Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: July 28, 2008
Kenton Healthcare, LLC,	
Petitioner,	Civil Remedies CR1666 App. Div. Docket No. A-08-27
- v. -	Decision No. 2186
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Kenton Healthcare, LLC, (Kenton or Petitioner) appeals the September 28, 2007, decision of Administrative Law Judge (ALJ) Carolyn Cozad Hughes. Kenton Healthcare, LLC, CR1666 (2007) (ALJ Decision).

Following an evidentiary hearing and post-hearing briefing, the ALJ sustained the determination by the Centers for Medicare & Medicaid Services (CMS) that from September 15, 2005 through May 12, 2006, Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h)(2), one of the federal requirements governing the participation of long-term care facilities in the Medicare and Medicaid programs. That regulation requires that such facilities "ensure that . . . [e]ach resident receives adequate supervision and assistance devices to prevent accidents." This requirement is part of the quality of care regulation at 42 C.F.R. § 483.25 that requires facilities to 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."

The ALJ sustained CMS's determination of noncompliance with 42 C.F.R. § 483.25(h)(2) based on Kenton's failure to provide

adequate supervision for ten residents assessed as being at risk for wandering and/or elopement, putting these residents at risk of accidents. Some of these residents, the ALJ found, managed to exit undetected a locked "secure" unit and in some cases, the facility itself. Residents who left the facility were found in places such as the facility parking lot and, in one case, at a shopping center down the street from the facility. Some of the residents exited their "secure" unit and/or the facility more than once. The ALJ further sustained CMS's determination that Kenton's noncompliance posed immediate jeopardy to resident health and safety and its decision to impose a civil monetary penalty (CMP) of $4,050 per day for the period of noncompliance, an amount that the ALJ found reasonable under the applicable regulatory factors.

On appeal, Kenton argues that the ALJ's findings that it was not in substantial compliance with 42 C.F.R. § 483.25 for a period of 240 days and that its noncompliance for that entire period constituted immediate jeopardy are not supported by substantial evidence. Kenton also makes various legal arguments and argues that the total CMP amount is excessive. Kenton further argues that the ALJ was biased against Kenton and committed procedural error by declining to issue a subpoena for one of Kenton's witnesses who did not appear at the hearing.

For the reasons discussed below, we reject Kenton's arguments and affirm the ALJ's conclusions that Kenton was not in substantial compliance with the participation requirement at 42 C.F.R. § 483.25(h)(2) during the stated period and that CMS's finding of immediate jeopardy with respect to Kenton's noncompliance with that requirement was not clearly erroneous. We also affirm the ALJ's determination that $4,050 per day is a reasonable CMP amount for the immediate jeopardy period. We specifically conclude that the ALJ's findings of fact and conclusions of law are supported by substantial evidence and free of legal error, and find no procedural error.

Applicable Legal Provisions

Long-term care facilities participating in the Medicare and Medicaid programs are subject to the survey and enforcement procedures set out in 42 C.F.R. Part 488, subpart E, to determine if they are in substantial compliance with applicable program requirements which appear at 42 C.F.R. Part 483, subpart B. "Substantial compliance" means a level of compliance such that "any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. "Noncompliance," in turn, is defined as

"any deficiency that causes a facility to not be in substantial compliance." Id.

A long-term care facility found not to be in substantial compliance is subject to various enforcement remedies, including per-day CMPs. 42 C.F.R. §§ 488.402(c), 488.408. For noncompliance determined to pose immediate jeopardy, CMS may impose per-day CMPs that range from $3,050 - $10,000 per day. The regulations set out a number of factors that CMS considers in determining the amount of a CMP. 42 C.F.R. § 488.438(f).

"Immediate jeopardy" is defined as "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination that a deficiency constitutes immediate jeopardy is a determination of the level of noncompliance which "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2); Woodstock Care Center, DAB No. 1726, at 9 (2000), aff'd, Woodstock Care Ctr. v. Thompson, 363 F.3d 583 (6th Cir. 2003). The provider bears the burden of proving that CMS's immediate jeopardy determination is clearly erroneous. E.g., Liberty Commons Nursing & Rehab Center – Johnston, DAB No. 2031 at 18-19 (2006), aff'd, Liberty Commons Nursing & Rehab Ctr. – Johnston v. Leavitt, 241 Fed. Appx. 76 (4th Cir. 2007).

Numerous Board decisions have explained the requirements of 42 C.F.R. § 483.25(h)(2). See, e.g., Liberty Commons Nursing and Rehab - Alamance, DAB No. 2070, at 3 (2007), aff'd, Liberty Commons Nursing and Rehab Ctr. - Alamance v. Leavitt, No. 07-1329, 2008 WL 2787675 (4th Cir. July 18, 2008), citing Golden Age Skilled Nursing & Rehabilitation Center, DAB No. 2026 (2006); Woodstock Care Center. Although section 483.25(h)(2) does not make a facility strictly liable for accidents that occur, it does require that the facility take all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents. Woodstock, 363 F.3d at 589-90 (a facility must take "all reasonable precautions against residents' accidents"). "Facilities have the 'flexibility to choose the methods of supervision' to prevent accidents so long as the methods chosen are adequate in light of the resident's needs and ability to protect himself or herself from a risk." Liberty Commons Nursing and Rehab - Alamance at 3, citing Golden Age at 11 and Woodstock, 363 F.3d at 590.

Standard of Review

Our standard of review on a disputed conclusion of law is whether ths ALJ decision is erroneous. Our standard of review on a disputed finding of fact is whether the ALJ decision is supported by substantial evidence on the record as a whole. Guidelines - Appellate Review of Decisions of Administrative Law Judges Affecting A Provider's Participation In the Medicare and Medicaid Programs, http://www.hhs.gov/dab/guidelines/prov.html; Batavia Nursing and Convalescent Inn, DAB No. 1911, at 7 (2004), aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson, 143 Fed.Appx. 664 (6th Cir. 2005). The Board reviews alleged procedural errors (including an abuse of discretion under the law or applicable regulations) to determine if they existed and, if so, whether they were prejudicial. Guidelines; see, e.g., Royal Manor, DAB No. 1990 (2005); Spring Meadows Health Care Center, DAB No. 1966 (2005).

Case Background and the ALJ Decision

The Kentucky Cabinet for Health Services (State agency) conducted an annual survey of Kenton's nursing facility, located in Lexington, Kentucky, during the period of late April through May 2, 2006. Based on the survey, the State determined, and CMS agreed, that Kenton was not in substantial compliance with 20 federal requirements for participation and that its noncompliance with one of those requirements, 42 C.F.R. § 483.25(h)(2), posed immediate jeopardy to resident health and safety beginning on September 15, 2005. ALJ Decision at 2-4. CMS subsequently determined that the immediate jeopardy was abated on May 13, 2006 and that the facility achieved substantial compliance with all requirements of participation on May 18, 2006. Id. at 4, citing CMS Ex. 23, at 6, 8.

Kenton filed a timely hearing request challenging CMS's findings of noncompliance with respect to only one requirement, CMS's determination that Kenton was not in substantial compliance with 42 C.F.R. § 483.25(h)(2) at the immediate jeopardy level for the period September 15, 2005 through May 12, 2006, for which CMS imposed a CMP of $4,050 per day.[1] ALJ Decision at 2-4.

[1] The ALJ correctly concluded that CMS's findings of noncompliance with the additional requirements were final and binding, and Kenton does not appeal that conclusion. ALJ Decision at 4, citing 42 C.F.R. § 498.20(b). Similarly, Kenton has not challenged CMS's findings of noncompliance at less than the immediate jeopardy level for the period May 13 through May 17, 2006 or the $500 per day CMP imposed for that noncompliance.

(continued...)

The ALJ held a hearing on April 25, 2007. After post-hearing briefing, the ALJ issued a decision containing the following findings of fact and conclusions of law (FFCLs), each of which Kenton challenges on appeal:

> A. From September 15, 2005, through May 12, 2006, the facility was not in substantial compliance with the program participation requirement set forth at 42 C.F.R. § 483.25(h)(2).
>
> B. The facility's deficiencies posed immediate jeopardy to resident health and safety.
>
> C. I find reasonable the imposition of a $4050 per day CMP.

For the reasons stated below, we find that these FFCLs are supported by substantial evidence on the record as a whole and free of legal error.

Analysis

A. The ALJ's finding that Petitioner was not in substantial compliance with the federal participation requirement at 42 C.F.R. § 483.25(h)(2) from September 15, 2005, through May 12, 2006 is supported by substantial evidence and free from legal error.

In finding noncompliance with 42 C.F.R. § 483.25(h)(2), CMS relied on the Statement of Deficiencies (SOD), which cited Kenton's failure to provide adequate supervision to 12 residents. CMS Ex. 1, at 109-34. The ALJ discussed and upheld the findings of noncompliance with respect to ten of those residents.[2] We have reviewed and uphold the ALJ's findings with respect to all 10 residents but limit our discussion to five of them: Resident 11, Resident 17, Resident 3, Resident 53 and Resident 26. To uphold the ALJ's finding of noncompliance with the regulation, it is not necessary to discuss the ALJ's findings for the remaining residents. See Hotel Reed Nursing Center, DAB No. 2154 (2008) (discussing four residents but finding that the failure to provide adequate supervision to even one was of sufficient scope and severity to support the ALJ's finding of noncompliance with 42 C.F.R. §483.25(h)(2)); Ridge Terrace, DAB No. 1834, at 6

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[1](...continued)
Accordingly, those findings are final and binding as well.

[2] The ALJ's decision does not discuss or make findings with respect to the other two residents.

(2002)("[E]ven one isolated instance of non-compliance having a potential for more than minimal harm may be the basis for a finding that the petitioner is not substantially complying with the applicable participation requirement.") Furthermore, the ALJ Decision contains a thorough discussion of the salient facts for each resident (which are undisputed in any material respect) as well as careful citation to evidence in the record. The evidence cited by the ALJ, and the record as a whole, supports her findings that Kenton failed to provide each of the ten residents with the supervision required for the facility to be found in substantial compliance with 42 C.F.R. § 483.25(h)(2).

Resident 11

There is no dispute that on April 4, 2006, Resident 11 left Kenton undetected, using her walker, and was later found at a shopping center down the street from the facility and across a cross-street. ALJ Decision at 18, citing P. Ex. 7, at 33 (note by Director of Nursing); see also P. Ex. 28, at 3 (facility document entitled "Elopement Timeline").[3] It is also undisputed that Resident 11, who was admitted to the facility on August 20, 2005 at the age of 87, had Alzheimer's disease, dementia and severe cognitive impairments, was legally blind in one eye and walked with an unsteady gait, using a cane or walker. Resident 11 also had a history of falls prior to admission, and Kenton assessed her as needing assistance with ambulation and transfers due to her fall risk, which was related to her dementia, decreased mobility and psychotropic medications. ALJ Decision at 16, citing P. Ex. 7, at 191, 202, 253. Kenton did not place Resident 11 in a secure unit.

The parties argued below about whether Kenton should have known that Resident 11 was at risk for elopement, with the ALJ noting that the record contained inconsistent assessments on that issue. Id. at 19 (citations omitted). A November 2005 care plan identifies the resident as at risk for both wandering and elopement due to Alzheimer's and confusion. P. Ex. 7, at 195. In its appeal brief, Kenton acknowledges that care plan but also cites an elopement risk assessment in February 2006 indicating wandering but no elopement risk. Petitioner's Appeal Brief (P. Br.) at 13. Kenton also cites staff statements that while the

[3] The ALJ noted that Kenton's records were vague as to how the resident was found but also noted that Kenton had not disputed the account on the SOD that an off-duty staff member spotted her when driving by the shopping center. Kenton also does not dispute this on appeal. Moreover, the circumstances regarding the resident's recovery, as the ALJ found, are not critical to the decision of this case.

resident wandered, she did not attempt to leave the facility. Id. As the ALJ noted, however, these staff statements also indicate that Resident 11 paced the hallways and wandered into other units. See ALJ Decision at 18, citing P. Ex. 26, at 3, 5, 6.

Moreover, the resident's care plan identified Resident 11 as at risk for falls and needing a "one person assist with ambulation." Id. at 19, citing P. Ex. 7, at 191, 202. The ALJ also found that staff should have been aware of the resident's vulnerability while walking based on falls the resident suffered in August 2005 and March 2006: on the first occasion, she fell while getting up without assistance during the night; on the second, she fell when struck by another resident's motorized wheelchair.[4] We agree with the ALJ that in light of this evidence, staff was on notice that Resident 11 required close supervision while ambulating and that had she received this supervision, she should not have been able to leave the building and walk down a busy street (and across another street) to a shopping center undetected by staff, regardless of whether staff knew she was at risk for elopement as well as falls. See ALJ Decision at 19. That Resident 11 was able to elope is substantial evidence that staff were not providing the one-person assist with ambulation and supervision for wandering required by her care plan.

We also agree with the ALJ that the fact that Resident 11 was not injured during her elopement is irrelevant. Neither a finding of noncompliance nor a finding of immediate jeopardy requires a showing of actual harm. 42 C.F.R. § 488.301 (definitions of substantial compliance and immediate jeopardy). As the ALJ concluded, given the undisputed dangerous course traversed by the resident during her time outdoors, the fact that she was found uninjured is fortunate but cannot be attributed to any action by Kenton. ALJ Decision at 19.

Kenton asserts that it made "immediate responses" to the resident's elopement by checking all doors for proper functioning, increasing monitoring of Resident 11 (who continued to wander and tried to leave the unit several times, apparently

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[4] Kenton argues on appeal that the ALJ should not have cited evidence of falls by this and other residents since the falls were not noted in the SOD under this deficiency and CMS did not cite them as evidence; however, we find no error. The ALJ did not cite this evidence to support a deficiency not found by CMS but, rather, to show the facility's awareness that this resident needed supervision while ambulating in order to prevent accidents. The fall evidence is relevant to the supervision deficiency in this respect.

unsuccessfully), classifying her as high risk for elopement and providing her with a green armband. P. Br. at 13. Even assuming this is true, Kenton's reassessments of Resident 11 and its adoption of interventions directed at preventing future elopements would not alter the fact that Kenton did not provide adequate supervision to the resident prior to her April 4 elopement under very dangerous circumstances. The ALJ concluded that the failure of supervision involving Resident 11, by itself, would justify a finding of noncompliance with the regulation, and we agree. Id.

Resident 17

Kenton admitted Resident 17 on September 6, 2005, noting that she had Alzheimer's disease, dementia, depression, arthritis (among other illnesses) and walked with a cane. ALJ Decision at 9, citing P. Ex. 6, at 1-3. On appeal to the Board, Kenton agrees that Resident 17 was at risk for elopement due to repeated requests to leave the facility and was assigned to the Magnolia Unit. P. Br. at 9.[5] According to Kenton, the Magnolia Unit was a "secure" unit, with locked doors and coded keypads, that was intended to accommodate up to 30 residents with diagnoses of Alzheimer's disease or other types of dementia or who otherwise needed to be housed in a secure unit. Id. at 7, citing P. Ex. 37, at 5-6. A care plan developed upon admission identified wandering as among the resident's problem behaviors, and set goals of minimizing problem behaviors and reducing the risk of injury to the resident and others through approaches including one-to-one visits, observing and re-directing the resident as needed, providing diversional activities, observing for interventions that worked, and providing medications. Id. at 10, citing P. Ex. 6, at 179-180.

The ALJ found that Resident 17 exited the facility undetected on two occasions, September 15 and 23, 2005. On September 15, a staff member reported that the resident was walking with her cane outside the facility. ALJ Decision at 11, citing P. Ex. 6, at 5 (nurse's note). The ALJ found that the staff responsible for the resident's care were unaware of her departure before the resident was found outside, and the record did not disclose how long she had been gone. Id. Kenton characterizes this incident a bit

[5] The Care Plan pages cited by Kenton for the elopement risk appear to be dated after the elopements. P. Ex. 6, at 171, 175. However, as indicated above, and as the ALJ noted, the resident was assessed for wandering at the time of admission, and the facility Administrator testified that the resident was at risk for elopement. ALJ Decision at 10, citing CMS Ex. 3, at 37; P. Ex. 37, at 8 (Larmour Decl. at ¶ 20A).

differently, asserting that the resident "unsuccessfully attempted to leave the Facility premises by following a visitor out the side door of the Magnolia Unit" but "was observed within a few minutes by a nurse aide who immediately brought the resident back into the Unit." P. Br. at 9. We note at the outset that this assertion is not a denial that the resident was not observed at the time she left the building (which would be belied by the nurse's note in any event), only an assertion that she did not leave Kenton's property. (We also note that both September exits appear on Kenton's "Elopement Timeline.") Moreover, there was nothing to stop residents who managed to exit to the parking lot without detection from leaving the facility's property, since the parking lot was not fully enclosed or gated, and the fence around the facility, as the surveyor testified, did not completely enclose the facility grounds and had gaps large enough for a person to walk through. CMS Ex. 27, at 3-4 (Willhite Decl. at ¶ 8); Tr. at 21-23; see also P. Ex. 25 (DVD video of facility); P. Br. at 6-7 (reporting that a "privacy hedge" enclosed "the remaining length" of the property where there was no fence). Additionally, we agree with the ALJ that Kenton presented no evidentiary support for its factual assertions about this incident. ALJ Decision at 11, citing P. Ex. 37, at 9.

In its appeal to the Board, Kenton does not deny that Resident 17 exited the building undetected on September 23. The SOD recounts, based on the surveyor's interviews, that a staff member driving into the facility parking lot encountered the resident walking toward the car and notified facility staff who then retrieved the resident, as she was attempting to get into an ambulance. ALJ Decision at 12, citing CMS Ex. 1, at 114. Kenton states that on September 23, Resident 17 "succeeded in exiting the side door of the Magnolia Unit by following a visitor out the door" and was "**immediately** retrieved by the Facility staff nurse in the Facility's parking lot . . . ." P. Br. at 10 (emphasis in original). Later Kenton asserts, seemingly inconsistently, that the resident was alone for "approximately two minutes" and was retrieved "almost immediately." Id. at 12 (emphasis added).

The ALJ found, and we agree, that there is little or no support in the record for the facts asserted by Kenton as to how Resident 17 exited on September 23 and how long she was gone. The ALJ correctly noted, with one exception, that the ten employee statements cited by Administrator Larmour in support of her view of this incident do not address Resident 17, but address wandering, elopement or exit-seeking behavior by other residents. The one exception is the statement by "Juan Varela" that the ALJ said she could not find in the record. The Varela statement is in the record. See P. Ex. 27, at 61. However, we find no basis

for according significant weight to it. The statement is hearsay, having been taken by another employee over the phone on May 24, 2006, approximately six months after the elopement, apparently in preparation for informal dispute resolution with the State agency, since it was part of Kenton's submission for that process. A hearsay statement is admissible in these proceedings and may constitute substantial evidence if it has appropriate indicia of reliability. Florence Park Care Center, DAB No. 1931, at 10 (2004), citing Richardson v. Perales, 402 U.S. 389, 402 (1971). However, we find no indicia here that would require giving greater weight to Mr. Varela's statement than to the statement to the surveyor by the nurse who found Resident 17 and notified staff. In addition to being non-contemporaneous and not signed or attested to by Mr. Varela and having been made in the course of litigation, the statement does not allege that Mr. Varela witnessed Resident 17's departure or subsequent discovery and does not indicate the basis for his knowledge of the facts averred. In any event, Mr. Varela's statement does not undercut the critical facts stated on the SOD, that Resident 17 did exit the facility and was found, after some time interval, in the parking lot.

Moreover, like the ALJ, we note that if Kenton sought to directly challenge the account of Resident 17's September 23 exit that appears on the SOD, it could have produced a statement by the nurse who found Resident 17 in the parking lot or a contemporaneous investigation report. It produced neither. We also note, as did the ALJ, the Administrator's apparent confusion about this incident since nine out of the ten statements she cites address wandering, elopement or exit-seeking behaviors by other residents, not Resident 17. Kenton also did not cross-examine the surveyor about the account in the SOD of Resident 17's departure when the surveyor testified at the hearing. Thus, the Varela statement notwithstanding, substantial evidence in the record supports the ALJ's acceptance of the SOD's account of Resident 17's September 23 exit.[6]

In any event, the ALJ cited other instances of failure to adequately supervise Resident 17. She found that Resident 17 managed to exit the Magnolia Unit on October 16, 2005 and was

[6] Kenton repeats here its assertion before the ALJ that Resident 17 simply stepped out onto the porch for a breath of fresh air. P. Br. at 8. However, the ALJ found that this assertion, which relies on the Administrator's declaration, was based on a physician's statement that actually referred to Resident 3, not Resident 17. ALJ Decision at 12-13, citing P. Ex. 34, at 3. On appeal, Kenton does not dispute or address this analysis.

found in "the dish room in dietary." ALJ Decision at 14. Kenton does not address that incident on appeal. The ALJ also found that on April 20, 2006, the resident followed a visitor out of the locked unit; this event was witnessed by a surveyor and conceded by the administrator.[7] ALJ Decision at 15; P. Ex. 37, at 9 (Larmour Decl. at ¶ 20A.i); CMS Ex. 1, at 115; CMS Ex. 3, at 4. In addition, Resident 17 displayed other exit-seeking behaviors, attempting to follow staff out of the unit on March 31, 2006 and to get out the door on April 2, 2006. ALJ Decision at 15.

The ALJ also found that Kenton did not consider changes to Resident 17's care plan or its implementation in response to the resident's departures and attempted departures from the unit; did not identify the risk of elopement as a problem in the resident's care plan prior to April 27, 2006 (approximately seven months after her September elopements); failed through March 2006 to enter earlier care plan information on wandering interventions into the resident's "CNA Care Plan" and "SRNA Plan of Care," which the facility created to assist nurses aides in caring for residents; did not include Resident 17 in the "elopement book" that the facility intended to contain pictures and elopement histories of at-risk residents so that staff would be able to identify them; and provided no evidence that Resident 17's departures were adequately investigated. Id. at 7-8, 10-12, 12-16. The ALJ also found that the facility did not begin performing the 15-minute safety checks ordered after the resident's departure on September 15 until after the resident left a second time on September 23. Id. at 11-12, citing P. Ex. 37, at 9 (Larmour Decl. ¶ 20Ai) and P. Ex. 6, at 9-14, 131 et seq. The ALJ also rejected Kenton's claim that it had responded properly to the September 15 departure by permanently locking the door through which Kenton asserted the resident had exited. The ALJ found instead that Kenton had not provided evidence that the door was the problem or had been locked, other than the Administrator's declaration, which the ALJ considered "questionable," apparently because the Administrator "repeatedly confuse[d] Resident 17 with the other residents, which supports CMS's assertion that she was not familiar with Resident 17's elopement history." Id. at 13.

Kenton argues that no further changes in the resident's care plan were necessary since it had permanently locked the side door and discontinued using that door as an exit for staff and visitors,

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[7] The SOD discloses that by this time Resident 17 resided in the special care unit, another locked unit for "high risk" residents. CMS Ex. 1, at 115; ALJ Decision at 7.

again citing the Administrator's declaration. P. Br. at 12, citing P. Ex. 37, at 10. However, as noted above, the ALJ gave valid reasons for not according much weight to Administrator Larmour's testimony on this issue. Accordingly, we will not disturb the ALJ's determination. See Lutheran Home at Trinity Oaks, DAB No. 2111, at 22-25 (2007) (ALJ gave valid, sufficient reasons for the weight she assigned to particular pieces of evidence, including the testimony of witnesses, some of whom provided written testimony and did not appear in person). We also note that while Kenton's "Elopement Timeline" says that Resident 17 was found on September 15 at the side of the building and on September 23 at the rear of the building, Petitioner Exhibit 28, at 3, the record is not clear as to what doorway or doorways she went through to get to those locations.

Even assuming there was clear evidence that Resident 17 left the facility through the side door on either or both occasions, we agree with the ALJ that it is not clear that merely locking the door, without additional interventions, would provide sufficient supervision to someone with Resident 17's demonstrated risk for elopement and persistent exit-seeking behavior. Even assuming the side door was the only exit directly to the outside from the Magnolia Unit, a resident in that unit could get outside by leaving the Magnolia Unit unsupervised and going to another part of the facility where there was an exit to the outside. In this regard, it is important to note that during the time in question the facility did not have an electronic monitoring system with the potential to lock a door and alert staff when a resident tried to exit. The ALJ correctly noted that CMS had not suggested that the absence of such a system establishes noncompliance, ALJ Decision at 7, and we are not suggesting that it does. As the Board has indicated, a facility is free to choose its methods of supervision so long as the methods a facility chooses are "adequate [to prevent accidents] in light of the resident's needs and ability to protect himself or herself from a risk." Liberty Commons Nursing and Rehab - Alamance at 3, citing Golden Age at 11 and Woodstock, 363 F.3d at 590. Thus, Kenton was free to choose a secure unit system rather than the electronic system it transitioned to after the survey, but Kenton was required to anticipate, and remove to the extent possible, the risks posed by the secure unit system to wandering or elopement prone residents who managed to exit the secure unit unsupervised or were not placed in the secure unit (like Resident 11).

In addition, as the ALJ also noted, the facility is required to recognize the accident risks that exist within the facility as well as outside the facility, such as the possibility that a

resident will wander into a kitchen (or dish room), and to provide the supervision necessary to prevent access to those areas. ALJ Decision at 8. Thus, as the ALJ found, the debate pursued by Kenton about the meaning of the term "elopement" and whether all of the incidents cited by CMS in this case fit that definition "misses the point of the regulation, which is to keep residents safe." ALJ Decision at 8. The regulation focuses not on whether an accident occurs but, rather, on whether the facility has provided supervision and assistance devices adequate to prevent an accident. This requires anticipating what accidents might occur – whether inside or outside the facility, on or off facility grounds – and then taking adequate preventive measures, which may vary depending on the circumstances of each facility and the characteristics of each resident.

Thus, we need not resolve any dispute as to whether all of the exits in this case were "elopements" because the issue is not the exits per se or whether the resident was found on or off facility property but the lack of supervision that resulted in the exits. However, we agree with the ALJ's statement about the written policy that Kenton cites for its definition of elopement. According to that policy, a resident has not eloped and is not "missing" unless he/she actually leaves facility grounds without signing out and has not eloped and is not missing if seen leaving the building or walking away when staff responds to a door alarm. P. Ex. 13, at 1. We agree with the ALJ that this policy is "problematic if it results in the facility's failure to investigate thoroughly incidents that do not fall within its definition of elopement."[8] ALJ Decision at 8. We also note that Kenton did not apply this narrow definition in the "Elopement Timeline" it created, which lists seven of the exits cited by the surveyors and includes exits from the facility to facility property as well as Resident 11's exit to the shopping center. See P. Ex. 28, at 3. The definition reflected in the timeline seems more consistent with the definition accepted by the parties in Willow Creek Nursing Center, DAB CR1351, at 6, aff'd, DAB No. 2040 (2006), which includes any unsupervised, unknown exit from the facility of a resident who is cognitively impaired or not capable of protecting himself/herself from harm. We note that Kenton cites Willow Creek as "CMS's own definition of elopement." P. Br. at 8. It is not clear that the precise definition accepted by the parties in Willow Creek necessarily reflects CMS's or the Secretary's definition for all cases. Nonetheless,

[8] The policy also seems to have been designed more for residents who are capable of signing themselves in and out but do not return, as opposed to residents with dementia or cognitive impairments serious enough to make them elopement risks.

notwithstanding the citation to its own "policy," Kenton seems clearly to have accepted in creating its "Elopement Timeline" that at least seven of the exits in this case were elopements.

Based on our discussion above, we reject Kenton's argument that the ALJ held Kenton strictly liable for resident departures by noting the absence of an electronic monitoring system and by addressing resident departures that might not have fallen under Kenton's policy on elopement. Kenton also argues that the ALJ applied a strict liability standard by failing to consider measures that the facility took to supervise the residents. The principal measure Kenton cites, placing residents in the Magnolia Unit, was, as the ALJ observed and as we discussed regarding Resident 17, essentially ineffective, because of the "apparent ease" with which demented, vulnerable, wandering residents who were not safe unsupervised even within the facility were able to exit the "purportedly secure" unit on a fairly regular basis. ALJ Decision at 21, n.17; 40. The ALJ accurately noted 13 incidents in which residents managed to exit the Magnolia Unit to other parts of the facility or to the outside of the building. ALJ Decision at 11, 12, 14, 15, 29, 31, 35. Kenton has shown no error in the ALJ's findings about the lack of security of the Magnolia Unit.

The ALJ also considered most of the other measures Kenton claims to have implemented (these include monitoring residents, redirection, reassurance, room changes, training staff, permanently locking an exit door (which we addressed above) and making another door or doors more difficult to exit using the coded keypad). P. Br. at 30-31, 34-35. Kenton has not in any event shown that these measures were effective at stopping the residents' unsupervised departures from their units or from the facility. Also, Kenton's claims of frequent monitoring with respect to some residents were contradicted by records showing delays in implementing such monitoring and that monitoring was ineffective in addressing behaviors of residents who still made frequent attempts to depart their units (e.g., Resident 53). Other measures such as inservice training to address behaviors of certain residents were not taken timely. See, e.g., ALJ Decision at 25, 27, 37 (finding that instructions in care plans for Residents 26 and 16 and CNA Care Plans for Resident 16 to "inservice staff" were not made until April 2006 and that training was not shown to have occurred until late April, after the start of the survey). To the extent the measures Kenton describes were timely implemented, their ineffectiveness highlights the importance of the other measures that the ALJ found Kenton failed to consistently apply and on which the ALJ focused, most notably inconsistently noting wandering

precautions, making accurate assessments, and adopting interventions in the care plans or plans that nurse aide staff used in caring for these residents.

Resident 3

Resident 3, an 88-year-old woman admitted to the facility on January 11, 2006, had dementia, hypertension, vertigo, depression, muscle weakness and difficulty walking; she used psychotropic medication and frequently required oxygen because she had episodes of hypoxia. ALJ Decision at 20, citing P. Ex. 3, at 20, 256. On admission, and again in March 2006, Resident 3 was assessed as being at risk for wandering, elopement and serious injury from falls. Id., citing CMS Ex. 10, at 43. The ALJ observed that Resident 3 suffered several falls during January 2006 while attempting to get out of bed, thus making facility staff aware that she was at significant risk whenever she attempted to walk unsupervised and without assistance. Id. at 20, citing P. Ex. 3. Despite these assessments, Kenton placed Resident 3 in a non-secure unit.

The ALJ found that Resident 3 exited the building twice on March 4, 2006. The first time, a staff member found Resident 3 on the "front walkway" without her walker. ALJ Decision at 20-21, citing P. Ex. 3, at 50; CMS Ex. 10, at 51. The second time, a visitor alerted staff that a woman had pushed the code buttons and gone out the front door; staff then found Resident 3 outside on a "ramp," again without her walker. Id. Kenton's own "Elopement Timeline" confirms the two exits. P. Ex. 28, at 3. The ALJ cited other incidents of wandering or exit-seeking behavior by Resident 3 during March 2006 that are documented in Kenton's records. These incidents include wandering into other residents' rooms on and off the unit late at night, packing clothes and bed linens and announcing to staff she was going home, and attempting to exit a fire door by punching in the code buttons. ALJ Decision at 20-21 (citations omitted). Three days before the March 4 elopements, Resident 3 wandered to another unit and asked a staff member how she could open the door to the outside. Id. at 20, citing P. Ex. 3, at 45; CMS Ex. 10, at 50. A nurse's note written on March 5 stated that Resident 3 "needs to be on Magnolia." Id. at 21, citing P. Ex. 3, at 52. On March 6, the facility moved Resident 3 to the secure Magnolia Unit, and on the same date, the resident twice attempted to leave the unit. Id., citing P. Ex. 3, at 50, CMS Ex. 10, at 21, 51. (On March 10 she was moved off the Magnolia Unit and back to her old room, apparently at the insistence of her family. Id. at 20-22.) The ALJ also noted that the resident experienced additional falls in March and April. Id. at 22.

The essence of the ALJ's noncompliance determination was that despite this history, the facility did not appear to appreciate Resident 3's vulnerability to injury from wandering or elopement and did not care plan for the risk posed by those behaviors until after the start of the State agency's survey in late April. The ALJ found that the care plan the facility developed on January 31, 2006 said nothing about wandering or elopement, despite noting the risk of injury related to falls, and was not changed following her exits from the facility in March. Id. at 20-21, citing CMS Ex. 10, at 32-33, 45. Care plan entries with interventions to address Resident 3's desire to go outside were added April 27 and May 5. Id. at 23, citing P. Ex. 3, at 368; see also P. Ex. 3, at 356. The CNA Care Plans from February and April contain no wandering precautions, the ALJ found, despite an instruction in the February CNA Care Plan to chart any incident of Resident 3 ambulating unassisted (that was removed in the March 2006 plan). Id. at 22, citing P. Ex. 3, at 351, 354, 457; CMS Ex. 10, at 42.

Kenton does not dispute the ALJ's determination that the facility failed to timely revise its care plans for Resident 3 in response to the many instances of wandering and exit-seeking behavior that the resident displayed.[9] Kenton instead argues, as it did before the ALJ, that there was no noncompliance because the resident was not at risk for injury from her exits to what Kenton describes as a front porch of the facility. Kenton relies on statements from two physicians, one a treating physician who stated that the resident was not so "cognitively impaired" as to be at risk for harm from going out to the "porch," and the other an expert witness who, based on reviewing Resident 3's records, stated that Resident 3 did not wander from the facility because her exits were purposeful.[10] P. Br. at 14, 43-44, citing P. Exs. 34, at 3; 40, at 1. The ALJ rejected those arguments on the ground that Kenton provided no foundation for the treating physician's conclusion that the resident was not at risk for injury from leaving the facility. The ALJ observed that this conclusion seemed to be at odds with the facility's own documents, such as the nurses notes of the March 4 incident that described Resident

[9] The ALJ pointed out that updates to the CNA Care Plans occurred late in April, after the surveyors had raised their concerns. ALJ Decision 24.

[10] Kenton also repeats its argument that Resident 3 did not successfully elope from the facility according to what Kenton says is CMS's definition of elopement. As we have already discussed, the issue is safety of the resident, not whether the incident was an elopement.

3 as having been on the "front walkway" and later "on the ramp" rather than on a porch. ALJ Decision at 23, citing P. Ex. 3, at 50, and CMS Ex. 10, at 51. The ALJ also concluded that the purposefulness of the resident's exits from the building had no bearing on whether she was at risk for injury, and rejected any suggestion that Resident 3 could safely leave the facility unsupervised.

The ALJ's determination to accord little weight to the physicians' statements is reasonable. The treating physician's statement is conclusory and does not reference or indicate consideration of the many other incidents (which Kenton does not dispute) of wandering and elopement-type behavior Resident 3 displayed. The statement also does not address the well-documented risk that the resident faced due to physical impairments, including her risk of injury from falling or from ambulating unassisted. As the ALJ noted, Kenton's Director of Nursing advised that the resident risked "falling, having injury, and/or even death." Id. at 22, citing CMS Ex. 10, at 34. Kenton also does not explain how the purposefulness of the resident's behavior would negate any of the risks that this frail resident faced from wandering and from exiting her unit and the facility itself. Once outside the facility, the resident faced additional hazards and there were no barriers to keep her from making her way out onto the street beyond the facility, regardless of whether the ramp or walkway to which she exited also may be accurately described as a "porch." Accordingly, Kenton has not shown that the ALJ's determination that Kenton was noncompliant in its care of Resident 3 was not supported by substantial evidence or was erroneous as a matter of law.

Resident 53

Resident 53 resided at Kenton for what the ALJ called "a short but memorable stay." Id. at 28. He was admitted to Kenton on February 22, 2006 and discharged to the Veterans Administration Medical Center on February 23, 2006 because Kenton was unable to confine him in a locked unit. Id. at 28-29; P. Ex. 12, at 2, 16. Resident 53 was 83 years old, had organic brain syndrome, was paranoid and confused and assessed by Kenton as a high risk for wandering. ALJ Decision at 28, citing P. Ex. 12, at 2, 25, 47, 106. Records from his prior placement warned that he was "a high wandering risk and needs to be on a locked unit." Id., citing P. Ex. 12, at 104. These records also recited a history of wandering "all day and all night" and the difficulty staff had in redirecting him. Id. at 29, citing P. Ex. 12 at 100, 107-117. A record from the Veterans Administration Medical Center indicated that the resident's daughter could not care for him at home

because of his wandering and confusion and threats of violence. Id. at 28-29, citing P. Ex. 12, at 97. Notwithstanding these warnings, Resident 53's CNA Care Plan contains no wandering precautions. Id. at 29, citing P. Ex. 12, at 67.

Resident 53 was assigned to the Magnolia Unit, which he left four times during his brief stay. His first exit was on February 22, when he followed someone out the door. Id., citing P. Ex. 12, at 25. Later that day, he attempted to enter the code to the exit door. Id. A nurse's note following that attempt stated that he would be monitored, and he was put on 15-minute checks. Id., citing P. Ex. 12 at 25, 27-29. Nonetheless, Resident 53 was able to exit to the special care unit twice on February 23 and to the parking lot at 2:00 p.m., where he was found near the maintenance shed. Id. citing P. Ex. 12, at 26. The record contains no evidence as to how long he was gone or that any investigation was done. Id.

Based on these findings, the ALJ concluded that Kenton had not adequately supervised the resident despite his known elopement risk, and we find no basis to disturb that finding. Kenton argues that it responded adequately to the resident's behaviors by instituting 15-minute checks on the resident and by discharging the resident, and asserts that an initial care plan it developed contained an intervention, redirection.[11] P. Br. at 42, citing P. Ex. 40, at 5. That intervention from the admission care plan was not included in the CNA Plan of Care that Kenton introduced. The CNA Plan of Care, under "Wandering Precautions," contains only pre-printed options, not checked for this resident, to use electronic monitoring and to check on the resident at different intervals. P. Ex. 12, at 45, 67. In any event, given the information from his prior placement that redirecting this resident was difficult, the viability of that intervention as a supervision intervention, standing alone, would be questionable. Indeed, although the ALJ Decision indicates that Resident 53 was redirected after the episode where he tried to enter the exit

[11] Kenton also argues that it changed the exit code to make it "very difficult to read," but the exhibit pages Kenton cites for that assertion, from the Administrator's declaration, make no mention of that measure. P. Br. at 43, citing P. Ex. 37, at 11-12. Elsewhere, the declaration states that the Magnolia Unit code "is written backwards" to confuse a resident who might attempt to exit, and that the exit code procedure had been changed in November 2005. P. Ex. 37, at 7, 18-19 (¶¶ 16, 20E). Those measures, assuming they were taken prior to the survey, were obviously ineffective in stopping Resident 53's exits in February 2006.

code, the use of that intervention thereafter was apparently as unsuccessful as the 15-minute monitoring since the resident exited three more times.

Kenton also disputes the ALJ's determination that there was no adequate investigation of the resident's departure from the facility on February 23, but the nurses notes it cites as evidence of an investigation discuss a different incident, the resident's exit from the Magnolia Unit on February 22. P. Reply at 11, citing P. Ex. 12, at 25.

Kenton also argues that the resident resided at the facility for less than the time in which the facility was required to complete a care plan for the resident.[12] P. Reply at 11. That argument misses the point, as this deficiency finding was not based on violations of the regulation requiring comprehensive assessments and care plans. The brevity of the resident's stay did not lessen Kenton's responsibility to adequately supervise the resident while he was there. In Woodstock Care Center, the Board sustained a deficiency under 483.25(h)(2) with respect to a resident who had been noted upon admission to have a history of wandering and attempting to elope and eloped on the day she was admitted. Kenton too had ample warning, from two prior placements, of the resident's history of wandering as well as the paranoia and threatening behavior the resident displayed shortly before admission. The ALJ found that Kenton "well understood" the challenge Resident 53 presented but did not provide the supervision it knew he needed. ALJ Decision at 28-29, citing P. Ex. 12, at 97, 100, 104, 107-117. Substantial evidence supports that finding.

Resident 26

Resident 26 was admitted to the facility on March 14, 2005, having recently suffered a cerebrovascular accident that left her with weakness and paralysis on her right side, aphasia (inability to speak), and many related problems, including a seizure disorder. ALJ Decision at 24, citing P. Ex. 9, at 8, 41-45, 54, 55, 57. When admitted, Resident 26 was not considered at risk for wandering or elopement and was not placed in a secure unit. Id., citing P. Ex. 9, at 305, 332, 334. On October 3, 2005,

[12] Kenton refers to a "14 day window for completing a nursing care plan." P. Br. at 42. The regulations require that a facility complete a comprehensive assessment of a resident within 14 days after admission, and develop a comprehensive care plan within seven days after completion of the comprehensive assessment. 42 C.F.R. § 483.20(b),(k).

Resident 26 exited the front door of the facility three times in her wheelchair by pushing visitors who were entering or exiting out of the way. Id. at 24-25, citing P. Ex. 9, at 64; CMS Ex. 21, at 70. The resident made other attempts to exit the facility on October 5 and 7 and November 4 and 7, 2005. Id. at 25, citing P. Ex. 9, at 65, 67, 74.

After the November 7 attempt, the facility moved the resident to a room in another unsecure unit. Id., citing P. Ex. 9, at 74. Social Service notes indicate that on November 8, 2005, the resident continued to wander to the front of the building, became more upset and anxious, and hit at a staff member. P. Ex. 9, at 725. On November 9, Resident 26 left her new unit multiple times and at one point was found in the parking lot.[13] ALJ Decision at 26, citing P. Ex. 9, at 77-78. After that exit, she apparently was transferred to the Magnolia Unit. Id., citing P. Ex. 9, at 725; see also P. Ex. 9, at 78 (nurses notes).

On October 3, 2005, the facility added "risk for elopement" to Resident 26's care plan and listed interventions, which included "observe location and redirect as needed." ALJ Decision at 25, citing CMS Ex. 21, at 18-19. However, these instructions were not added to the resident's subsequent SRNA Plan of Care, for November 2005, and she was not noted as an elopement risk in the SRNA Plan of Care until December 2005. Id., citing P. Ex. 9, at 427; see also P. Ex. 9, at 452. During the survey, the surveyor observed that staff were not following Resident 26's care plan. The surveyor saw the resident in the dining room unsupervised with no staff present, and, when asked, the nurse responsible for the resident and a CNA did not know where she was. The staff member who left the resident alone in the dining room admitted not knowing she was an elopement risk. Id. at 27, citing CMS Ex. 1, at 123-124; CMS Ex. 21, at 4. The ALJ was also concerned about the inadequacy of the facility's investigation following Resident 26's November 9, 2005 exit to the parking lot. Id. at 28. Based on these failures to supervise, the ALJ found that Kenton did not substantially comply with section 483.25(h)(2) with respect to its care of Resident 26. Id.

On appeal, Kenton does not directly dispute the ALJ's findings but repeats assertions about the nature of Resident 26's behavior and its care of the resident that the ALJ rejected. Kenton asserts that when the resident left the facility on November 9,

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[13] Kenton's Elopement Timeline indicates that Resident 26 left the facility on November 19, 2005. P. Ex. 28, at 3. Nurses notes show that the resident left the facility on November 9. P. Ex. 9, at 78.

she simply exited to the "front porch" and was "immediately retrieved" by staff. P. Br. at 15, citing P. Ex. 9, at 76. The ALJ found this claim "at odds with the contemporaneous record, which puts her in the parking lot." ALJ Decision at 26. The exhibit page Kenton cites, nurses notes from November 9, 2005, does not support its assertion, and subsequent nurses notes from the same day show that, as the ALJ found, the resident was found in the parking lot. P. Ex. 9, at 78. Kenton asserts that after this incident, it implemented 15-minute checks, but does not dispute the ALJ's finding that the exhibit page Kenton cites, a record of some 15-minute safety checks, shows only one hour of checks, shortly after the incident. P. Br. at 15, citing P. Ex. 9, at 140; see ALJ Decision at 26. And while Kenton asserts, without citing to the record, that it investigated the November 9 incident, Kenton does not address the ALJ's finding that the incident report provides minimal information about the incident, merely stating that the resident had been found in the parking lot by the admission nurse and that no injuries were noted. ALJ Decision at 26, citing CMS Ex. 21, at 11.

Kenton argues that its failure to investigate Resident 26's departure (and other resident departures) was not cited in the SOD and thus should not have been addressed by the ALJ. P. Br. at 79. As with the ALJ's discussion of resident falls not noted in the SOD, we find no error. The ALJ did not find Kenton deficient for failure to investigate per se, but instead treated the facility's failure to determine the circumstances of resident departures as part of a pattern of inaction that may have led to additional elopements and therefore a greater risk of accidents. The ALJ addressed evidence contained in records Kenton introduced as evidence in a proceeding in which, ultimately, Kenton bore the burden of proving its substantial compliance with the requirement that it provide adequate supervision and assistance devices to prevent accidents. The ALJ reviews that issue de novo. See, e.g., Sunbridge Care and Rehabilitation for Pembroke, DAB No. 2170, at 26 (2008); Emerald Oaks, DAB No. 1800, at 16 (2001). Kenton was thus on notice that the ALJ would determine whether the record as a whole contained evidence of the deficiency, including the failure to take appropriate measures to prevent further resident departures, which logically includes determining the circumstances of past departures.

Kenton also asserts that it monitored the resident, spoke to her husband about transferring her to a secure unit and transferred her to the Magnolia Unit on November 9, and changed the exit code procedure for the door through which she exited so that it was more difficult to open. However, Kenton does not dispute the ALJ's overall findings about Kenton's failure to maintain timely

the resident's CNA Care Plan and its failure to implement care plan measures. Changing the exit code procedure does not address the failure to follow the care plan's instruction to observe the resident's location. There is no basis to disturb the ALJ's finding of noncompliance with respect to Resident 26.

Kenton also argues that the ALJ should not have cited Kenton's failure to timely update or maintain the CNA Care Plan and the SRNA Plan of Care as evidence of the deficiency. (In addition to citing this failure with respect to Resident 26, the ALJ cited similar findings with respect to Residents 16 and 17 as evidence of the deficiency.) Kenton argues that those documents were created by the facility and are not the care plan required by the regulations. The deficiency at issue here, however, is not based on the regulation requiring facilities to maintain a comprehensive plan of care for each resident, 42 C.F.R. § 483.20(d),(k), and the ALJ did not address the requirements of that regulation.[14] The facility, moreover, created the CNA and SRNA care plans to assist nurse aides in caring for residents. P. Br. at 44, n.10; see ALJ Decision at 10. Kenton's failure to include in those plans important information about a resident's risk of wandering or elopement would clearly hinder the staff's ability to provide the needed care and supervision required by the regulation. The Board has confirmed that the measures that a facility adopts to care for its residents are evidence of the facility's evaluation of what must be done to attain or maintain a resident's highest practicable physical, mental, and psychosocial well-being, as required by section 483.25. Woodland Village Nursing Center, DAB No. 2053, at 8-9, (2006), aff'd, Woodland Village Nursing Ctr. v. U.S. Dep't of Health & Human Servs., 239 Fed.Appx. 80 (5th Cir. 2007), citing Spring Meadows Health Care Center at 16-18 (addressing facility failures to observe their own policies for resident care). Failure to fully employ those measures as intended may thus be, as it is here, evidence that the facility failed to provide residents with needed care and supervision as required by the regulation. Thus, the ALJ did not err by citing Kenton's failures to update the CNA and SRNA care plans.

In summary, we conclude that substantial evidence supports the ALJ's findings of noncompliance for the five residents discussed above and the remaining residents discussed by the ALJ, and that

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[14] Before the ALJ, Kenton did not contest CMS's determinations with respect to three deficiencies alleging that that Kenton failed to comply substantially with requirements of the regulation addressing comprehensive care plans at 42 C.F.R. §§ 483.20(k)(1), (k)(3)(i) and (k)(3)(ii). CMS Ex. 1, at 72-93.

the ALJ committed no error of law in concluding that Kenton was not in substantial compliance with 42 C.F.R. § 483.25(h)(2).

B. The ALJ did not err in finding CMS's determination of immediate jeopardy not clearly erroneous or in concluding that the immediate jeopardy continued throughout the period September 15, 2005 - May 12, 2006.

As noted above, "immediate jeopardy" is "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination that a deficiency constitutes immediate jeopardy must be upheld unless it is clearly erroneous, and provider bears the burden of proving that CMS's immediate jeopardy determination is clearly erroneous. 42 C.F.R. § 498.60(c)(2); Woodstock Care Center; Liberty Commons Nursing & Rehab Center – Johnston.

Kenton argues that there was no immediate jeopardy because none of the residents who wandered or left their units, the facility, or the facility grounds were injured.[15] As the regulatory language indicates, immediate jeopardy does not require actual harm but only a likelihood of serious harm. See, e.g., Eastwood Convalescent Center, DAB No. 2088, at 16 (2007). As the ALJ observed, Kenton housed many residents who were vulnerable and demented and clearly at risk of accidents – many from falls – if left unsupervised within the facility; they were at even greater risk if they managed to leave the facility. ALJ Decision at 40. Yet, as the ALJ found, and the record shows, a number of residents "were able to exit their purportedly secure unit and/or the building on a fairly regular basis." Id. Kenton kept other residents who had been assessed as wanderers or at risk of elopement in unsecure units even after they demonstrated exit-seeking behavior, sometimes successfully. Regardless of whether

[15] As the ALJ noted, CMS disputed Kenton's assertion that no resident was harmed, at least with respect to Resident 11, the resident who was found at the shopping center. ALJ Decision at 39. CMS asserts that Resident 11 suffered serious emotional harm as a result of her elopement, citing evidence about the resident's "tears and confusion" upon being found at the shopping center. CMS Response at 20, citing Tr. at 39; CMS Ex. 1, at 120; CMS Ex. 22, at 64. It is not necessary to decide this issue since, as discussed above, immediate jeopardy can exist without actual harm. However, we note that the quality of care requirement encompasses residents' mental as well as physical well-being. 42 C.F.R. § 483.25.

the latter practice per se would be a basis for finding noncompliance, Kenton had an obligation to assure that residents at risk of elopement residing in unsecure units received sufficiently close supervision to prevent their leaving the unsecured units on their own and wandering into unsafe areas or leaving the building. Clearly, Kenton did not provide such supervision since the residents did exit their units or, in some cases, the facility.

The likelihood of serious harm befalling these residents is evident in the record facts. Some residents were found in Kenton's parking lot, where one resident walked in front of an operating automobile, and where there were no effective barriers to keep the residents from proceeding further. See CMS Ex. 27 at 3 (Willhite Decl. at ¶ 8 – describing how the facility's parking lots were connected to Waller Avenue by a side driveway and none of the lots were fully enclosed or gated). Another resident (Resident 11) managed to make her way down the street (with her walker) and across another street to a shopping center while in the vicinity of railroad tracks as well as commercial establishments and the traffic they entail. Id. at 3, ¶ 7; ALJ Decision at 18, citing P. Ex. 7, at 33; P. Ex. 28, at 3. Although Kenton claims its staff retrieved Residents 17 and 26 "immediately" upon discovering them outside the facility, Kenton has not shown that staff observed the residents leaving the building or knew they were missing until the residents were found, sometimes by visitors. There can be little doubt that serious harm is likely to befall vulnerable residents under these circumstances. Indeed, as the ALJ noted, the fact that residents were found uninjured was merely fortuitous, not attributable to facility action. ALJ Decision at 9, 19.

Kenton bears the burden of proving that CMS's determination of immediate jeopardy is clearly erroneous. Kenton has shown no error, much less clear error. We find no error in the ALJ's finding that Kenton did not carry its burden of proving that CMS's determination of immediate jeopardy was not clearly erroneous. Accordingly, we uphold that finding.

Kenton argues that even if it was not in substantial compliance, or immediate jeopardy existed, at the time of some of the elopements, the ALJ erred in finding that immediate jeopardy continued for the entire period of September 15, 2005 through May 12, 2006. We find no error. The regulations provide that remedies imposed for a facility's noncompliance continue until "[t]he facility has achieved substantial compliance, as determined by CMS or the State based upon a revisit or after an examination of credible written evidence that [CMS or the State]

can verify without an on-site visit; or . . . CMS or the State terminates the provider agreement." 42 C.F.R. § 488.454(a); see also 42 C.F.R. § 488.440 (providing that a per-day CMP accrues until the facility achieves substantial compliance or the provider agreement is terminated). The facility has the burden of proving that it achieved substantial compliance on a date earlier than that determined by CMS. Sunbridge Care and Rehabilitation for Pembroke at 36; see also Lake Mary Health Care, DAB No. 2081, at 30 (2007) (rejecting the idea that CMS must establish a lack of substantial compliance during each day in which a remedy remains in effect).

Kenton falls far short of meeting its burden to prove that it achieved substantial compliance earlier than May 13, 2006. At the outset, Kenton has not even affirmatively asserted that it achieved substantial compliance, or abated the immediate jeopardy, on any specific earlier date, much less submitted proof that it did so. Kenton merely cites certain interventions it allegedly made after the elopements of Resident 17 on September 23, 2005, Resident 26 on November 9, 2005 and Resident 53 on February 23, 2006.[16] Kenton cites its alleged permanent closure of the door through which it says Resident 17 eloped from the Magnolia Unit and communications to staff and family about not using the door. We have previously stated that we accept the ALJ's conclusion that there was no reliable evidence that the door was the problem or that Kenton took that action. Even assuming the door was permanently closed, there was no basis for concluding that this measure would eliminate the supervision problem. Kenton also says that it trained staff and did 15-minute checks. P. Br. at 52. While the record shows that Kenton ultimately did some in-service training, this did not occur, as the ALJ found, until late April, during the survey. See ALJ Decision at 27, citing CMS Ex. 1, at 123-24, CMS Ex. 21, at 4; Id. at 37, citing P. Ex. 5, at 397. While there is evidence that 15-minute checks were instituted with respect to Resident 17 and some other residents for periods of time after specific incidents, this appears to have been sporadic and temporary, and Kenton points to no evidence to the contrary. Moreover, some training involved a new program using green wrist bands to identify residents at risk of elopement; the new program had not yet been implemented when Kenton's staff told the surveyors about the training on April 26, 2006. Id. at 27.

[16] Kenton also reiterates its unsupported arguments that Resident 3 only went out on the front porch and that this did not put her at risk.

Kenton also notes that upon finding Resident 26 in the parking lot after she exited the facility on November 9, 2005, it recoded the key pad of the door she reportedly used to make it more difficult to enter the code and open the door.[17] However, the effectiveness of this intervention is at best questionable given the facility's apparent practice of posting exit codes on signs above key pads. See ALJ Decision at 21, n.17 and 26, n.21 (citing P. Ex. 25, a DVD of views inside and outside the facility). Furthermore, locked doors cannot reasonably be relied on as adequate to keep residents from exiting the unit once residents have shown that they can leave the unit (or the facility) despite doors being secured. We also note that the admission care plan for Resident 17 and the revised care plan for Resident 26 required staff to observe the residents and to redirect them as necessary, Resident 17 because of his wandering behavior and Resident 26 because of her elopement risk. Recoding key pads or permanently closing doors did not obviate Kenton's responsibility to implement these care planned interventions.

The ALJ determined that the failure to identify residents as elopement risks in their care plans and to add care plan interventions, even though they had been assessed as at risk for elopement, was a major systemic failure contributing to the inadequate supervision and resulting resident exits. Yet, she found, Kenton did not cure this defect in the care plans for Residents 3, 11, 17, 28 and 52 until April 27, during the survey (Residents 16 and 27 were noted as elopement risks in care plans of "April 2006)"). ALJ Decision at 14-15, 17-19, 21, 23, 30, 32. Kenton cites no evidence to the contrary.[18] While Resident 26 was identified as an elopement risk in her care plan on the date of her first exit from the facility on October 3, 2005, Kenton

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[17] This was apparently a different door than the one that Resident 17 used to exit the Magnolia Unit and the facility in September 2005, which Kenton reports that it sealed. At the time that Resident 26 exited the facility on November 9, 2005, she was apparently not in a secure unit.

[18] Kenton asserts that it developed a care plan for Resident 17 that addressed wandering, but does not mention the resident's risk of elopement. P. Reply Br. at 3-5. While Kenton reports identifying Resident 11 as a risk for elopement in a care plan upon admission, id. at 7, and the ALJ found that a care plan dated November 29, 2005 identified her as at risk for elopement, Kenton does not deny the ALJ's findings that subsequent care plans do not identify a risk of elopement until arm band and electronic monitoring interventions were added on April 27. ALJ Decision at 17-19.

does not seem to have reevaluated the adequacy of those interventions based on the resident's multiple subsequent exits until April 2006, when additional interventions were added. CMS Ex. 21, at 18, 19.

Another systemic problem the ALJ found was Kenton's failure to always include pictures and elopement histories of at-risk residents in the "elopement book" kept by the facility to assist staff in recognizing such residents. She also noted evidence that not all facility staff had access to the book and that some staff denied knowledge of its existence. Id. at 7. The ALJ noted that Kenton did not directly challenge this evidence, and she also rejected Kenton's argument that inclusion in the book was not necessary since staff would have known that all residents residing on a secure unit were elopement risks. Id. The ALJ could reasonably infer, as she did, "that the facility considered inclusion in the elopement book necessary to attain or maintain resident well-being." Id. at 7-8, citing Spring Meadows Health Center at 20. Moreover, Kenton's argument overlooks the fact that not all of the residents who were at risk of elopement were housed in secure units.

Kenton asserts that, after Resident 3's March exits (which Kenton has unpersuasively argued did not put her at risk), no other elopement occurred until Resident 11 eloped to the shopping center in April 2006 and that this "demonstrate[s] that the interventions of the Facility were effective and that it came back into compliance earlier than the surveyors alleged." P. Br. at 53-54. However, Resident 3's exits occurred on March 4, 2006, barely a month before Resident 11's elopement. Furthermore, Resident 11's elopement, and the facts surrounding it, support the ALJ's finding that the systemic problem of inadequate supervision persisted at least into April 2006. Moreover, Kenton created a Timeline (in addition to the previously discussed Elopement Timeline) that documents 19 incidents of attempted exits or exits to locations within the facility between June 9, 2005 and April 23, 2006. P. Ex. 28, at 1-2. This too indicates a systemic problem with supervision throughout the immediate jeopardy period.

In sum, we find no error in the ALJ's findings that CMS's determination of immediate jeopardy was not clearly erroneous and that the immediate jeopardy lasted from September 15, 2005 through May 12, 2006.

C. The ALJ did not err in finding that $4,050 per day is a reasonable amount for the CMP.

Kenton argues that the total amount of the CMP imposed by CMS, and upheld by the ALJ, for the immediate jeopardy period – $972,000 – is excessive.[19] Kenton asserts that this is the largest total CMP imposed on a nursing facility of which it is aware, citing a list it prepared of other Board and ALJ decisions that it claims involved similar deficiencies. P. Br. at 67-71. Kenton further argues that the CMP is so large that it will deprive the facility of funds needed to assure compliance and may ultimately force the facility to close. This, Kenton argues, is contrary to the purpose of CMPs, which it says are meant to provide a facility with an incentive to comply with program requirements, but not to punish a facility or force it out of business.

We find no merit in Kenton's argument that the CMP amount is unreasonable, especially when compared to CMPs in other cases. The total amount of the CMP in this case is based on CMS's choice to impose a per-day CMP of $4,050, which remained in effect for 240 days due to Kenton's noncompliance for that period of time. CMS's decision to impose a per-day CMP as opposed to some other remedy, such as a per-instance CMP, is a choice committed to CMS's discretion by the regulations which is not subject to review. See 42 C.F.R. §§ 488.408 (listing per-day and per-instance CMPs as separate and distinct remedies from among which CMS may choose); 488.408(g)(2) (a facility may not appeal the choice of remedy, including the factors considered by CMS or the State in selecting the remedy); 498.3(d)(11) (the choice of remedy to be imposed on a provider is not subject to appeal); see also 42 C.F.R. 42 C.F.R. § 488.438(e)(2) (where a basis for imposing a CMP exists, the ALJ cannot review CMS's exercise of discretion to impose a CMP).

We find Kenton's argument that the CMP imposed here is unreasonable when compared to CMPs imposed in other cases unpersuasive. As we noted in Brier Oak Terrace Care Center, DAB No. 1798 (2001), the regulations give CMS considerable discretion in the amount of a CMP it is permitted to impose. The regulations specify the ranges of CMPs for noncompliance at the

[19] This amount represents $4,050 per day for 240 days of noncompliance at the immediate jeopardy level (September 15, 2005 through May 12, 2006). Kenton does not challenge the additional CMP of $2,500, calculated at $500 per day for five days of noncompliance at the less than immediate jeopardy level (May 13 through May 17, 2006). The total CMP amount is thus $974,500.

immediate jeopardy and non-immediate jeopardy levels and require only that in determining an amount within the applicable range CMS and the ALJ consider the factors in 42 C.F.R. § 488.438(f). 42 C.F.R. § 488.408(d),(e). Those factors differ from case to case and, as we stated in Brier Oak, "the factors in each case cannot be quantified to determine the appropriate amount of a CMP." DAB No. 1798, at 15.

Kenton also asserts that the ALJ incorrectly applied the factors that must be considered in determining the amount of a CMP: the facility's history of noncompliance (including repeated deficiencies), its financial condition, its degree of culpability for the cited deficiencies, the seriousness of the noncompliance, and the relationship of one deficiency to the other deficiencies resulting in noncompliance. 42 C.F.R. §§ 488.438(f), 488.404. Kenton argues that in considering the facility's financial condition, the ALJ erred by addressing the financial condition of a related business entity, by excluding written testimony on the issue of its financial condition from one of Kenton's witnesses who failed to appear at the hearing for cross-examination and by refusing to issue a subpoena to compel the same witness's appearance. The ALJ declined to issue a subpoena on the ground that Kenton did not request the subpoena at least five days before the date set for the hearing, as required by the regulations. ALJ Decision at 5, n.1, citing 42 C.F.R. § 498.58. Kenton, however, reports that this witness, who was an employee of a company that owns long-term care facilities and provided management services to Kenton, gave no indication that she ultimately would not appear at the hearing as scheduled. Kenton argues that the ALJ denied Kenton its due process rights in declining to issue a subpoena and excluding her written testimony.

We find no merit to these argument. First, in refusing to issue the subpoena, the ALJ applied the plain language of the subpoena regulation. Moreover, while Kenton may have expected its witness to appear, it could have protected itself by timely requesting a subpoena. Under the circumstances, striking the written direct, rather than reconvening the hearing at a later date to permit CMS to cross-examine the witness, was reasonable and well within the ALJ's discretion. Second, we find that, contrary to what Kenton argues, the ALJ did not take into consideration the financial condition of a related business entity in determining whether the CMP amount was reasonable. Instead, the ALJ found that since Kenton had offered no evidence on the nature of the relationship between the two entities, "I need not even consider the questions of their relative responsibilities, and whether I can include the

financial condition of the management entity in my considerations."[20] ALJ Decision at 43.

Third, we agree with the ALJ that Kenton has not presented sufficient evidence to determine its financial survivability. See id. This would be true, even if the stricken testimony were admitted into the record. Specifically, Kenton's evidence, including the affidavit of its witness that the ALJ excluded from the record, does not support Kenton's assertions that payment of the penalty will force Kenton to cease operations.

Kenton's witness, the Chief Financial Officer (CFO) of Northpoint Senior Services, a corporation "that manages and has ownership interests in several long-term care facilities in Kentucky" and which "provides management services" to Kenton, described Kenton as a separate corporate entity from Northpoint and stated that payment of the $972,000 CMP will very likely require Kenton to close. P. Ex. 35, at 2, 4 (¶¶ 1, 3, 6). She stated that Northpoint typically receives a five percent management fee "if the facility has sufficient cash flow" to pay the fee and that the facility was projected to have a net operating income for calendar year 2006 (also the fiscal year) of $687,000 after payment of management fees of $434,000, but that the facility would have a net loss of $213,000 after payment of rent, and a loss of $1,185,000 if the CMP is paid. We agree with the ALJ, however, that this statement fails to address factors such as the facility's financial reserves, its credit-worthiness, and other long-term indicia of its survivability. ALJ Decision at 43.[21] Notably, the management company's posited five percent management fees of $434,000 suggest that Kenton had at least gross revenues of $8,680,000 (the affidavit does not describe the amount used to calculate the five percent management fees). Kenton also does not address whether it could obtain financing of a debt to CMS or whether it could negotiate an alternate schedule for payment of the management fee. Accordingly, with or without the stricken testimony, Kenton has not shown that its financial condition makes a CMP of $4,050 per day unreasonable for the duration of its noncompliance at the immediate jeopardy level with one

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[20] We also note that the stricken written direct testimony does not shed dispositive light on that relationship.

[21] The ALJ applied the factors considered by the ALJ in Ridge Terrace, DAB CR938, at 4-5 (2002). While we do not here determine conclusively what factors may be relevant to considering the financial effect of a CMP, we agree that a facility seeking to show how it would be affected by a CMP might reasonably be expected to address those factors.

requirement and noncompliance with 19 other requirements at the less than immediate jeopardy level.

We next turn to the other factors that the ALJ addressed in determining that the CMP of $4,050 per day was reasonable. Most significant was Kenton's history of noncompliance. The ALJ found that the facility had a significant history of noncompliance, pointing out that the facility was found to be not in substantial compliance with at least six requirements in May 2004, with the most serious being an isolated deficiency involving actual harm that was not immediate jeopardy; that in 2005, it was not in substantial compliance with four requirements, the most serious being a widespread deficiency that involved no actual harm with potential for more than minimal harm that was not immediate jeopardy, and that many of the deficiencies cited during the 2006 survey had been cited previously. ALJ Decision at 41-42.

On appeal, Kenton does not deny that this is a history of significant noncompliance, but argues that the ALJ erred by considering the history that occurred under a previous owner and by failing to consider the amount of the money and effort that Kenton invested in improving the conditions at the facility once it assumed ownership on May 1, 2004. P. Br. at 4-5, 73-74. We find no error. The regulations provide that when there is a change of a facility's ownership, the existing provider agreement will automatically be assigned to the new owner, and that an assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued. 42 C.F.R. § 489.18(c),(d). Those terms and conditions include, but are not limited to, any existing plan of correction, and compliance with applicable health and safety standards. Id. Thus, the ALJ correctly recognized that the new owner of a facility acquires the relevant compliance history/issues of the facility if it undertakes to assume the facility's provider number. ALJ Decision at 41, n.31, citing CarePlex of Silver Spring, DAB No. 1683, at 11-13 (1999) and CarePlex of Silver Spring, DAB No. 1627 (1997); accord Crestview Parke Care Center, DAB No. 1836 (2002), rev'd on other grounds sub nom Crestview Parke Care Ctr. v. Thompson, 373 F.3d 743 (6th Cir. 2004). Furthermore, the evidence of record strongly indicates that whatever efforts Kenton made after assuming ownership were not enough to prevent very serious noncompliance that occurred under its own ownership.

Additionally, two of the other factors – the seriousness of the noncompliance, and the relationship of one deficiency to the other deficiencies resulting in noncompliance – weigh heavily in favor of increasing the CMP above the minimum per-day amount

permitted by the regulations for immediate jeopardy, which is $3,050. See 42 C.F.R. § 488.438(a)(1)(i) (setting a range of $3,050 to $10,000 per day for immediate jeopardy-level noncompliance). As the ALJ concluded, "[b]y itself, the widespread scope of the immediate jeopardy deficiency merits an increase in the per day amount beyond the minimum." ALJ Decision at 43. Moreover, Kenton did not challenge any of the 19 additional deficiency findings cited in the SOD. See CMS Ex. 1. A number of these deficiencies, as the ALJ noted, reflected a pattern of noncompliance or widespread noncompliance, and three involved actual harm. ALJ Decision at 43-44 and n.33. She further noted that the number and circumstances of these deficiencies suggested some of the same systemic problems underlying the immediate jeopardy noncompliance, such as problems with care planning, investigating incidents, and ultimately protecting residents from injury, for which the facility must be considered culpable.

Kenton also argues that the ALJ's finding that it was highly culpable is undercut by the fact that no resident suffered actual harm or injury, but this is irrelevant. Culpability is defined as "neglect, indifference or disregard for resident care, comfort or safety," 42 C.F.R. § 488.438(f)(4), regardless of whether actual harm results. The evidence of record shows widespread systemic problems consistent with this definition. Kenton asserts that it is "much less culpable than many of the facilities that have been fined at much lower amounts." P. Br. at 76. However, we have already rejected Kenton's attempt to compare the CMP here with those in other cases since the factors cannot be quantified. We have before us the evidence in this case, which clearly supports the ALJ's assessment of all the factors and her determination that $4,050 per day is a reasonable CMP amount.

Kenton's argument that the CMP is too large to serve the regulations' purpose of providing the facility with an incentive to comply with program requirements provides no basis to reduce the CMP. This Board has held that the Secretary, by including CMPs among the remedies CMS may impose for noncompliance, has already determined that CMPs serve a remedial purpose. Sunbridge Care and Rehabilitation for Pembroke at 37-38 (citations omitted); see also CarePlex, DAB No. 1683, at 7-8 (indicating that the Secretary's promulgation of 42 C.F.R. § 488.438(f) setting out the factors to be considered when determining a CMP amount implements the remedial purpose of the alternative sanctions (including CMPs) provided for in the governing statute). Because we have determined that there was no error in the ALJ's application of the factors in 42 C.F.R. § 488.438(f),

arguments about the remedial purpose of alternative sanctions consequently furnish no basis for reducing the CMP.

In sum, we conclude that the ALJ did not err in determining that $4,050 per day is a reasonable CMP amount; her determination is consistent with the applicable regulatory factors and contains no error of law.

Finally, we find no merit in Kenton's argument that the findings and rulings it contends are erroneous and that we addressed above cumulatively demonstrate that the ALJ was biased. Kenton also provided no evidence to support its allegations that the ALJ was rude and condescending and that she should have agreed to hold the hearing in Lexington, Kentucky (instead of Cincinnati, Ohio) and did not devote sufficient time to the hearing. Kenton has not identified any specific example of the ALJ's demeanor at the hearing or during the case that supports its accusations. Kenton has not shown that the ALJ Decision resulted from some basis other than what the judge learned from her participation in the case, the limited standard that the Board has articulated for finding that an ALJ was biased. St. Anthony Hospital, DAB No. 1728, at 84 (2000), aff'd, 309 F.3d 680 (10th Cir. 2002). Nothing to which Kenton points shows any reason for the ALJ's resolution of the case other than her assessment of the evidence and arguments presented in the legal proceeding before her. Kenton may disagree with the ALJ's assessments, but such disagreement does not substantiate a claim of bias.

Conclusion

For the reasons stated above, we affirm the ALJ Decision.

/s/
Judith A. Ballard

/s/
Constance B. Tobias

/s/
Sheila Ann Hegy
Presiding Board Member