR at 9. Each citation charged Pinecrest with violating a different Medicare participation requirement. CMS may, in its discretion, charge a facility with violating any number of applicable requirements based on a given set of circumstances. *See Brian Center Health and Rehabilitation/Goldsboro*, DAB No. 2336, at 6 (2010). The presence of multiple immediate-jeopardy-level deficiencies is a reasonable basis for setting a CMP higher than the applicable regulatory minimum of $3,050 per day. *Cf. Van Duyn Home and Hospital*, DAB No. 2368, at 23 (2011) ("Generally, we would expect to

[12] Although CMS is not required to explain how it considered the regulatory factors, CMS's June 7, 2010 notice of noncompliance (attached to Pinecrest's July 23, 2010 request for hearing) explicitly states that CMS did consider the factors when determining the CMP amounts.

see multiple regulatory factors contributing to the imposition of a CMP of nearly $10,000 per day."); *Barbourville Nursing Home*, DAB No. 1962, at 20 (2005) (holding that it was "not . . . unreasonable to impose a CMP of $4,050 per day based on the existence of two immediate jeopardy deficiencies, regardless of their scope"), *aff'd, Barbourville Nursing Home v. U.S. Dept. of Health and Human Servs.*, 174 F. App'x 932 (6th Cir. 2006). On the other hand, we find in the record before us no basis to reject the ALJ's conclusion that Pinecrest's "noncompliance was sufficiently egregious that I would have sustained the penalty amount even if Petitioner had manifested only one of the three immediate jeopardy level deficiencies that I find in this decision." ALJ Decision at 8. Thus, even if we had found a legal basis for Pinecrest's argument that the citation of noncompliance under three regulations was redundant (which we did not), we would have upheld the $6,150 per-day CMP.

Finally, there is no merit to Pinecrest's argument that CMS or the ALJ erred by not considering whether the alleged (but unspecified) actions Pinecrest took after the elopements, but before the survey, affected its "degree of culpability." RR at 9. Actions Pinecrest may have taken after the elopements do not excuse its culpability for the noncompliance found based on the circumstances surrounding those elopements. Moreover, Pinecrest's noncompliance was based in important part on its inaction (e.g., failure to investigate) after the elopement. Culpability is defined as including, but not limited to, "neglect, indifference, or disregard for resident care, comfort or safety." 42 C.F.R. § 488.438(f)(4). We have upheld the ALJ's conclusion that Pinecrest in several respects failed to implement policies to prevent resident neglect. We agree with the ALJ that that failure, and the other noncompliance discussed in this decision, reveal an organization "indifferent to the dangers of elopement and the potential consequences to the facility's residents' health and safety." ALJ Decision at 4. Accordingly, there is ample evidence of Pinecrest's culpability and thus no basis to reduce the CMP based on that factor.

For all of these reasons, we affirm the ALJ's conclusion that the $6,150 per-day CMP is reasonable.

Conclusion

The ALJ Decision is affirmed in its entirety.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Sheila Ann Hegy
Presiding Board Member