Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Life Care Center of La Center
(CCN: 18-5320),

Petitioner

v.

Centers for Medicare & Medicaid Services.

Docket No. C-10-106
Decision No. CR2361

Date: May 3, 2011

DECISION

Petitioner Life Care Center of La Center challenges the determination of the Centers for Medicare & Medicaid Services (CMS) that it was not in substantial compliance with program participation requirements. Petitioner also challenges CMS's imposition of a civil money penalty (CMP) of $3550 per day for the period July 27, 2009 through August 13, 2009, and $100 per day from August 14, 2009 through September 16, 2009. For the reasons discussed below, I sustain CMS's imposition of the CMPs. I sustain also a two-year prohibition on Petitioner's ability to offer a nurse aide training and competency evaluation program (NATCEP).

I. Background

Petitioner is a long-term care facility located in La Center, Kentucky. Petitioner participates in the Medicare and Medicaid programs. The Kentucky State Survey Agency (state agency) completed a complaint survey of Petitioner's facility on August 14, 2009. The survey cited a deficiency under 42 C.F.R. § 483.25(h) (Tag F323, scope and severity level J).[1] By letter dated September 3, 2009, CMS notified Petitioner that it

[1] A scope and severity level of J denotes an isolated deficiency that constitutes immediate jeopardy to resident health and safety. State Operations Manual (SOM), section 7400E; 42 C.F.R. §§ 488.301, 488.408.

was imposing a $3550 per day CMP effective July 27 through August 13, 2009, and a $100 per day CMP beginning August 14, 2009 and continuing until Petitioner achieved substantial compliance or the facility was terminated; a discretionary denial of payment for new admissions (DPNA) effective September 18, 2009, if Petitioner was out of substantial compliance on that date; termination on February 14, 2010, if Petitioner was out of substantial compliance on that date; and loss of NATCEP as a result of the extended survey. P. Ex. 2. By letter dated October 5, 2009, Petitioner was notified that it had been found in substantial compliance as of September 17, 2009, and that the DPNA and termination remedies did not go into effect. P. Ex. 3. The $100 per day CMP stopped accruing as of September 16, 2009, Petitioner having been found in substantial compliance as of September 17, 2009. Petitioner requested a hearing by letter dated October 29, 2009.[2]

I held a hearing in this case in Louisville, Kentucky, on September 21, 2010. A 137-page transcript (Tr.) was prepared. Testifying were C. McIntosh, R.N. (Surveyor McIntosh), a surveyor with the state agency, and T. S. Cooper, R.N., Petitioner's Director of Nursing (DON Cooper). I admitted CMS Exhibits (CMS Exs.) 1 – 12 and Petitioner's Exhibits (P. Exs.) 1 – 27. P. Ex. 27 is the deposition testimony of G. Atkins, Petitioner's Administrator (Administrator Atkins). Both parties filed post-hearing briefs (CMS and P. Br.) and post-hearing reply briefs (CMS and P. Reply).[3]

II. Issues

The issues before me are:

1. Whether Petitioner was in substantial compliance with participation requirements in the Medicare and Medicaid programs; and

2. Whether the remedies imposed are reasonable.

III. Controlling Law

Sections 1819 and 1919 of the Social Security Act (Act) and the regulations at 42 C.F.R. Part 483 govern Petitioner's participation in Medicare and Medicaid. Sections 1819 and 1919 of the Act provide the Secretary of Health and Human Services (Secretary) with authority to impose remedies, including CMPs, against long-term care facilities for failure to comply with participation requirements.

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[2] In its hearing request, Petitioner makes due process arguments I am without authority to hear. Petitioner's hearing request at 4. The arguments are preserved for appeal.

[3] At the close of the hearing Petitioner moved for summary disposition arguing that CMS failed to establish a *prima facie* case of a violation. Tr. at 100-02. Petitioner's motion is moot given my decision here, but it is otherwise denied.

Regulations define the term "substantial compliance" to mean:

> [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.

The Secretary has delegated to CMS and the states the authority to impose remedies against long-term care facilities not complying substantially with federal participation requirements. The applicable regulations at 42 C.F.R. Part 488 provide that state survey agencies, on behalf of CMS, may survey facilities participating in Medicare and Medicaid to ascertain whether the facilities are complying with 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. Under Part 488, a state or CMS may impose a CMP against a long-term care facility if a state survey agency ascertains that the facility is not complying substantially with participation requirements. 42 C.F.R. §§ 488.406, 488.408, and 488.430. The CMP may begin to accrue as early as the date that the facility was first substantially out of compliance or may continue to accrue until the date the facility achieves substantial compliance, or until CMS terminates the facility's provider agreement. 42 C.F.R. § 488.440.

The regulations specify that if a CMP is imposed against a facility based on an instance of non-compliance, the CMP will be in the range of $1000 to $10,000 per instance. 42 C.F.R. § 488.438(a)(2). When a CMP is imposed against a facility on a per-day basis, it must fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP, from $3050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. § 488.438(a)(1)(i), (d)(2). The lower range of CMP, from $50 per day to $3000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). "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.

Sections 1819(f)(2)(B) and 1919(f)(2)(B) of the Act prohibit approval of a NATCEP if within the last two years the facility has been subject to, among other things, an extended or partial extended survey; imposition of a CMP of not less than $5,000; or imposition of a denial of payment for new admissions.

A facility may challenge the scope and severity that CMS cites only if a successful challenge would affect the range of CMP amounts that CMS imposed or would affect the facility's NATCEP. 42 C.F.R. § 498.3(b)(14), (d)(10)(i). CMS's determination as to the scope and severity of non-compliance "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). This includes CMS's finding of immediate jeopardy. *Woodstock Care Center*, DAB No. 1726, at 9 (2000), *aff'd, Woodstock Care Center v. U.S. Department of Health and Human Services,* 363 F.3d 583 (6th Cir. 2003).

The Departmental Appeals Board (Board) has long held that the net effect of these regulations is that a provider has no right to challenge the scope and severity assigned to a non-compliance finding except in the situation where that finding is the basis for an immediate jeopardy determination. *See, e.g., Ridge Terrace,* DAB No. 1834 (2002); *Koester Pavilion,* DAB No. 1750 (2000).

IV. Discussion

I make numbered findings of fact and conclusions of law (Findings) to support my decision. I set them forth below as separate headings, in bold and italic type, and discuss each in detail.[4]

1. Petitioner failed to comply substantially with the participation requirement at 42 C.F.R. § 483.25(h).

42 C.F.R. § 483.25 requires that:

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

[4] I have reviewed the entire record, including all the exhibits and testimony. Because the Federal Rules of Evidence do not control the admission of evidence in proceedings of this kind (*see* 42 C.F.R. § 498.61), I may admit evidence and determine later, upon a review of the record as a whole, what weight, if any, I should accord that evidence or testimony. To the extent that any contention, evidence, or testimony is not explicitly addressed or mentioned, it is not because I have not considered the contentions. Rather, it is because I find that the contentions are not supported by the weight of the evidence or by credible evidence or testimony.

The subsection at 42 C.F.R. § 483.25(h) references accidents[5] and requires that:

> (h) *Accidents.* The facility must ensure that –
>
> (1) The resident environment remains as free of accident hazards as is possible; and
>
> (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

In the case of *Meridian Nursing Center*, DAB No. 2265, at 3 (2009), the Board described the requirements of this subsection, stating:

> Section 483.25(h)(1) requires that a facility address foreseeable risks of harm from accidents "by identifying and removing hazards, where possible, or where the hazard is unavoidable because of other resident needs, managing the hazard by reducing the risk of accident to the extent possible." *Maine Veterans' Home – Scarborough*, DAB No. 1975, at 10 (2005). Section 483.25(h)(2) requires that a 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." *Briarwood Nursing Center*, DAB No. 2115, at 11 (2007), citing *Woodstock Care Ctr. v. Thompson*, DAB No. 1726 (2000) (facility must take "all reasonable precautions against residents' accidents"), *aff'd, Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 (6th Cir. 2003).

The Board has also held that 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." *Briarwood Nursing Center*, DAB No. 2115, at 5, *citing Liberty Commons Nursing and Rehab – Alamance*, DAB No. 2070, at 3 (2007).

The Board stated in *Briarwood Nursing Home*, DAB No. 2115, that:

> [T]he "mere fact that an accident occurred does not, in itself, prove that the supervision or devices provided must have been inadequate to prevent it." Josephine Sunset Home, DAB No. 1908, at 13 (2004). On the other hand,

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[5] The Board references the SOM in defining an accident as:

> "an unexpected, unintended event that can cause a resident bodily injury," excluding "adverse outcomes associated as a direct consequence of treatment or care (e.g., drug side effects or reactions)." SOM Appendix PP, Guidance to Surveyors, Part 2, SOP 483.25 Quality of Care (Rev. 274, June 1995 (SOM Guidance).

Woodstock Care Center, DAB No. 1726, at 4. An elopement is an accident as it is an unexpected and unintended event that can cause a resident bodily injury.

> it is not a prerequisite to finding noncompliance under section 483.25(h)(2) that any actual accident have occurred or be caused by the inadequate supervision to find noncompliance. Woodstock at 17. The occurrence of an accident is relevant to the extent the surrounding circumstances shed light on the nature of the supervision being provided and its adequacy for the resident's condition. St. Catherine's Care Center of Findlay, Inc., DAB No. 1964, at 12 (2005) (accident circumstances may support an inference that the facility's supervision of a resident was inadequate). The focus is on whether the facility took all reasonable steps to ensure that a resident receives supervision and assistance devices that met his or her assessed needs and mitigate foreseeable risk of harm from accidents. Woodstock Care Center v. Thompson, 363 F.3d at 590 (facility must take "all reasonable precautions against residents' accidents").
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> > The regulation speaks in terms of ensuring that what is "practicable" and "possible" to do is done. What is thus required of facilities is not prescience but reason and professional judgment in assessing what can be done to make residents (given their special needs) safe, through removing accident hazards, providing appropriate devices, and ensuring adequate supervision.
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> Josephine Sunset Home, at 14-15.

Briarwood Nursing Center, DAB No. 2115, at 11-12.

The Board has also held that the regulations permit facilities flexibility in choosing the methods they use to prevent accidents, so long as the chosen methods constitute an adequate level of supervision. *Windsor Health Care Center,* DAB No. 1902 (2003), *aff'd Windsor Health Center v. Leavitt,* 2005 WL 858069 (6th Cir. April 13, 2005). A facility must anticipate what accidents might befall a resident and take steps — increased supervision or the use of assistance devices — to prevent them. *Aase Haugen Homes,* DAB No. 2013 (2006).

The state agency determined that Petitioner was noncompliant following a complaint survey of Petitioner's facility on August 11, 2009. During the survey, surveyors also identified immediate jeopardy and substandard quality of care. The state agency notified Petitioner of the surveyors' determinations on August 12, 2009. The state agency conducted a partial extended survey from August 13 through 14, 2009. A statement of deficiencies (SOD) dated August 14, 2009, alleges Petitioner's noncompliance began on July 27, 2009. Petitioner submitted an acceptable allegation of compliance on August 14, 2009, and the state agency removed the immediate jeopardy determination and revised Petitioner's level of noncompliance to a level "D" (indicating an isolated deficiency that constitutes no actual harm with a potential for more than minimal harm but not immediate jeopardy). The SOD states that after August 14, 2009 the noncompliance continued "based on Petitioner's need to evaluate the changes in the policy/procedure and

the effectiveness of quality assurance activities related to implementation of system changes." CMS Ex. 1, at 9-10; P. Ex. 1, at 9-10.

The specific violation of 42 C.F.R. § 483.25(h) (Tag F323) that CMS alleges in this case involves Petitioner's failure to provide adequate supervision to Resident 1. The August 14, 2009 SOD alleges that on July 19, 2009, Petitioner assessed Resident 1 as at risk for elopement. Resident 1 left the facility without staff knowledge on July 27, 2009 and was found four blocks (approximately three-tenths of a mile) from the facility after crossing three roads with speed limits of 25 – 35 miles per hour. CMS Ex. 1, at 1-2; P. Ex. 1, at 1-2.

CMS alleges that Petitioner failed to adhere to its planned interventions for minimizing Resident 1's elopement risk, and failed to follow its elopement policy and procedures, putting at risk Resident 1 and other similarly-situated residents. CMS asserts these failures resulted in Resident 1's elopement eight days after admission. CMS also alleges that Resident 1's elopement put Petitioner on notice of a systemic risk in its elopement practices, but, despite that notice of risk, Petitioner made no meaningful changes to mitigate that risk. Below, I find CMS has made a *prima facie* case that Petitioner failed to minimize Resident 1's elopement risk, which was foreseeable and constituted immediate jeopardy to Resident 1 and other residents during the relevant time, and that Petitioner failed to make sufficient changes in its policies and procedures to mitigate the elopement risk after Resident 1's elopement. I find further that Petitioner failed to rebut CMS's case.

Facts:

Petitioner is a 70-bed facility in a rural area. P. Ex. 27, at 6. The facility has four main entrances that families and employees may use. P. Ex. 27, at 11. The exit doors are opened from the inside via an electronic keypad system that requires entry of a code. The building can be entered from the outside without use of a keypad. The locks and keypads are routinely tested and operated properly at the time of survey. At the relevant time, Petitioner did not have locked interior doors, a staffed reception desk, or an electronic Wanderguard system. Petitioner's staff shared exit codes with residents' families upon request, and this enabled those family members to leave the facility without staff involvement. Prior to Resident 1's elopement, Petitioner asserts that there had never been a problem with its system and CMS has presented no evidence to the contrary. Tr. at 28, 40-41, 69, 71; P. Ex. 27, at 23, 55-56.

At the relevant time, Petitioner had a resident population of both residents who were elopement risks and other residents who were not. The two populations were integrated, although Administrator Atkins testified, without further explanation, that elopement risk residents received more supervision if required. P. Ex. 27, at 62-63; CMS Ex. 7.

Resident 1 was admitted to the facility from Lourdes Hospital on July 19, 2009. Her admission diagnoses included, among other things, depressive disorder, Alzheimer's disease, anxiety state, adult failure to thrive, and altered mental status. CMS Ex. 2, at 14. In her hospital discharge summary, her physician (who asserted he knew Resident 1 well) states that she,

> Presented to the office with her granddaughter stating that she has been having some confusion. She has been very forgetful over the past several weeks. She has been walking around the outside of her house, down the street, through the neighborhood, forgetting where she is. She has also been disoriented to person, place, and time on occasions. In the office she seemed quite pleasant in no acute distress but had some short-term memory defects on mini mental status examination.

CMS Ex. 2, at 42. The physician notes as discharge diagnoses her advanced age with adult failure to thrive and her need for nursing home placement, mental status changes which were chronic in nature with confusion, and Alzheimer's dementia. CMS Ex. 2, at 42-43.

A Resident Transfer Record notes that Resident 1 was "confused" and "wanders" and that she "needs [a] safe place to wander." CMS Ex. 2, at 45. A medical and psychiatric history notes that prior to her hospitalization she drove herself to Evansville, Indiana, and was unaware of how she got there or why she was there. CMS Ex. 2, at 23.

Petitioner assessed Resident 1 upon admission as an elopement risk. An elopement risk assessment dated July 19, 2009, notes that she was: cognitively impaired with poor decision making skills; had diagnosis such as, among other things, dementia, Alzheimer's, and depression; ambulated independently; had a history of elopement while at home; expressed a desire to go home; had been recently admitted; had changes in status; and had family who voiced concern that she had wandering tendencies and might try to leave the facility. CMS Ex. 2, at 15-16. The summary of the assessment notes that the resident was at risk of elopement as she requested to go home three hours after arriving. It notes as interventions exit and stairwell alarms; that she was on a secured unit[6]; that she would be checked every two hours or more as needed; that her room would be personalized with familiar objects and photographs; and that staff was to be aware of her wander risk. CMS Ex. 2, at 16. There is no documentary evidence that two hour checks were performed. Tr. at 98; P. Ex. 27, at 64-66. A July 19, 2009 interim care plan notes her wandering and exit behaviors and history of elopement from her home. It notes as interventions educating the family, providing for safe wandering, involving her in activities, encouraging family visits, and evaluating her exit seeking behaviors to

[6] The summary of assessment form does not describe what a "secured unit" comprises. Petitioner did not have a locked unit, but Petitioner assessed Resident 1 as appropriate for the level of security it did have. Tr. at 53.

determine their causes and patterns. On July 25, 2009, using visual barriers as needed was added. After the elopement, the facility added 15 minute checks (July 27, 2009) and putting a nametag on the resident (July 30, 2009). A physician order notes the addition of bed and chair alarms. P. Ex. 10, at 2; P. Ex. 14, at 3; CMS Ex. 2, at 6.

Resident 1 was assessed to be at risk for falls based on her score of "10" on a July 19, 2009 fall risk assessment, which documents that she had fallen within the prior 90 days, and had cognitive status and behavioral changes, health conditions, and medications which increased her risk of falls. CMS Ex. 2, at 40. A minimum data assessment (MDS) dated July 24, 2009, notes that she needed partial physical support to maintain balance while standing. P. Ex. 9, at 3. Her interim care plan notes that she was at risk for physical injury from falls due to unsteady ambulation, her inability to understand safety strategies, and her diagnosis of Alzheimer's. Interventions included educating her family on fall risk, monitoring and encouraging her use of proper footwear, and a low bed. She declined using a hip protector. CMS Ex. 2, at 11, 39.

Petitioner's initial data collection tool from July 19, 2009, notes that Resident 1, although alert and oriented, had short and long-term memory loss,[7] requires assistance to make daily decisions, and that her mental status varies throughout the day. CMS Ex. 2, at 25. A social services assessment from July 19, 2009, notes that Resident 1 was alert with confusion, and had poor decision making skills and decreased cognition. CMS Ex. 2, at 24. The July 24, 2009 MDS notes that the Resident made poor decisions and needed supervision. P. Ex. 1, at 1, 5.

Resident 1 displayed confusion during the period between her admission and elopement. Nurse's notes on July 19 found her "alert and confused" and "does not know where she is"; on July 21, 2009, she was "not real sure where she is" and was "confused about where she is"; on July 22, 2009, she was alert with confusion and needed reminders with her daily routine; and on July 24, 2009 she was alert and confused. P. Ex. 15, at 1-2.

In short, although Resident 1 was alert, at the relevant time Petitioner had assessed Resident 1 as an elopement risk, finding that she was confused, a wanderer, needed a safe place to wander, was unable to understand safety strategies, and was at risk for falls.

It is undisputed that Resident 1 eloped the facility on July 27, 2009 (although Petitioner now attempts to frame the elopement as an "unaccompanied walk"). Although it was

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[7] Petitioner notes that Resident 1's initial nursing assessment on July 19, 2009 indicated that she had long-term memory deficits, but the comprehensive assessment (MDS) completed on July 30, 2009, indicates no such problem. P. Ex. 6, at 1; P. Ex. 9, at 1. DON Cooper testified with regard to this discrepancy only that on July 19 the nurse determined that Resident 1 had long-term memory loss but at some point after that staff decided that determination was incorrect. Tr. at 126. There is no explanation of record for how the discrepancy occurred or why it was decided that the Resident in fact had no long-term memory deficit. I note the discrepancy, but it does not affect my decision.

never determined conclusively how Resident 1 eloped the facility, Administrator Atkins' investigation of the elopement is essentially undisputed by CMS. In a July 30, 2009 notification letter (apparently to the state agency as a "follow-up to an incident reported on July 27," although addressed to "Whom It May Concern"), Administrator Atkins stated that at approximately 5:30 p.m. on July 27, 2009, facility staff reported that they were unable to locate Resident 1. She was noted to be absent during delivery of the supper meal (which Resident 1 took in her room while she and her roommate watched television). Staff began an immediate search of the facility and grounds. On-duty staff reported seeing her as recently as five to ten minutes earlier. The search was expanded beyond facility grounds. At approximately 5:45 p.m., Resident 1 was returned to the facility by an off-duty employee who had heard the Resident was missing, went to look for her, and found her walking on a side road four blocks from the facility. Resident 1 was unharmed. Administrator Atkins questioned Resident 1 about the incident. Resident 1 told Administrator Atkins that she had "just gone for a walk." She stated that she went out the Wing 3 exit door after "someone . . . held the door open for me to go through." CMS Ex. 3.

A resident/family education assessment on July 21, 2009, notes that DON Cooper discussed with Resident 1 that she needed to stay at the facility for a while and Resident 1 indicated to DON Cooper that she knew that. After the elopement, Administrator Atkins spoke with the Resident with regard to leaving the facility unattended and educated the Resident on the importance of staff being aware of her location. Resident 1 expressed understanding and regret for breaking facility policy. P. Ex. 18, at 1-2. DON Cooper testified at hearing, however, that because Resident 1's mental status varies throughout the day it was "conceivable" that she might forget what she was told. Tr. at 125.

As additional information regarding the elopement, Surveyor McIntosh testified that she was told that on the day of the elopement a resident across the hall from Resident 1 was dying, and that this resident had a lot of visitors coming in and out utilizing the Wing 3 door. The investigation determined Resident 1 went out the Wing 3 door behind a visitor. She went approximately 0.3 miles or four blocks from the facility, crossing three roads with speed limits from 25 to 35 miles per hour. She was found near an area of fairgrounds, close to a cemetery. Tr. at 38-39; CMS Ex. 8, at 1. In an interview with the registered nurse who assessed Resident 1 on her return to the facility, as reflected in Surveyor McIntosh's surveyor notes, the registered nurse informed Surveyor McIntosh that Resident 1 was confused and wanted to see her husband in the cemetery. Apparently Resident 1 had been in the habit of visiting the cemetery daily prior to her placement in Petitioner's facility. CMS Ex. 4, at 12.

Petitioner had an elopement policy at the relevant time. CMS Ex. 9; P. Ex. 20. The policy defines an elopement as an incident in which a resident leaves facility grounds without staff knowledge; the resident has impaired decision making abilities and is unaware of his/her safety needs. The policy provides that a system of identification would be created for elopement risk residents to assist staff and law enforcement in identifying a resident after an elopement, which system might include an identification

bracelet, identification on a resident's clothing, or a photograph of a resident. The policy also provides for a system to notify staff that exit doors have been opened in areas accessible to residents to include, among other things, monitoring practices when door alarms are disabled or during instances of high traffic, and monitoring practices for exits that are not visible to staff but are readily accessible to residents. CMS Ex. 9, at 2; P. Ex. 20, at 2.

Following the elopement, as asserted by Administrator Atkins in her notification letter and found elsewhere in the record, facility safety precautions were reviewed to determine factors contributing to the elopement. She notes that all exit doors were equipped with a keypad system whose codes were changed on a monthly basis. The codes were changed after the elopement and all doors were checked to determine if they were functioning properly. No problems were noted in weekly checks of the doors and alarms. Resident 1 was placed on 15 minute checks and no additional episodes of exit seeking behavior were noted. Bed and chair alarms were ordered by her physician to notify staff of her location, but were discontinued because the Resident did not like them. The exit doors were posted to make visitors aware to ask for assistance before allowing a resident outdoors and letters were sent to families reinforcing this information. Staff held a meeting with Resident 1's family to discuss safety concerns and possible alternative placement in a locked unit. Resident 1 was given a nametag to wear to identify her as a resident. On July 30, 2009, Resident 1 was relocated to another facility. CMS Ex. 3; P. Ex. 27, at 41, 45-46; P. Ex. 14, at 3; P. Ex. 27, at 83-84; P. Br. at 13. After Resident 1's relocation, however, other elopement risk residents remained at Petitioner's facility. CMS Ex. 7.

After Resident 1's elopement, Petitioner did not change its policy regarding monitoring exits and entrances, or specifically monitor the exits when visitors were in the facility, or upgrade monitoring of elopement risk residents. Effective August 12, 2009, Petitioner implemented a new policy that it would not provide door codes to residents' visitors or family members. Visitors, residents and family members were still free to come and go, but on leaving the building all visitors were to be assisted by a staff member. Tr. at 42; CMS Exs. 6, 8.

Discussion:

CMS alleges that Petitioner violated its own elopement policy and thus failed to supervise Resident 1 adequately, leading to her elopement from the facility. CMS extrapolates from this that Petitioner's failure put all similarly-situated residents at risk of elopement. CMS alleges also that once Resident 1 eloped, Petitioner was on notice of a systemic risk to its elopement-risk residents that Petitioner failed to address adequately. CMS asserts that the issue in this case is not whether Petitioner's assessments of Resident 1 or its retrieval procedures after Resident 1's elopement were sufficient, but whether Petitioner's supervision was adequate to prevent the elopement itself.

CMS alleges specifically that: (1) Petitioner determined that its staff needed to check Resident 1 every two hours, yet Petitioner did not provide this planned intervention and

Administrator Atkins admitted that she did not know whether anyone was checking the Resident every two hours and that she did not have documentation showing checks every two hours. CMS Ex. 2, at 16; Tr. at 98; P. Ex. 27, at 65; (2) Petitioner did not have a photograph of Resident 1 in its elopement risk binder, in violation of its elopement risk policy. CMS Ex. 1, at 6-7; CMS Ex. 4, at 12; CMS Ex. 9, at 2; (3) Petitioner did not monitor the Wing 3 exit, which was not visible to staff at the nursing station, but was accessible to residents, in violation of its elopement risk policy. CMS Ex. 9, at 2; CMS Ex. 1, at 3; CMS Ex. 3, at 2; Tr. at 31-33; P. Ex. 27, at 77-78; (4) Petitioner did not monitor its exit doors or elopement-risk residents during instances of higher traffic, in violation of Petitioner's elopement risk policy. CMS Ex. 9, at 2; P. Ex. 27, at 75-76; Tr. at 28; (5) Petitioner had no redundancies of protection. CMS Ex. 1; and (6) After being put on notice that its policy of giving the keypad code to visitors posed a risk to Resident 1 and other elopement risk residents, Petitioner failed to make meaningful changes, such as stopping the giving-out of the keypad code, increasing monitoring of residents, or monitoring entrance and exit doors. Instead, Petitioner continued to give the keypad code to residents and failed to increase resident supervision. CMS Ex. 4, at 15.

CMS also disputes Petitioner's argument, set forth below, that any alleged deficient practice was merely Petitioner's appropriate attempt to balance Resident 1's autonomy with her safety. CMS notes Petitioner's assertions that in balancing these concerns it did not restrict her ability to move about the facility, assigned her to a room with an alert, oriented, and "chatty" roommate near the Wing 3 exit, and served her meals in her room to facilitate socialization with her roommate. CMS argues that these rationales are irrelevant to keeping her safe. CMS stresses that respect for Resident 1's autonomy does not preclude inclusion of a photograph in an elopement risk book, monitoring her every two hours, monitoring entrance and exit doors, or increasing monitoring during high traffic periods. Tr. at 98-99. CMS argues that Petitioner is not noncompliant because it placed Resident 1 near the Wing 3 exit; rather, it is noncompliant because it placed her by an unmonitored exit without increased supervision or assistance devices to prevent elopement.

CMS argues also that Petitioner's attempt to portray the elopement as a casual walk by a Resident with minor cognitive deficits who did not necessarily need skilled nursing care is inaccurate. Resident 1's physician diagnosed her with chronic mental status changes with confusion, stated she had Alzheimer's dementia, adult failure to thrive, and needed nursing home placement. CMS Ex. 2, at 42. Resident 1 also had a history of becoming lost and confused in her neighborhood and became lost while driving her car. While she was at the facility she was noted to be confused. When Petitioner discharged Resident 1 it was to a more secure facility. The evidence thus does not support — and in fact strongly refutes — the notion that she was on a casual walk on a planned, safe route. Rather, when Surveyor McIntosh interviewed the registered nurse who assessed Resident 1 after she was returned to the facility, the nurse indicated that Resident 1 was confused and wanted to see her husband in the cemetery. That Resident 1 ultimately returned home, or that she now visits the facility occasionally, is simply irrelevant.

Petitioner argues that CMS has not made its *prima facie* case of noncompliance and that Resident 1's unaccompanied "walk" has been conflated to a regulatory violation. Petitioner asserts that this incident was not a typical elopement situation where a confused resident wanders from a nursing facility and subjects herself to hazards such as getting lost, exposed to cold, or being run over by a car. Instead, Petitioner says that Resident 1 "simply slipped out of the center without telling anyone (apparently when a visitor held a door open) to take a walk on a nice afternoon, but in a manner that suggests that she had planned a safe route in a familiar area she was capable of navigating." P. Br. at 1-2. Petitioner acknowledges that residents "leav[ing]" facilities unaccompanied can, in some cases, pose a risk of serious harm. However, as acknowledged by CMS, Petitioner argues that facilities have a regulatory duty to protect resident rights and to promote autonomy. Balancing the imperative of keeping residents safe with the need to respect residents' rights and dignity demands the exercise of informed and competent judgment. Here, Petitioner's witnesses testified they did not consider Resident 1 to present a significant elopement risk (as she did not exhibit exit-seeking behavior or aimless wandering and appeared to acclimate to the facility) and that the facility care-planned accordingly. While it was "undesirable" that Resident 1 eloped, Petitioner insists that the event was not the result of unreasonable staff judgments, actions or omissions that would support a determination of immediate-jeopardy noncompliance. P. Br. at 2-3. In fact, Surveyor McIntosh conceded that Petitioner's staff had to balance residents' safety against their autonomy. P. Reply at 9; Tr. at 79. Petitioner argues that its staff assessments and care plans considered and implemented what staff believed to be Resident 1's most pressing needs on admission; physical and emotional support while she was recovering from recent upsetting, traumatic events, including the loss of her husband and the incarceration of a daughter.

Petitioner recognizes that a facility can violate section 483.25(h) even if no accident actually occurs. It argues, however, that such a violation must involve a significant lapse in oversight and cannot be constructed by retrospectively piecing together a hypothetical series of supposed omissions. P. Reply at 8. Petitioner asserts that DAB precedent acknowledges that 42 C.F.R. § 483.25(h) does not require complete success in protecting residents and that no long-term care facility is able to or expected to guarantee that no untoward event will occur on their premises (*Woodstock Care Center*, DAB No. 1726) and that a facility's interventions must take into account the unique condition and needs of its residents, *i.e.*, whether a resident is an active exit seeker. *Mitchell Village Care Center*, DAB No. CR1589 (2007). However, *Mitchell Village* also notes that a facility must be able to show that there are redundancies of protection or multiple interventions to take into consideration the probability of the failure of a single intervention or system, and is therefore inapposite here.

Petitioner argues that merely because Resident 1 managed to get outside the facility without staff knowledge that is not *ipso facto* a deficiency. Such a conclusion has been found by the Board to be overly simplistic. *Willow Creek Nursing Center*, DAB No. 2040 (2006). I note, however, that in *Willow Creek*, the Administrative Law Judge (ALJ) found specifically that the facility's interventions for an eloping resident were sufficient

to prevent that resident from eloping undetected and unsupervised, unlike in the situation here. Thus, this argument is also inapposite.

Petitioner asserts CMS's argument that Petitioner failed to provide adequate supervision because it did not follow its elopement policy mischaracterizes the evidence. Petitioner argues that its policy requires local administrators and staff to make assessments about resident needs and that Petitioner's staff made such assessments in this case. Petitioner suggests that CMS took out of context its elopement policy directive that Petitioner should develop a system to notify staff when exit doors are disabled. That would refer to a situation where a locked unit is being repaired, *Aase Haugen Homes*, DAB No. 2013, as easily distinguished from the situation discussed here where a dying resident may have received more visitors than normal. Petitioner argues also that the provision of the elopement policy stating that facilities should monitor exit doors not visible to staff, but readily accessible to residents, refers to doors from individual resident rooms that open to courtyards or patios, not, as CMS asserts, to main corridor doors not visible to staff. CMS infers that Petitioner's elopement policy covers exit doors not capable of being seen by a nurse seated at a nearby nursing station. However, Petitioner asserts that the layout of its facility is similar to the layout at other facilities and the layout is rarely hazardous because nurses and nursing aides circulate in hallways. Petitioner argues that except for locked or secure facilities or units, no facility continuously monitors every door. Because Petitioner is open to the community, Administrator Atkins testified she does not admit or retain residents who require close monitoring or a locked or secure unit.

Petitioner asserts further that CMS's arguments are faulty with regard to Petitioner's having been put on notice of a systemic risk after Resident 1's unsupervised walk, or that the circumstances of Resident 1's unsupervised walk might be extrapolated to other residents to show there were systemic causes that created or enhanced elopement risk at the facility. According to Petitioner's view of the evidence, at most, its staff misjudged Resident 1's likelihood of leaving the facility unannounced. That its staff overreacted to the Resident's unsupervised walk by discharging her, says Petitioner here, illustrates their extreme sensitivity to the issue.

Petitioner asserts that CMS's argument that Petitioner's only system to protect residents from elopement was reliance on door locks which could easily be defeated is unsupported. It asserts that Administrator Atkins' testimony makes clear that in her consideration of resident safety she did not admit or retain residents who were exit seekers and that the facility had not experienced past problems with its system. And, Petitioner goes on to argue, it is not clear that sharing exit codes contributed to Resident 1's leaving the facility, as its doors could be opened from outside.

Petitioner asserts that CMS's argument that Petitioner made no meaningful changes after the elopement is incorrect. It says that changes were made after the elopement, both for Resident 1 (personal alarms, 15-minute checks, use of a nametag, consideration for discharge), as well as policy and procedural changes such as door signs, letters to families regarding changes, and changed door-lock codes. While CMS argues such changes were

not "meaningful," Petitioner claims that CMS offers no evidence as to what it means by that term. Petitioner notes that CMS does not dispute that staff immediately considered implementing changes to Resident 1's care plan and operating procedures, but alleges Petitioner's actions were tardy and insufficient. CMS does not, Petitioner's argument goes, point to a professional standard requiring more immediate changes.

Petitioner's arguments are unavailing. Petitioner asserts that Resident 1's elopement is not a "typical" elopement situation. In fact it rather plainly is perfectly typical of such incidents as reflected in the jurisprudence of this forum over decades. Perhaps more tellingly, Petitioner's own policy defines an elopement as an incident where a resident leaves facility grounds without staff knowledge, and where the resident has impaired decision making abilities and is unaware of his or her safety needs. Resident 1 was assessed twice by Petitioner as an elopement risk and her elopement fits precisely within Petitioner's definition of an elopement; she left facility grounds without staff knowledge, she had impaired decision making abilities (at a minimum Alzheimer's dementia and short-term memory loss), and she was unaware of her safety needs (she was confused, was a wanderer, and was assessed to need a safe place to wander). Resident 1 took advantage of an opportunity to elope, apparently leaving the facility when a door was opened by a visitor. She did not ask anyone at the facility whether she could take a walk, she did not ask to be accompanied or let staff know she was planning a walk, and she had not been assessed or care-planned as independent enough to go out on a walk alone. And in spite of Petitioner's efforts so to cast it, the question is not whether Resident 1 determined to take a walk on a sunny day and did so. The salient question is whether Petitioner adequately supervised Resident 1, whom it had assessed as an elopement risk (and by extrapolation whether Petitioner adequately supervised all its elopement risk residents) and, if it did not do so, whether Petitioner addressed this systemic risk after the elopement of Resident 1 brought the matter sharply to its attention. I find Petitioner simply failed in its obligation to do so. Moreover, the risk to Petitioner's elopement prone residents from its noncompliance was foreseeable, and Petitioner failed to do all that it could to mitigate that risk.

CMS has specifically alleged six instances of noncompliance by Petitioner. I do not find a violation of the regulations in the fact that Petitioner did not document that its staff checked Resident 1 every two hours. CMS did not show that documentation of two-hour checks, as opposed to simply conducting two-hour checks, is a standard of care. CMS does not dispute that Resident 1 was actually seen within two hours of the time she eloped. While Petitioner may have erred by not ensuring that Resident 1's photo was placed in the elopement risk binder, or may have erred by not keeping up its elopement risk binder, the absence of Resident 1's photograph from the binder is not critical to my decision. Petitioner's elopement policy provides that the photographs are there to assist staff and the authorities in retrieving a resident once the resident has eloped. While an elopement binder photograph might be used in other facilities to prevent elopement, it is not clear that in Petitioner's facility the binder was ever intended or used for this purpose.

What is critical to my decision in this case is Petitioner's failure to monitor its doors to prevent elopement. Petitioner's elopement policy itself provided for a system to notify staff when exit doors are opened in areas accessible to residents, to include monitoring practices during instances of high traffic and monitoring for exits not visible to staff but readily accessible to residents. Below, I note that Petitioner's interventions were not adequate to comply with its own elopement policy. Because of this I am not persuaded by Petitioner's arguments and assertions that its supervision of its elopement risk residents, both before and after Resident 1's elopement, was adequate.

Facilities are required to take all reasonable measures to protect their residents from foreseeable accident hazards. Elopement though facility doors not adequately monitored is such an accident hazard. Here Petitioner accepted residents who were assessed to be elopement risks, such as Resident 1. Although Administrator Atkins seeks to qualify how elopement-prone Petitioner's residents actually were by testifying that Petitioner did not admit or retain residents who require close monitoring or a locked or secure unit, Administrator Atkins does not explain how Petitioner's assessed elopement-risk residents were adequately monitored. Her testimony that elopement risk residents received more supervision, with no explanation of what that supervision consists of, is not credible. Moreover, there is no intricate balancing required between residents' safety and their autonomy by making sure that exit and entrance doors are adequately monitored. The evidence shows that Petitioner's interventions to protect its elopement risk residents were seriously inadequate and it is thus a matter of luck, and not of planning or procedure, that no resident eloped prior to Resident 1's elopement.

At the time of Resident 1's elopement Petitioner did not have locked interior doors, a staffed reception desk, or an electronic Wanderguard or other system to alert it when an elopement prone resident was about to go out a door. Individuals could enter Petitioner's four main doors at will. The only deterrent to anyone's freely leaving the facility was that an individual must have the code to a keypad on the door. This code was given to residents' families freely on request. The Wing 3 exit from which Resident 1 eloped was not visible to staff at the nursing station. Petitioner did not require that staff monitor the doors during an instance of high traffic when a resident who was dying was receiving more visitors than normal, and did not appear to realize that a high-traffic event was taking place. Petitioner's doors were thus essentially unmonitored despite the presence of elopement-risk residents in the facility. Petitioner's argument that its elopement policy's reference to monitoring doors that were not visible as being limited only to doors from individual resident rooms is not credible. Its argument that its layout is rarely hazardous because nurses and nursing aides circulate in the hallways is equally unpersuasive, as is Administrator Atkins' testimony, noted above, that she does not admit or retain residents who require close monitoring or a locked or secured unit. Petitioner admittedly mixed elopement and non-elopement risk residents in its facility where the only impediment to an elopement from a door such as the Wing 3 door was a keypad, or the hope that nobody might open a door and let a resident out at a time when a nurse was not circulating in the hallway to stop the elopement.

Petitioner failed to address this systemic risk after Resident 1's elopement. While the keypad codes were changed, the codes were still being given to families. While Resident 1 was placed on 15-minute checks, there is no indication that other elopement risk residents were re-assessed to determine whether they should be watched more closely. While the exit doors were posted with notices asking visitors to seek assistance before allowing a resident out a door, there is no indication of how a visitor could tell who was a resident and who was not. Administrator Atkins testified that staff did not put a nametag on every elopement-risk resident and acknowledged that some residents are more easily distinguished from the general nursing home population than others. P. Ex. 27, at 73-74, 84. Most importantly, there was nothing done to make sure that the doors were monitored. It was not until August 12, 2009, that Petitioner implemented a policy that required staff to assist all visitors leaving the building.

Petitioner's noncompliance here does not hinge solely on the elopement of Resident 1. Had the resident not eloped, the hazard caused by Petitioner's failure properly to supervise its residents and monitor its doors would still have existed. The hazard was not diminished simply because Petitioner asserts no resident had eloped before. Petitioner continued to give out the keypad code to families, thus creating the risk that a visitor who did not recognize someone as a resident could let that resident out without staff knowledge, and did not otherwise increase its monitoring of its doors or its elopement risk residents.

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

Immediate jeopardy exists if a facility's noncompliance has caused, or is likely to cause, "serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination as to the level of a facility's noncompliance (which includes an immediate jeopardy finding) must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a heavy burden to show no immediate jeopardy and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1962, at 11 (2005); *Florence Park Care Center*, DAB No. 1931, at 27-28 (2004), *citing Koester Pavilion*, DAB No. 1750 (2000).

I find that CMS's determination of immediate jeopardy here is not clearly erroneous. Petitioner's failure to adequately supervise Resident 1 and monitor its doors with anything other than the keypad left its elopement risk residents at grave risk of elopement. Resident 1 actually eloped. Petitioner argues there is no basis to infer that Resident 1 was at risk during her elopement and asserts that the Resident was used to walking alone and was on a level sidewalk, in mild weather, in the opposite direction from a busy street and in a town she knew well. Petitioner asserts that the testimony of its Administrator and DON show that the facility was fully meeting the Resident's needs and that the testimony trumps the contemporaneous documentation prepared by the

facility. I disagree with that very forced view of this evidence. Petitioner ignores the fact that Resident 1's physician determined that she had chronic confusion and Alzheimer's dementia, that she had been walking through her neighborhood forgetting where she was, and that Petitioner itself assessed her as confused and at risk from falls due to unsteady ambulation, as a resident who needed a safe place to wander, and as unable to understand safety strategies.[8] Unsupervised and outdoors, Resident 1 was, at the least, at risk of being struck by a car or falling and injuring herself. While Resident 1 was apparently uninjured by her elopement, the likelihood of serious harm or death to this resident during an elopement is patent.

3. The CMP imposed is reasonable, and the two-year prohibition against Petitioner's conducting a NATCEP is required by law.

To determine whether the CMP imposed is reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f), which are: (1) the facility's history of noncompliance; (2) the facility's financial condition; (3) factors specified in 42 C.F.R. § 488.404; and (4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort, or safety. The absence of culpability is not a mitigating circumstance in reducing the amount of the penalty. The factors listed in 42 C.F.R. § 488.404 include: (1) the scope and severity of the deficiency; (2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and (3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

In reaching a decision on the reasonableness of the CMP, I must consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by Petitioner with the kind of deficiency found, in light of the above factors. I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Center*, DAB No. 1848, at 21 (2002).

CMS imposed a penalty of $3550 per day for the period July 27, 2009 (the day of Resident 1's elopement) through August 13, 2009, and of $100 per day from August 14, 2009 through September 16, 2009. Both the penalties are in the low range of penalties for immediate jeopardy and non-immediate jeopardy situations. CMS does not cite facility history as a factor justifying higher CMPs and Petitioner does not argue that its financial condition affects its ability to pay the CMPs. I find Petitioner culpable, because it failed to institute measures to prevent elopement. And the deficiency is serious, in that

[8] Administrator Atkins attempted to downplay Resident 1's fall risk by testifying that all unsteady ambulation means is that a person might stumble or tire after walking and have some difficulty walking. P. Ex. 27, at 60-61. In this instance, however, a resident eloping a facility who might stumble or tire after walking, or who might have some difficulty walking, is at risk of serious injury from falls.

it constitutes immediate jeopardy to Resident 1 and other elopement risk residents at the facility.

I have considered the duration of the CMPs assessed. Petitioner has the burden of proving that it achieved substantial compliance on a date earlier than that determined by CMS. Petitioner argues that if there is any noncompliance it ended on July 30, 2009, when Resident 1 was discharged from the facility. However, although Petitioner now argues that CMS never demonstrated that other residents posed an elopement risk after Resident 1's discharge, the evidence shows that other facility residents were also assessed to be elopement risks, as testified to by Administrator Atkins. P. Ex. 27, at 62-63; CMS Ex. 7. Petitioner has not shown otherwise that it was in substantial compliance with participation requirements prior to September 17, 2009, the date CMS determined Petitioner to be in substantial compliance. In light of all the factors involved, and reviewing the duration of the CMPs imposed, I find imposition of a CMP of $3550 per day for the period of immediate jeopardy from July 27, 2009 through August 13, 2009, and $100 per day from August 14, 2009 through September 16, 2009 to be reasonable.

Sections 1819(f)(2)(B) and 1919(f)(2)(B) of the Act prohibit approval of a NATCEP if, among other things, within the previous two years the facility was subject to an extended or partial extended survey or been assessed a CMP of not less than $5000. CMS stated in its September 3, 2009 notice letter that Petitioner was prohibited from conducting a NATCEP based on the extended survey. As I have sustained a CMP of more than $5000, Petitioner is also prohibited by imposition of the CMP from conducting a NATCEP.

V. Conclusion

For the reasons discussed above, I find that Petitioner's facility was not in substantial compliance with Medicare participation requirements and that its noncompliance posed immediate jeopardy to resident health and safety. I affirm as reasonable the CMPs imposed and sustain the prohibition on Petitioner's ability to offer a NATCEP for two years.

/s/
Richard J. Smith
Administrative Law Judge