Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Woods Edge Pointe,	)	Date: March 6, 2007
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-03-261
	)	Decision No. CR1565
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

For the reasons set forth below, I conclude that Woods Edge Pointe (Petitioner or Facility) was not in substantial compliance with participation requirements governing nursing home facilities at an immediate jeopardy level on December 26, 2002. Accordingly, I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose a per instance civil money penalty (CMP) in the amount of $3,300.

I. Background

Petitioner is a long-term care facility located in Cincinnati, Ohio. Petitioner is authorized to participate in the federal Medicare program as a skilled nursing facility (SNF) and in the Ohio State Medicaid program as a nursing facility (NF). In response to a complaint initiated against Petitioner, a complaint investigation was completed by the Ohio Department of Health (state survey agency) on January 7, 2003. The investigation was conducted by Susan Best, R.N., a state surveyor. CMS Ex. 1, at 1. Specifically, the complaint related to a resident (R69) who eloped from the custody of Petitioner's employees during a medical visit to an off-site facility. The state survey agency determined, as reported in the CMS Form 2567 Statement of Deficiencies (SOD), that on December 26, 2002 Petitioner was not in substantial compliance with federal Medicare and Medicaid participation requirements, and that the noncompliance resulted in immediate jeopardy to Petitioner's residents. The state survey agency also determined that immediate jeopardy had been abated on the same day (December 26, 2002). CMS

concurred with the state survey agency and, on January 24, 2003, CMS notified Petitioner that CMS was imposing a per instance CMP in the amount $3,300 for the noncompliance described in the January 7th SOD at F Tag 698, citing F Tag 324.

On February 6, 2003, Petitioner timely submitted a request for hearing to challenge CMS's determination. The case was assigned to me for a hearing and decision.

A hearing was held before me on July 26, 2005, in Cincinnati, Ohio. Eric Hershberger, Esq. appeared on behalf of Petitioner, and James Walsh, Esq. appeared on behalf of CMS. The proceedings are recorded in a transcript (Tr.) with pages numbered 1 through 162. CMS Exhibits (CMS Exs.) 1 through 9 were offered and admitted as evidence. Tr. at 5. Petitioner's Exhibits (P. Exs.) 1 through 9 were offered and admitted into evidence. Tr. at 8. Susan Best, R.N., the state surveyor who prepared the SOD in this case (Tr. at 15 - 106), testified for CMS. Susie Squires, the facility's Activity Director (Tr. at 107 - 156); testified on behalf of Petitioner. The parties submitted post hearing briefs (CMS Br. and P. Br., respectively) and CMS submitted a reply brief (CMS Reply). During the hearing, I also admitted Administrative Law Judge Exhibit (ALJ Ex.) 1.

II. Applicable law

Petitioner is considered a long-term care facility under the Social Security Act (Act) and regulations promulgated by the Secretary of Health and Human Services (Secretary). The statutory and regulatory requirements for participation by a long-term care facility are found at sections 1819 and 1919 of the Act and at 42 C.F.R. Part 483.

Sections 1819 and 1919 of the Act invest the Secretary with authority to impose CMPs against a long-term care facility for failure to comply substantially with federal participation requirements.

Pursuant to the Act, the Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility that is not complying substantially with federal participation requirements. Part 488 of 42 C.F.R. provides that facilities participating in Medicare may be surveyed on behalf of CMS by state survey agencies in order to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10 - 488.28. The regulations contain special survey conditions for long-term care facilities. 42 C.F.R. §§ 488.300 - 488.335. The regulations at 42 C.F.R. Part 488 give CMS a number of different remedies that can be imposed if a facility is not in compliance with Medicare requirements. Under Part 488, a state or CMS may impose a per instance or per day CMP against a long-term care facility when a state survey agency concludes that the facility is not complying substantially with federal participation requirements. 42 C.F.R. §§ 488.406, 488.408, 488.430.

The regulations specify that a CMP which is imposed against a facility can be either a per day CMP for each day the facility is not in substantial compliance, or a per instance CMP for each instance that a facility is not in substantial compliance. 42 C.F.R. § 488.430(a). When penalties are imposed for an instance of noncompliance, the penalties will be in the range of $1,000 - $10,000 per instance. 42 C.F.R. § 488.438(a)(2).

The regulations define "substantial compliance" as "a 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." 42 C.F.R. § 488.301.

Substantial noncompliance that is immediate jeopardy is defined as "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301.

The Act and regulations make a hearing before an ALJ available to a long-term health care facility against whom CMS has determined to impose a CMP. Act, section 1128A(c)(2); 42 C.F.R. §§ 488.408(g), 498.3(b)(12), (13). The hearing before an ALJ is a *de novo* proceeding. *Anesthesiologists Affiliated, et al.*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991).

When a penalty is imposed and appealed, CMS must make a prima facie case that the facility has failed to comply substantially with federal participation requirements. To prevail, a long-term care facility must overcome CMS's showing by a preponderance of the evidence. *Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd*, *Hillman Rehabilitation Center v. U. S. Dept. of Health and Human Services, Health Care Financing Administration*, No. 98-3789 (GEB), slip op. at 25 (D.N.J. May 13, 1999); *Batavia Nursing and Convalescent Inn*, DAB No. 1911 (2004). Under *Hillman* and *Batavia*, CMS bears the burden of coming forward with evidence sufficient to establish a prima facie case that Petitioner failed to comply with participation requirements. Once CMS has established a prima facie case of noncompliance, Petitioner has the ultimate burden of persuasion, and to prevail, Petitioner must prove by a preponderance of the evidence that it was in substantial compliance with each participation requirement at issue. *Hillman*, DAB No. 1611, at 3 - 8.

III. Issues

The issues in this case are: 1) whether, on December 26, 2002, Petitioner was in substantial compliance with Medicare and Medicaid participation requirements, specifically, 42 C.F.R. § 483.25(h)(2); 2) if Petitioner is found not to be in substantial compliance, whether CMS's immediate jeopardy determination was clearly erroneous; and 3) whether the amount of the CMP imposed is reasonable.

IV. The parties' arguments

Petitioner asserts that, under section 483.25(h)(2), a facility cannot be held *per se* liable in instances where the accident at issue occurred somewhere other than on a ***facility's physical site***, and where the hazard was not reasonably foreseeable. P. Br. at 2 (emphasis added). Petitioner argues that there is no regulatory language or anything similar which would allow application of the regulation to any occurrence away from the physical facility, and that such matters are "best left, if at all, for the common law remedies of private enforcement through civil lawsuits by the individuals allegedly affected." *Id.* To support its argument that it can only be liable for accidents occurring on the facility's physical site, Petitioner relies heavily on two Civil Remedies Division decisions, *Northgate Healthcare Center*, DAB CR1005 (2003) and *Greenwood Rehabilitation Center*, DAB CR1220 (2004). Specifically, Petitioner hinges the majority of its argument on three words among many discussed in *Northgate* - **"on its premises."** *Northgate Healthcare Center*, DAB CR 1005, at 9. Petitioner concludes its argument by asserting that a facility has met its obligation to its residents where the residents' needs are "adequately addressed though staffing and other reasonable and legal efforts to control and confine the environment." *Id.*

CMS contends that Petitioner's reliance on the *Northgate* and *Greenwood* decisions in support of its position is misguided. Neither of these cases is analogous to the instant matter. *Northgate* and *Greenwood* both dealt with resident accidents which occurred on the facility's physical property. These cases simply do not provide any guidance relating to the present facts. In addition, CMS argues that saying a facility is not subject to strict liability for accidents on-site, as articulated in *Greenwood*, does not, as Petitioner suggests, logically dictate that a facility has no regulatory duty to protect its residents from harm or accidents off-site. CMS Reply at 2. CMS further argues that, based on Petitioner's own assessments of R69, the harm at issue was definitely foreseeable.

V. Findings of fact and conclusions of law

I make findings of fact and conclusions of law (Findings) to support my decision in this case. I set forth each Finding below as a separate heading. I discuss each Finding in detail.

A. The evidence supports CMS's finding of past noncompliance by Petitioner at the time of the January 3, 2003 complaint investigation.

In the SOD dated January 7, 2003, Petitioner was cited with a deficiency at the immediate jeopardy level, for a past incident of noncompliance with respect to Quality of Care - Accidents, 42 C.F.R. § 483.25(h)(2) (F Tag 698, at F Tag 324).

The regulation regarding Quality of Care requires that:

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

42 C.F.R § 483.25(h)(2); *see also,* CMS Ex. 1, at 1.

1. F Tag 324

The SOD cites a specific finding of past noncompliance with respect to F Tag 698 for Resident (R) 69. CMS Ex. 1, at 1 - 4. The specific allegation is that Petitioner failed to ensure [that] each resident received adequate supervision which posed a threat to resident safety and well-being when a resident eloped after he was left unattended in a medical office building restroom.[1] The lack of supervision in addition to the lack of knowledge of staff accompanying this resident, that he had been assessed at high risk for elopement, placed R69 in immediate jeopardy and at risk for injury on December 26, 2002 at 3:40 P.M. *Id.* at 1.

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[1] The medical office building was not the location of R69's appointment. The appointment was in the hospital building on the medical campus. The medical building, from which R69 eloped, was in close proximity to the appointment site.

a. R69

The SOD documents that R69 was admitted into the facility's locked unit on April 6, 2002, with diagnoses of diabetes mellitus, dementia, Wernicke's Syndrome,[2] and a status post head injury which required a craniotomy with resulting memory loss. CMS Ex. 1, at 3; CMS Ex. 6, at 3, 5. On R69's admission into the facility, the admitting physician examined the resident and noted that R69 had a history of wandering and behavioral elopement. CMS Ex. 6, at 3. The attending physician also noted that the resident didn't know where he was, and he had sustained memory loss due to an attack in previous years. *Id.* The Minimum Data Set (MDS) assessments, dated April 28, 2002 and October 7, 2002, indicated that R69 had short/long term memory loss, that his cognitive skills for daily decision-making were moderately impaired with poor decision-making skills, and he required supervision. CMS Ex. 1, at 3; CMS Ex. 6, at 8, 37. The physician's admitting history, as well as the resident's physical, dated April 16, 2002, indicated that R69 had exhibited violent behavior, as well as wandering and elopement behaviors. CMS Ex. 6, at 3. The April 28, 2002-care plan noted interventions to circumvent the resident's elopement from the facility, and the necessity for R69 to be housed in a secured unit. CMS Ex. 1, at 3; CMS Ex. 6, at 32. The Kardex, dated April 28, 2002, noted that R69 was at high risk for elopement. CMS Ex. 1, at 3; CMS Ex. 5, at 7; CMS Ex. 6, at 35. At the time of the elopement, R69 was 53 years old, mobile, but unsteady when walking or standing. CMS Ex. 6, at 9 - 10. On December 24, 2002 (two days before the elopement), R69 was diagnosed with: organic brain syndrome secondary to brain trauma, Wernicke's Syndrome, history of alcohol abuse (in remission for one year), status post-craniotomy in 1999, dementia, and glucose intolerance. P. Ex. 8, at 1.

On December 26, 2002, R69 left Petitioner's facility with the facility's Activity Director and Activity Assistant for scheduled tests at a local hospital. CMS Ex. 1, at 2. Upon completion of the tests, it was discovered that the facility van was not working. Ms. Susie Squires, the Activity Director, called the facility for assistance, and instructed Mr. Stan Nixon, the Activity Assistant, to wait at the entrance of the medical office building for help. In the interim, Ms. Squires and R69 went inside of the medical office building as the resident had complained of being cold while outside (the temperature was reported as 26 degrees Fahrenheit at the time). *Id.* On the day of his appointment, R69 was dressed in a winter jacket, sweat pants, slip-on mocassin-type shoes with no socks, and was not wearing either a hat or gloves. *Id.*; Tr. at 136 - 137. After going inside of the medical office building, R69 told Ms. Squires that he needed to go to the bathroom. Ms.

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[2] Individuals who suffer from Wernicke's Syndrome "have difficulty dealing with current situations, . . . short and long-term effects as far as memory deficits, poor judgment, ability to recall information or to assimilate new information that's coming in." Tr. at 19; *see also,* CMS Br. at 7.

Squires instructed R69 to wait by the bathroom door when he finished. Ms. Squires then proceeded to go into the ladies' room, thus leaving the resident unsupervised for a period of time. When she came out, Ms. Squires saw no sign of R69. At approximately 3:40 p.m., she searched the bathroom and the surrounding area. When unable to locate the resident, Ms. Squires notified the security personnel, the local police, and Petitioner. During the search for R69, it was reported that an ambulance was missing. Approximately six and a half hours after R69's disappearance, the resident was located by local police more than 20 miles from the facility. *Id.* When intercepted by the police, the missing ambulance keys were found in R69's pocket; however, the ambulance was not located until two days later. *Id.* Ultimately, the resident was returned to the facility's locked unit.

i. Petitioner's interpretation of 42 C.F.R. § 483.25(h)(2) is not supported by applicable case law.

Petitioner contends that its duty to provide adequate supervision and assistive devices under 42 C.F.R. § 483.25(h)(2) is limited to providing adequate supervision and protection from accidents which occur on its premises. First, Petitioner's interpretation as to the applicability of section 483.25(h)(2) to this matter is misconstrued. Upon closer examination of the language used by Petitioner in its arguments, Petitioner alludes to the perceived principle that section 483.25(h)(2) is applicable only when read in conjunction with section 483.25(h)(1), which mandates that facilities must ensure that a resident's environment remains free of accident hazards where possible. Petitioner's argument is an inaccurate reading of the applicability of section 483.25(h)(2). As CMS correctly points out, an appellate panel of the Departmental Appeals Board (the Board), in *Woodstock Care Center*, DAB No. 1726 (2000), *aff'd*, *Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003), has previously determined that:

> . . . the two parts of the regulatory provision expressly use different words to address different concerns. The use of two different terms would be superfluous if both referred to the same responsibility to protect residents from environmental hazards. We do not find the use of different terms ("accident" and "accident hazard") to be mere surplusage. Rather, they indicate a substantive distinction between the two subsections of section 483.25(h). The two subsections define different duties: one to provide a safe environment and the other to provide adequate supervision and assistance devices.

Woodstock Care Center, DAB No. 1726, at 13.

In this case, Petitioner was not cited for failing to safeguard against accident hazards, but for failing to provide adequate supervision during the December 26th hospital visit.

ii. An affirmative duty of care is not tantamount to the implementation of a *strict liability* standard.

Petitioner's argument that it is being held to a *strict liability* standard is without merit. Determinations which hold a facility to an affirmative duty of care for its residents do not equate to the implementation of a *per se* or *strict liability* standard. The Board has found that:

> . . . a facility is not required to do the impossible or be a guarantor against unforeseeable occurrences, but is required to do everything in its power to prevent accidents.

Koester Pavilion, DAB No. 1750, at 24 (2000).

The Board's discussion in *Woodstock* provides guidance as to a facility's duty of care. In *Woodstock*, the Board held that a facility is obligated to take measures that are designed, to the extent that is practicable, to ensure that residents do not sustain accidents that are reasonably foreseeable.

Therefore, in applying the *Koester* and *Woodstock* standards to the case before me, I must determine whether Petitioner provided the necessary care to R69, which was previously determined by the facility's comprehensive assessment and care plan. I must decide, based on the resident's noted mental deficiencies, whether Petitioner took reasonable measures to safeguard against accidents during R69's December 26th hospital visit.

My decision in this case turns on whether Petitioner took measures, to the extent practicable, to ensure that R69 did not elope, given Petitioner's recognition that the resident was at risk for elopement. The regulations do not require that a facility use any particular system to prevent elopements. Using an outcome-oriented approach, facilities have the flexibility to use a variety of methods, but they are responsible for achieving the required results. *Woodward Hills Nursing Center*, DAB CR991 (2003).

iii. The risk of harm to R69 was reasonably foreseeable.

It is indisputable, based on the facts in this case, that the risk of harm to R69 was foreseeable. In fact, Petitioner had previously determined R69 to be at risk for elopement due to diminished cognitive awareness for safety brought on by dementia. A specific goal noted in the resident's care plan was that R69 would not leave the facility unattended.

CMS Ex. 6, at 19 - 22, 32; CMS Reply at 4. At various points in time prior to R69's December 26th elopement, the resident was diagnosed with, among other things, dementia, Wernicke's Syndrome, organic brain syndrome secondary to brain trauma, a history of alcohol abuse, moderately impaired decision-making abilities, and short/long-term memory problems. P. Ex. 8, at 1 - 4, 8, 22, 37 - 39, 46; CMS Ex. 6, at 3, 5. In spite of the resident's mental deficiencies, he was ambulatory - capable of walking around the facility and transferring himself unassisted. CMS Ex. 6, at 9. However, the MDS assessment performed by Petitioner's staff on April 29, 2002 noted, among other things, that R69 exhibited a tendency to "wander" which was described as irrational movement where the resident is oblivious to personal needs or safety. *Id.* at 22. To address the established care plan goals, numerous interventions were put into effect which included consistent monitoring of the resident in an effort to circumvent potential elopement and placing the resident in a secured unit, and monitoring his movements in an effort to prevent unattended departure from the facility. *Id.* at 32.

At the hearing, Susie Squires, Petitioner's Activity Director, provided testimony regarding the different levels of security on the locked unit. According to Ms. Squires, when initially admitted to the secured unit, residents are admitted at the "red privilege level," and are not permitted to leave the secured unit. Tr. at 112. She went on to state that a resident is downgraded to the "yellow privilege level" if there is no evidence of aggressive behavior, at which point the resident is permitted to leave the secured unit when accompanied by facility staff. *Id.* at 112 - 113. R69 was not downgraded to yellow privilege until October 2, 2002. At that time, R69 was able to go on a scheduled outing off-site with supervision, and could only leave the facility with approval of the resident's POA/guardian. CMS Ex. 6, at 36. Based on a very well-documented medical record, it is indisputable that Petitioner was on notice of the heightened potential for the resident's elopement.

iv. Petitioner failed to sufficiently prepare its staff for proper supervision of R69 to prevent accidents.

Petitioner argues that R69's elopement and risk of harm was not foreseeable because the staff was properly trained in accordance with policies established by the facility to take the resident to a medical appointment. P. Br. at 3. Petitioner suggests that there was no indication that the Activity Director or Assistant "knew or should have known that this gentleman would leave the premises (let alone 'steal' a van) when he asked to go to the bathroom after the facility's transport van broke." P. Br. at 3. Further, Petitioner contends that the staff was sufficiently trained, according to facility policy and procedure, for the transfer of a resident to an off-site medical appointment. *Id.* Petitioner also makes reference to staff CPR training and whether R69 exhibited an altered state of mind or exhibited any stress on December 26, 2002. *Id.* Petitioner rationalizes that the lack of

any outward signs of an altered state before the resident's appointment justifies the staff's omission of the anti-anxiety medication Ativan prior to R69's departure from the facility. *Id.* Petitioner concludes that it was the lack of any outward indication of a problem which suggested that the resident was more than capable of going to the bathroom unattended and without any incident. Much of Petitioner's assertions on this point are irrelevant and designed to divert attention away from the issue. The issue relative to this argument is not whether facility personnel assigned to accompany R69 to the December 26th hospital visit were properly trained, in accordance with the facility's policy. The issue is whether Ms. Squires and Mr. Nixon had understood R69's diagnosis and behaviors and his need for supervision at the time of the hospital visit.

According to R69's medication administration record (MAR), on December 13, 2002, Ativan was ordered to be given one hour prior to a scheduled appointment. P. Ex. 8, at 3. When questioned at the hearing why Ativan would be order for a patient prior to a medical appointment, Ms. Best testified that the medication "often calms a Resident down if they have had known anxiety prior to procedures or behaviors. It gives them a sense of calmness so they can tolerate the procedure better." Tr. at 33.

Ms. Best further testified that, during the January 7th complaint investigation, she was advised by both Ms. Squires and Mr. Nixon that neither was aware of R69's potential as a flight risk. Tr. at 36 - 37; *see also*, CMS Ex. 7, at 12. Ms. Squires' statement later became an issue to the facility management, and a second interview between Ms. Best and Ms. Squires was arranged. *Id.* Ms. Best testified that at the second interview Ms. Squires was accompanied by facility management. Tr. at 36. It was during the second interview that Ms. Squires advised the state surveyor that she was in fact aware of R69's potential as a flight risk "overall," but "not at that time." Tr. at 140. Ms. Squires stated, at the hearing, that she would consider everyone in the facility as a flight risk. Tr. at 143.

On cross-examination, Ms. Squires testified that she was unaware of specific instructions regarding R69's care and supervision when taking him out of the facility. She was aware of the fact that the resident was housed in a secured unit and had "yellow level privileges." Tr. at 113 - 114, 144. Ms. Squires further stated that December 26th was the first time she had been with the resident on an outing and had no prior knowledge or experience with him in such settings. *Id.* at 151. The witness indicated that on the day of the hospital visit, R69 seemed calm, but admitted that she had no prior gauge of behavior in such an environment for comparison purposes. *Id.* at 116, 151.

It is apparent from Ms. Squires' testimony that she was not provided proper training and guidance by the facility to sufficiently deal with R69 outside of the controlled environment of the facility setting. It is also clear from the record that, whether R69 exhibited signs of stress or calm, he required consistent supervision. While Petitioner

argues that there is nothing to show that R69 was diagnosed with Wernicke's Syndrome, it is irrelevant whether his brain deficiencies were caused by Wernicke's Syndrome or a blow to the skull. What is relevant is the fact that such mental deficiencies did exist which increased the risk for accidental harm. Petitioner's argument relative to the lack of documentation of any signs of problematic behavior, which would lead a reasonable person to conclude that elopement was highly probable, or that increased observation of the resident was warranted, is not convincing.

Had Ms. Squires had proper knowledge of R69's condition, mental state, and wandering and elopement behavior, she would have quite assuredly been on notice of the need to monitor the resident at all times - whether in getting a drink of water from a water fountain or going to the bathroom. Something as simple as standing outside of the bathroom while the resident was inside would have circumvented any possibility of elopement and the resident's subsequent appropriation of the ambulance. There was only one way in and out of the men's room. Tr. at 42; P. Ex. 9, at 8. As to the alleged confiscation of the ambulance, Petitioner postulates that it is "untenable and speculative conjecture" to accuse R69 of stealing the vehicle when accused by individuals with no knowledge to that fact, *i.e.*, Susan Best the state surveyor. P. Br. at 5. However, Petitioner ignores the fact that a copy of the police report on this matter was provided to Ms. Best at the time of the survey by Petitioner's own staff member, Josh Abner, an ancillary nurse. Tr. at 41. Further, it was stated in a Post Elopement Conference/I.D.T. Note, drafted by Mr. Abner and signed by six staff members in addition to Mr. Abner, that an ambulance was reported stolen by security personnel, and that R69 was found approximately five hours later with the keys to the same stolen ambulance in his pocket. CMS Ex. 6, at 54. Based on the evidence, it is reasonable to conclude that the vehicle was indeed taken by R69 subsequent to his elopement. To assert that Ms. Best fabricated information as a "pretext to the complaint survey" is baseless and unsupported by any facts on this record.

v. <u>CMS's immediate jeopardy classification is not clearly erroneous</u>.

CMS assigned a scope and severity level to the cited deficiency in this case as isolated and posing a risk of immediate jeopardy to the residents. CMS assessed a per instance CMP of $3,300. Although both parties presented arguments relating to the immediate jeopardy finding, neither raised the issue of whether I have jurisdiction to consider CMS's immediate jeopardy classification.

A per instance CMP can be from $1,000 to $10,000. There is no specifically defined range or amount for the citation of a per instance penalty for findings of immediate jeopardy. 42 C.F.R. § 488.438(a)(2). Thus, a finding of immediate jeopardy can have no effect on a range of penalties. If CMS has assessed a per instance CMP, the only way CMS's assessment of immediate jeopardy can be an appealable initial determination is if the finding of substandard quality of care will affect the facility's nurse's aide training program. Neither party in this case submitted evidence that Petitioner has a nurse's aide training program. If Petitioner has no program, I have no jurisdiction to consider CMS's assignment of immediate jeopardy to the noncompliance in question.

In the alternative, in the event Petitioner does, in fact, have an approved nurse's aide training program, then I find that Petitioner has not sustained its burden of proving that CMS's determination of immediate jeopardy in this case is 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. Admittedly, R69 did not appear to suffer any serious harm or injury as a consequence of his elopement at the time he was returned to the facility approximately six hours after his initial disappearance. Unfortunately on his return to the facility, he would not permit the staff to examine him nor take his vital signs. CMS Ex. 6, at 49. However, the following day after the resident's return to the facility, he did complain of right knee and ankle pain. CMS Ex. 1, at 2; CMS Ex. 5, at 7; CMS Ex. 6, at 50. X-rays were taken in response to the resident's complaint; and the results were negative for injury. CMS Ex. 6, at 59. Undoubtedly because of the severe temperature outside (reportedly 26 degrees Fahrenheit), he was cold. The fact that he did not suffer more substantial injury is fortunate. It is hard to imagine an elopement by an individual suffering from dementia, among other mental deficiencies, that fails to present a plausible likelihood of serious injury, particularly on a cold winter night. Ms. Squires, Petitioner's own witness, agreed during her testimony that R69 was not safe wandering around on his own that night and he could have hurt himself. Tr. at 152 - 153. In any event, CMS is not required to prove that R69 was actually injured as the result of his elopement to sustain the cited deficiency. Neither a finding of the lack of substantial compliance under section 483.25(h)(2), nor an immediate jeopardy determination, requires a finding of actual harm since noncompliance exists if there is a potential for more than minimal harm. *Lakeridge Villa Health Care Center*, DAB No. 1988, at 9 (2005). Clearly, CMS has established, and Petitioner has not rebutted, that Petitioner's failure to provide adequate supervision for R69 put him in situations that were likely to cause him serious injury, harm, impairment or death.

vi. The amount of the per instance CMP, $3,300, is reasonable.

A per instance CMP can be from $1,000 to $10,000. Petitioner maintains that CMS failed to establish its prima facie case at the scope and severity alleged, and thus the CMP should be reduced below $500. P. Br. at 6. Petitioner makes no argument relative to the amount of the CMP imposing a financial hardship on the facility, nor any other argument relative to the factors at 42 C.F.R. § 488.438(f).

CMS imposed a CMP at the lower range for per instance CMPs. Further, CMS argues that Petitioner has advanced no evidence alleging a threat to the facility's financial stability should a CMP of $3,300 be imposed in this case. CMS further cites that Petitioner also has a history of noncompliance in November 2000 and February 2002. The deficiencies cited in the February 2002 survey included noncompliance for failure to provide supervision and assistive devices to prevent accidents, F Tag 324. CMS maintains that "[u]nless a facility contends that a particular regulatory factor does not support that CMP amount, the ALJ must sustain it." *Coquina Center*, DAB No. 1860, at 33 (2002); *see also, Care Inn of Abilene*, DAB CR1034, at 18 (2003).

CMS has provided persuasive evidence to support its argument that the per instance CMP of $3,300 is reasonable. Because CMS has proven, by a preponderance of the evidence, that Petitioner was not in substantial compliance as alleged, I cannot change the type of penalty that has been assessed, and I do not find that the CMP of $3,300 is unreasonable under the circumstance presented in this case. 42 C.F.R. §§ 488.408(g)(2), 488.438(a)(2).

VI. Conclusion

For the reasons addressed above, I sustain CMS's determination and find that Petitioner was not in substantial compliance with participation requirements at 42 C.F.R. § 483.25(h)(2). I further sustain CMS's determination to impose a per instance CMP in the amount of $3,300.

/s/
Alfonso J. Montano
Administrative Law Judge