Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:		
Kenton Healthcare, LLC, CCN: 18-5450,	)	Date: September 28, 2007
Petitioner,	)	
- v. -	)	Docket No. C-06-528 Decision No. CR1666
Centers for Medicare & Medicaid Services.	)	

DECISION

Petitioner, Kenton Healthcare, LLC (Petitioner or facility), is a long term care facility located in Lexington, Kentucky, that is certified to participate in the Medicare program as a provider of services. Here, Petitioner appeals CMS's determinations that, from September 15, 2005, through May 12, 2006, it was not in substantial compliance with the Medicare "quality of care regulation," 42 C.F.R. § 483.25(h)(2), and that its deficiencies posed immediate jeopardy to resident health and safety. For this alleged noncompliance, CMS has imposed a civil money penalty (CMP) of $4050 per day. For the reasons set forth below, I find that, from September 15, 2005 through May 12, 2006, the facility was not in substantial compliance with 42 C.F.R. § 483.25(h)(2), and that its deficiencies posed immediate jeopardy to resident health and safety. I find reasonable the $4050 per day CMP.

I. Background

The Social Security Act (Act) sets forth requirements for nursing facility participation in the Medicare program, and authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations implementing the statutory provisions. Act, § 1819. The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the

Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301. Immediate jeopardy exists if the 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 its immediate jeopardy finding – must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c).

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance with program participation requirements. Act, § 1864(a); 42 C.F.R. § 488.20. The regulations require that each facility be surveyed once every twelve months, and more often, if necessary, to ensure that identified deficiencies are corrected. Act, § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a); 488.308.

Here, following its annual survey, conducted from late April through May 2, 2006, surveyors from the Kentucky Cabinet for Health Services (State Agency) concluded that the facility was not in substantial compliance with federal requirements for nursing homes participating in the Medicare program. Specifically, they found that the facility did not meet the following federal requirements:

- 42 C.F.R. § 483.10(b)(11) (Tag F157 – notification of changes) at a "D" level of scope and severity (isolated instance of noncompliance that causes no actual harm with the potential for more than minimal harm);

- 42 C.F.R. § 483.13(a) (Tag F221 – physical restraints) at a "D" level of scope and severity;

- 42 C.F.R. § 483.13(c) (Tag F225 – staff treatment of residents) at a "D" level of scope and severity;

- 42 C.F.R. § 483.15(a) (Tag F241 – dignity) at a "G" level of scope and severity (isolated instance of noncompliance that causes actual harm that is not immediate jeopardy);

- 42 C.F.R. § 483.15(g)(1) (Tag F250 – social services) at an "F" level of scope and severity (widespread noncompliance that causes no actual harm with the potential for more than minimal harm);

- 42 C.F.R. § 483.15(h)(2) (Tag F253 – housekeeping/maintenance) at an "E" level of scope and severity (pattern of noncompliance that causes no actual harm with the potential for more than minimal harm);

- 42 C.F.R. § 483.20 (Tag F272 – comprehensive assessments) at an "E" level of scope and severity;

- 42 C.F.R. §§ 483.20(d), 483.20(k)(1) (Tag F279 – comprehensive care plans) at an "E" level of scope and severity;

- 42 C.F.R. § 483.20(k)(3)(i) (Tag F281 – comprehensive care plans) at a "D" level of scope and severity;

- 42 C.F.R. § 483.20(k)(3)(ii) (Tag F282 – comprehensive care plans) at a "D" level of scope and severity;

- 42 C.F.R. § 483.25(c) (Tag F314 – pressure sores) at a "D" level of scope and severity;

- 42 C.F.R. § 483.25(d) (Tag F315 – urinary incontinence) at a "D" level of scope and severity;

- 42 C.F.R. § 483.25(f)(1) (Tag F319 – mental and psychosocial functioning) at a "G" level of scope and severity;

- 42 C.F.R. § 483.25(h)(1) (Tag F323 – accidents) at a "D" level of scope and severity;

- 42 C.F.R. § 483.25(h)(2) (Tag F324 – accidents) at a "K" level of scope and severity (pattern of noncompliance that poses immediate jeopardy to resident health and safety);

- 42 C.F.R. § 483.25(k) (Tag F328 – special needs) at a "G" level of scope and severity;

- 42 C.F.R. § 483.30(a) (Tag F353 – nursing services - sufficient staff) at an "F" level of scope and severity;

- 42 C.F.R. § 483.35(i)(2) (Tag F371 – sanitary conditions - food preparation and service) at an "F" level of scope and severity;

- 42 C.F.R. § 483.40(c)(1)-(2) (Tag F387 – frequency of physician visits) at a "D" level of scope and severity;

and

- 42 C.F.R. § 483.75 (Tag F490 – administration) at an "F" level of scope and severity.

CMS Ex. 1. CMS agreed with the surveyor findings.

Subsequently, CMS determined that, as of May 13, 2006, the facility's deficiencies no longer posed immediate jeopardy to resident health and safety, and that, as of May 18, 2006, the facility had achieved substantial compliance. CMS Ex. 23, at 6, 8.

Among other remedies, CMS has imposed a CMP of $4050 per day for 240 days of immediate jeopardy (September 15, 2005 through May 12, 2006) plus $500 per day for the period of noncompliance that did not include immediate jeopardy (May 13 through 17, 2006). ($972,000 + $2,500 = $974,500 total CMP). CMS Ex. 23, at 1-2, 5-6.

Petitioner here appeals only one of the cited deficiencies, 42 C.F.R. § 483.25(h)(2) – failure to prevent accidents. Transcript (Tr.) 1-2; P. Cl. Br. at 3. CMS's determinations on the unchallenged deficiencies are therefore final and binding. 42 C.F.R. § 498.20(b).

The parties filed opening briefs (CMS Op. Br. and P. Op. Br.) and submissions. Following the hearing, they filed closing briefs (CMS Cl. Br. and P. Cl. Br.) and reply briefs (CMS Reply and P. Reply). CMS has filed 27 exhibits (CMS Exs. 1-27) and Petitioner has filed 50 exhibits (P. Exs. 1-50). Initially, I admitted CMS Exs. 1-27 and P. Exs. 1-50. However, without adequate explanation, Petitioner failed to produce its witness, Barbara Turner, for cross-examination, so, in a ruling dated May 4, 2007, I granted CMS's motion to strike and excluded from the record P. Ex. 35, Barbara Turner's written direct testimony. Tr. 5; Ruling and Order (May 4, 2007); *see also* Acknowledgment and Initial Prehearing Order at 3 ("A party must produce for cross-examination any witness whose written direct testimony that party offers as evidence.") and 5 ("I may impose sanctions pursuant to section 1128A(c)(4) of the . . . Act for a party's failure to comply with any order included in this order.") (June 22, 2006); *Lutheran Home at Trinity Oaks*, DAB No. 2111, at 25 n.15 (2007) (ALJ may strike

testimony based on party's failure to comply with prehearing order).[1] I have therefore admitted CMS Exs. 1-27 and P. Exs. 1-34 and 36-50.[2]

II. Issues

With the exception of CMS's determination that the facility was not in substantial compliance with 42 C.F.R. § 483.25(h)(2), Petitioner does not appeal any of the deficiencies cited. CMS's determination that, from September 15, 2005, through May 17, 2007, the facility was not in substantial compliance with those un-appealed program participation requirements is therefore final and binding.[3] 42 C.F.R. § 498.20(b). Petitioner has not appealed CMS's imposition of a $500 per day penalty from May 13 through 17, 2007, so that determination is also final and binding.

Therefore, the sole issues before me are

1. Whether, from September 15, 2005, through May 12, 2006, the facility was in substantial compliance with 42 C.F.R. § 483.25(h)(2) (quality of care – failure to prevent accidents);

2. If the facility was not then in substantial compliance, did its deficiencies pose immediate jeopardy to resident health and safety?

and

3. If the facility was not in substantial compliance, is the $4050 per day penalty reasonable?

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[1] Petitioner expresses chagrin at my declination to issue a subpoena. The regulations require that a party "must file a written request for a subpoena with the ALJ at least 5 days before the date set for hearing." 42 C.F.R. 498.58. Valid policy underlies this requirement, not the least of which is to prevent delay in the adjudication of these cases.

[2] P. Ex. 3 does not include pages 380-399. Apparently, in numbering the pages for that exhibit, Petitioner inadvertently omitted those page numbers. The document therefore skips from page 379 to page 400.

[3] As discussed below, in determining the reasonableness of the CMP, my consideration is not limited to the seriousness of the one deficiency that has been appealed; I consider the scope, and severity of *all* the deficiencies cited.

III. Discussion

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).[4]

Under the statute and "quality of care" regulation, each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being, in accordance with the resident's comprehensive assessment and plan of care. Act, section 1819(b); 42 C.F.R. § 483.25. The regulation imposes on facilities an affirmative duty designed to achieve favorable outcomes "to the highest practicable degree." *Windsor Health Care Center*, DAB No. 1902, at 16-17 (2003); *Woodstock Care Center*, DAB No. 1726, at 25-30. Among other specific requirements, the facility is required to "take reasonable steps to ensure that a resident receives supervision and assistance devices designed to meet his or her assessed needs and to mitigate foreseeable risks of harm from accidents." *Windsor Health Care Center*, DAB No. 1902, at 5 (2003); *Asbury Center at Johnson City,* DAB No. 1815, at 12 (2002); *Koester Pavilion,* DAB No. 1750, at 25-26 (2000); *Woodstock Care Center*, DAB No. 1726, at 25; 42 C.F.R. § 483.25(h)(2). The regulation directs the facility to anticipate what accidents might befall a resident and to take steps – increased supervision or the use of assistance devices – to prevent them. *Guardian Health Care Center*, DAB No. 1943, at 18 (2004).

> A facility is permitted the flexibility to choose the methods it uses to prevent accidents, but the chosen methods must constitute an "adequate" level of supervision under all the circumstances.

Windsor, at 5.

In this case, the facility is located on a busy street, with heavy traffic.[5] Within a few blocks of the facility, an active railroad track crosses the street. CMS Ex. 27, at 3 (Willhite Decl. ¶ 7); CMS Ex. 24.

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[4] My findings of fact and conclusions of law are set forth, in italics and bold, in the discussion captions.

[5] The DVD that Petitioner submitted as P. Ex. 25 shows cars driving fast on the road immediately beyond the fence at the front of the facility.

The facility's population included residents who were assessed as wanderers and/or at risk for elopement. Unlike many (if not most) long term care facilities with such a resident population, Petitioner did not have in place an electronic monitoring system. CMS Ex. 27, at 4 (Willhite decl. ¶ 10). Instead, it housed some, but not all, of its high risk residents in one of two units (Special Care and Magnolia Unit) secured by locked doors with coded keypads. P. Ex. 37, at 5-6 (Larmour Decl. ¶¶ 10, 12). The Magnolia Unit accommodated up to 30 residents with diagnoses of Alzheimer's, or other types of dementia, or who otherwise needed to be housed in a secure unit. P. Ex. 37, at 6 (Larmour Decl. ¶ 13).

CMS does not suggest that the absence of an electronic monitoring system establishes noncompliance, but points out that a facility must have in place some effective means for preventing elopement. Pointing to what it characterizes as "a notably high number of elopements," CMS argues that the facility was not taking reasonable steps to protect its vulnerable residents. CMS Ex. 27, at 4 (Willhite Decl. ¶ 9). According to CMS, the facility did not adequately plan its residents' care to prevent injury from wandering and/or elopement. Nor did the facility reconsider or modify the care plans of those residents who managed to exit undetected the purportedly secure unit.

As the following discussions show, CMS's position is supported by review of the individual resident records. The care plans of residents "at risk" for wandering and/or elopement did not address those behaviors. When interventions were added to the care plans (usually following an incident), those interventions were routinely omitted from the plans provided to staff.

The facility also had in place an "elopement book," which was supposed to contain the picture and elopement history of its at-risk residents so that staff would be able to identify them. But, CMS complains, at-risk residents were not always included in that book, the book was not readily accessible on all units, and multiple staff denied knowledge of its existence. CMS Ex. 1, at 115; CMS Ex. 27, at 5-6 (Willhite Decl. ¶¶ 12-13). While not exactly denying CMS's charge, Petitioner argues that inclusion was unnecessary because staff would have known that all residents of the secured unit were at-risk.[6] But Petitioner's argument raises an obvious question: if staff recognize everyone in the unit

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[6] Petitioner also claims that certain residents housed in the secured unit were *not* at risk for elopement. For example, in her declaration, the facility administrator, Melissa Larmour, asserts that R3 (discussed in detail below) was "not assessed as an elopement risk and was assigned to a secured unit because of dementia." P. Ex. 37, at 13 (Larmour Decl. ¶ 20.C).

as an elopement risk, what is the purpose of an elopement book? I may reasonably infer that the facility considered inclusion in the elopement book necessary to attain or maintain resident well-being. *Spring Meadows Health Center*, DAB No. 1966, at 20 (2005).

Petitioner acknowledges that some incidents may have occurred involving some of its residents, but challenges CMS's characterization of most of those incidents as "elopements." According to Petitioner's written policy, a resident has not eloped and is not considered "missing" unless he/she actually leaves the facility *grounds* without signing himself/herself out. Further, if the resident "is seen leaving the building or is seen walking away as a result of responding to a door alarm," that resident has not eloped and is not missing. P. Ex. 13; P. Ex. 31, at 1; P. Ex. 37, at 3 (Larmour Decl. ¶ 5).

But such debate about the definition of elopement and whether particular incidents fall within the facility's definition misses the point of the regulation, which is to keep residents safe. As I have noted elsewhere:

> Critical to preventing accidents is a facility's recognition that a wandering resident might elope, and that a frail and confused resident is at increased risk when outside the facility without supervision.

Century Care of Crystal Coast, DAB CR1488, at 15 (2006), *aff'd* DAB No. 2076 (2007), (quoting *Medina Nursing Center*, DAB CR1469, at 9 (2006)); *see also Willow Creek Nursing Center*, DAB CR1351, at 6, *aff'd* DAB No. 2040 (2006) (an elopement occurs when a resident, who is cognitively impaired or not capable of protecting himself from harm, exits a facility unsupervised, without staff knowledge.)

Elopement is serious because it puts fragile individuals in harm's way. But inadequate supervision can jeopardize resident safety even if the resident never sets foot outside the facility. *Lake Park Nursing and Rehabilitation Center*, DAB No. 2035, at 13 (2006). Notwithstanding its definition of "elopement," a facility simply cannot have residents going unsupervised into potentially dangerous places. A parking lot, a kitchen, even a porch can pose significant dangers to an unsupervised, cognitively impaired individual, particularly if that resident is unsteady on his/her feet and at risk for falls.

Moreover, I find Petitioner's elopement policy problematic if it results in the facility's failure to investigate thoroughly incidents that do not fall within its definition of elopement. Where the facility's system for preventing elopements is based on housing its at-risk individuals in a locked and "secure" unit, it must investigate thoroughly whenever one of its residents exits that unit undetected, even if the individual does not leave the

building or the facility grounds. Under Petitioner's elopement policy, however, a resident's departure from the secure unit would not (and, as the following discussion shows, did not) compel further review so long as the incident did not fall within the facility's definition of elopement. Failure to investigate an accident can itself be evidence of inadequate supervision. *Lake Park Nursing and Rehabilitation Center*, DAB No. 2035, at 11 (2006).

Petitioner points out that no resident was seriously hurt. I need not find that a resident suffered actual harm as a result of these incidents. The *potential* for more than minimal harm is sufficient to establish substantial noncompliance. 42 C.F.R. § 488.301. Fortuitously, tragedies were averted in all of these cases – someone came along and noticed the resident – but happenstance is not a "reasonable step" designed to ensure that the resident receives supervision and assistive devices designed to meet his or her assessed needs and to mitigate foreseeable risks of harm from accidents. The facility's actions (or inaction) in these instances placed its residents at risk and constitute substantial noncompliance with the quality of care regulation. *Lake Park*, DAB No. 2035, at 8 (The absence of an accident does not establish that a facility provided adequate supervision); *see* 42 C.F.R. § 483.25(h)(2).

Resident 17 (R17)[7]

R17 was admitted to the facility on September 6, 2005, with diagnoses of Alzheimer's disease, dementia, hypertension, diabetes millitus, hypothyroidism, and depression. She had osteoarthritis and walked with a cane. P. Ex. 6, at 1-3. From the time of her admission, R17 wanted to go home. P. Ex. 6, at 3. A wander/elopement risk assessment

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[7] The voluminous medical records in this case are confusing because the nurses notes and other entries are not consistently in chronological or any other discernable order. *See, e.g.,* P. Ex. 6, at 17 (11/4, 11/7, 10/6, 10/ 8, 11/13, 11/14). Petitioner's use of these records to support its arguments compounds that confusion. The bulk of these records are never referred to, and, indeed, many pages of exhibits are simply irrelevant to the issues presented. In an order dated February 12, 2007, I reminded the parties that "it is not the judge's responsibility to parse through pages and pages of exhibits in an effort to find support for a party's factual assertions" and warned that I would not consider adequate any citation that does not refer to a specific page number. Order (February 12, 2007). In its closing briefs, Petitioner offers a series of seemingly unsupported assertions, and then string cites to multiple page numbers, a practice that seems to defeat the spirit, if not the letter, of my order, and makes it all the more difficult to see whether the cited documents support its arguments. *See, e.g.*, P. Cl. Br. at 10, 16, 17, 18, 19.

dated September 6, 2005, and updated December 15, 2005, and March 10, 2006, placed her at high risk for wandering. Although her September assessment was silent as to her elopement risk, according to Administrator Larmour, R17 was at risk for elopement.[8] CMS Ex. 3, at 37; P. Ex. 37, at 8 (Larmour Decl. ¶20A).[9]

R17 was housed in the Magnolia Unit. P. Ex. 37, at 8 (Larmour Decl. ¶20A).[10]

A care plan, apparently developed at the time of R17's admission, identifies wandering, resistence to care, periods of altered awareness, and "verbally abusive" among R17's problem behaviors, and sets the generic goals of "minimize behaviors as practically able and reduce risk for injury to self and others."[11] To achieve these goals, the plan's approaches include one-to-one visits, observe location and re-direct as needed, provide diversional activities, continue to observe for interventions that work, and medications as ordered. P. Ex. 6, at 179-180.

The facility provided staff instructions on resident care by means of a document called the "SRNA Plan of Care," and later the "CNA Care Plan." Attached to each such plan is a certification statement signed by staff attesting to their having provided the care called for on the face of the plan. However, R17's SRNA/CNA Care Plans consistently do not

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[8] Her December assessment places her at risk for elopement. CMS Ex. 3, at 37.

[9] Petitioner refers generally to P. Ex. 6, at 164-187, to support its assertions as to R17's assessments and care plans. But many of these documents were developed *after* May 18, 2006 (the effective date of the facility's return to substantial compliance). For example, the document found at P. Ex. 6, at 164-171, appears to be a care plan developed *September 14, 2006*; the document at P. Ex. 6, at 172-174, is a care plan initiated *June 1, 2006.*

[10] Curiously, one of Petitioner's witnesses, Nancy J. Stiles, M.D., asserts that the facility initially placed R17 on a unit that was not locked. P. Ex. 40, at 3 (Stiles Decl. ¶8). But this assertion seems inconsistent with the bulk of the evidence. P. Ex. 37, at 8 (Larmour Decl. ¶ 20Ai) ("Resident was assigned to the secured Magnolia Unit.")

[11] The effective dates for the care planning are somewhat confusing. The care plans are typed forms upon which hand-written notations, including dates, have been entered, and sometimes crossed out. Which entries were effective at which times is not always readily apparent. *See* P. Ex. 6, at 179–187. There are also multiple copies of the same basic document but containing different hand-written notations. *Compare* P. Ex. 6, at 179, *with* P. Ex. 6, at 180, 181. And some of the documents are simply not dated. P. Ex. 6, at 179, 195.

include the interventions called for in her care plan. Documents titled SRNA Plan of Care, dated September 2005, October 2005, and November 2005, do not mention wandering or any interventions. P. Ex. 6, at 197, 199, 201. In December 2005, the facility apparently changed the care plan's format. The new form (titled CNA Care Plan) includes a section labeled "wandering precautions," but that section is blank on R17's December 2005, January 2006, February 2006, and March 2006 care plans. P. Ex. 6, at 203, 205, 207, 209.

Nurses notes indicate that at 2:10 p.m. on **September 15, 2005**, "special care staff" reported that the resident was walking with her cane outside the facility. She was returned to her unit unharmed. The notes provide no indication as to how R17 exited the purportedly secure unit, nor how long she was gone. It appears that staff were not aware of her departure since nothing suggests that anyone had been looking for her. P. Ex. 6, at 5. According to the survey report form, surveyors spoke to the LPN and the CNA who had been responsible for R17's care at the time. Consistent with the nurses note, they said that they had not known that she was gone until a staff member from another unit saw her outside. CMS Ex. 1, at 113; P. Ex. 6, at 5. According to the survey form, neither had been aware that R17 was an elopement risk. CMS Ex. 1, at 113.

Aside from pointing to R17's presence on the Magnolia Unit as evidence that she was an elopement risk (P. Ex. 37, at 10), Petitioner offers little evidence to refute the survey report's statements. Instead, Petitioner – without citation to the record – makes factual assertions about the circumstances surrounding this incident (that R17 was following a visitor who exited via a side door, and that she was observed "within a few minutes" by a nurse aide who "immediately" brought her back). P. Cl. Br. at 9. Having reviewed every page of R17's medical record – P. Ex. 6 – and all of the declarations of witnesses, I found no support for Petitioner's factual assertions. Not even the facility's administrator, Melissa Larmour, makes any such claims with respect to the September 15 incident. *See* P. Ex. 37, at 9. (Larmour Decl. ¶ 20Ai).

A social service progress note, dated September 15, 2005, indicates that R17 "has been placed on 15-minute check and *noted as an elopement risk* after getting out of facility." CMS Ex. 3, at 41 (emphasis added). The record contains no documentation of 15-minute safety checks prior to September 23, 2005, however. Administrator Larmour does not claim that the checks were performed until after R17's September 23 exit from the facility. P. Ex. 37, at 9 (Larmour Decl. ¶ 20Ai); P. Ex. 6, at 9-14, 131 *et seq.*[12]

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[12] I discuss below the problems with that documentation.

Citing P. Ex. 6, at 9-14, and 131-137, Petitioner nevertheless claims that, following the September 15 incident, R17 was placed on 15-minute checks. P. Cl. Br. at 9. But those pages are documents generated following the September 23, October 9, and October 16 incidents; they do not represent a response to the September 15 departure.

Petitioner offers no incident report, contemporaneous statements from staff, nor other evidence that this incident was investigated; the incident was not reported to the State Agency, apparently because it did not fall within the facility's definition of an "elopement." *See, e.g.*, P. Ex. 39, at 2 (Meek Decl.) ("Kenton Healthcare maintains that in fact only 1 resident elopement occurred on 4/04/06 and that they properly investigated and reported the elopement incident to the [State Agency].") After the September 15 incident, no changes were made to R17's care plan. Indeed, Petitioner "points to no reason that [I] should assume that its level of supervision provided to [R17] increased after her elopement." *See Century Care of Crystal Coast*, DAB No. 2076, at 21 (2007).

Thereafter, R17 continued to express her desire to leave the facility and to return home. P. Ex. 6, at 5, 6, 7.

A nurses note dated **September 23, 2005**, indicates that the charge nurse "was notified" that R17 "got out from building;" a nurse found her walking in the parking lot, saying that she wanted to go home. P. Ex. 6, at 7; CMS Ex. 3, at 19, 34. CMS cites the survey report form and surveyor notes to establish that the surveyors interviewed the nurse who found R17. The nurse reported that she was driving to work and spotted R17 "in the middle of the roadway, walking towards the front of the car . . . ." CMS Ex. 1, at 114. R17 would not move to one side. The nurse stopped her car until the resident passed. The nurse apparently did not recognize the resident, but was suspicious, and informed facility staff. A nurse aide went out to check, and found R17 attempting to open the door of an ambulance. CMS Ex. 1, at 114; CMS Ex. 3, at 16.

Again, Petitioner does not refute CMS's assertions. As with the September 15 incident, Petitioner instead sets forth poorly supported (or wholly unsupported) "facts" about the circumstances surrounding this incident: that, following a visitor, R17 exited via a side door, and that she was "immediately" retrieved by a staff nurse. P. Cl. Br. at 9. But, relying on a May 30, 2006 letter from John W. Richard, M.D. – the facility's medical director who was also the physician for many of its residents – Administrator Larmour also claims that R17 "simply stepped out on the front porch for a breath of fresh air."[13] P.

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[13] I note that there were several steps outside the front door that could pose a danger to an individual with dementia or at risk for falls. P. Ex. 25 (DVD).

Ex. 37, at 5 (Larmour Decl. ¶ 8). I found these two assertions curious because "side" doors do not typically lead to "front" porches. In fact, Administrator Larmour confuses her residents; Dr. Richard's letter refers to *R3*, not R17. P. Ex. 34, at 3.

Administrator Larmour also claims that employee statements, including one from "Juan Varela" (who is not otherwise identified) establish that R17 was in the parking lot for no longer than two minutes. P. Ex. 37, at 10 (Larmour Decl. ¶ 20Aii). The record contains no statement from Juan Varela. The other employee statements referred to by Administrator Larmour discuss other residents; none mentions the incidents involving R17. P. Ex. 26. Indeed, Administrator Larmour repeatedly confuses R17 with the other residents, which supports CMS's assertion that she was not familiar with R17's elopement history.

I am nevertheless disturbed by CMS's failure to provide written declarations from surveyors attesting to their conversations with staff, and I recognize that, absent such corroboration, the survey report form and surveyor notes provide weak support for the circumstances surrounding the nurse's discovery of R17. However, if Petitioner wanted to challenge the assertions, it could have produced a statement from the quoted nurse or it could have produced evidence of its own investigation (e.g. incident report, contemporaneous statements from staff). I see none of that here. Petitioner ultimately offers no reliable evidence that this incident was investigated, and it was not reported to the State Agency. In any event, the details obtained through the surveyor interview here, while illustrative of the potential danger posed by R17's exit to the parking lot, are not critical to the outcome of this case. By establishing that she exited the facility and was found in the parking lot – facts that are undisputed – CMS has met its *prima facie* burden. *See Alden Town Manor Rehabilitation & HHC*, DAB No. 2054, at 8 (2006).

Petitioner also claims that, on September 23, 2005, the facility administrator ordered "permanently locked" the door from which the resident purportedly exited. Citing the administrator's declaration, it asserts that the key pad was removed from the outside of the door, and a notice sent to all staff and responsible parties notifying them not to use the door. P. Cl. Br. at 9. Aside from Administrator Larmour's questionable declaration, I do not see a lot of support for this. P. Ex. 37, at 9 (Larmour Decl. ¶ 20Ai). Petitioner has not provided a copy of the notice or any other corroborating evidence as to when, or if, the action was taken. Moreover, Petitioner has not established that this action (if taken at the time) would have solved the problem since no reliable evidence suggests that the door was the problem.

For 72 hours after R17's departure, from September 23 through 26, 2005, she was placed on 15-minute safety checks. CMS Ex. 3, at 19; P. Ex. 6, at 9-14.

Over the next two weeks, R17 appears to have suffered at least one, and possibly two falls. Nurses notes dated **October 2, 2005** indicate "follow-up" to fall, but the notes say nothing about the circumstances of the fall itself. P. Ex. 6, at 7-8; CMS Ex. 3, at 33, 34. I see no incident report nor evidence of any investigation. At noon on **October 9, 2005**, the nurses notes describe a "quarter size lump" above R17's left eye. R17 reported that she "fell this morning." P. Ex. 6, at 8; CMS Ex. 3, at 33.[14]

Following this possible fall, the facility again instituted "15-minute safety checks." I am skeptical of these, however, because safety-check sheets for October 9 place R17 in two different places at the same time. According to a sheet completed by LPN "B Cook," R17 was in her room from 7:00 a.m. until 3:00 p.m. on October 9. P. Ex. 6, at 133. Consistent with this, LPN Cook writes in a noon, October 9 nurses note that R17 has been "in bed sleeping" since 8:30 a.m. CMS Ex. 3, at 33. But another document that purports to be a record of 15-minute safety checks for the same period contradicts the "B. Cook" entries. An employee identified as "RH" places R17 "in bed" at 7:00 a.m. and 7:15 a.m.; "in shower" at 7:30 a.m.; in "sitting area" at 7:45 a.m., 8:00 a.m., 8:15 a.m.; "walking" at 8:30 a.m. and 8:45 a.m.; "sitting area" at 9:00 a.m. and 9:15 a.m.; and so forth throughout the day. "RH" places R17 in her room only at 10:00 a.m. and 10:15 a.m. P. Ex. 6, at 134.

On **October 16, 2005**, at 7:00 p.m., notes state that another resident returned to the Magnolia Unit, reporting, "There is a woman out in the hallway[;] I think she belongs back here." Although the writer of the note says that she "had just observed" the resident in the hallway, she also says that she and a nurse aide "began to search" for R17. They found her going into the dish room in dietary, and brought her back behind locked doors. The 15-minute checks were reinstituted until the following morning. P. Ex. 6, at 16, 136-137; CMS Ex. 3, at 22, 29. Again, no evidence suggests that the facility investigated the incident or thereafter reviewed R17's care plan.

Nor did the facility alter its instructions to staff. As noted above, the SRNA/CNA care plans through March 2006 say nothing about R17's wandering/elopement behavior. P. Ex. 6, at 197, 199, 201, 203, 205, 207, 209. Indeed, in re-assessing R17's risk for elopement in December 2005 and March 2006, the assessment form indicates that R17 has *no history* of elopement from the facility. CMS Ex. 3, at 37. A subsequent CNA Care Plan finally identifies R17 as an elopement risk, and indicates that she wears an

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[14] Subsequent notes, however, suggest that the lump may have been there all along. *See*, *e.g.*, P. Ex. 6, at 51.

identifying green armband and an electronic monitoring bracelet/wanderguard. The date on this document is not legible, but, inasmuch as the facility was not using electronic monitoring devices at the time of the survey, I surmise that this document was generated later, after the April/May survey. P. Ex. 6, at 211.

On March 31, 2006, R17 attempted to follow staff out of the unit and was redirected. P. Ex. 6, at 29. On April 2, 2006, nurses notes report that she was again attempting to get out the door. P. Ex. 6, at 29. Surveyors observed R17 engaged in exit-seeking behavior when, on April 20, 2006, she followed a visitor out of the locked unit. CMS Ex. 3, at 4; CMS Ex. 1, at 115.

The surveyors learned that R17 was not included in the unit's elopement book. CMS Ex. 3, at 6. Petitioner does not dispute this, but points to a March 7, 2006 activities assessment note that purportedly says that she "had a need to be escorted to group activities" as evidence that staff were aware of that R17 was an elopement risk and were closely supervising her. P. Cl. Br. at 10. Again, the documents Petitioner cites do not support the assertion. P. Ex. 6, at 183 is a care plan for pain. It has no entry dated March 7, 2006. It says nothing about escorting R17 to activities. Its only references to activities are dated after May 2006, and suggest that R17 should be assisted with her activities "as needed." P. Ex. 6, at 183, 214 is a checklist showing days R17 participated in various activities. In any event, since the facility itself made inclusion in the elopement book a part of its strategy for protecting its elopement-prone residents, I may reasonably infer that the facility did so because it determined that such action was necessary to attain or maintain resident well-being. *Spring Meadows Health Center*, DAB No. 1966, at 20 (2005); *see also St. Catherine's Care Center of Findlay, Inc.*, DAB No. 1964, at 13 n.9 (2005) (summary judgment appropriate under 42 C.F.R. § 483.25(h)(2) where the facility concedes that it identified a risk in the resident assessment and it either failed to plan for the risk or failed to follow its own plan). And then it failed to follow its own plans.

A care plan, dated April 27, 2006, finally identifies risk of elopement as a problem. The interventions are to monitor her whereabouts, redirect her to a safe area when wandering, encourage her to attend activities, offer her a snack or provide "diversional" activities during periods of wandering, and administer medications as ordered. An additional intervention – "apply safety device as indicated-code alert-bed/chair alarm" – has been crossed out, although the document does not indicate when it was crossed out. P. Ex. 6, at 175. The April 27, 2006 care plan also adds to the problem list risk for injury related to history of wandering. P. Ex. 6, at 176. On April 30, 2006, "socially inappropriate behaviors" and "pulling on unit doors" were added to the problem list. P. Ex. 6, at 179-180; CMS Ex. 3, at 6.

Based on all of this, I conclude that the facility's actions (or inaction) with respect to R17 justify a finding of substantial noncompliance with 42 C.F.R. § 483.25(h)(2). R17 was assessed as at-risk for injury due to wandering and/or elopement. She was even care-planned for it. But that planning was not then conveyed to staff through the SRNA/CNA care plans. Notwithstanding her placement on a purportedly "secure" unit, R17 managed to exit the unit three times, twice completely undetected. Yet, the facility provides no evidence that her departures were adequately investigated. Nor did the facility even consider changes to her care plan or its implementation. Finally, even though it opted to employ an elopement book as a means for preventing accidents, the facility did not include this vulnerable resident in that book.

Resident 11 (R11)

R11 was admitted to the facility on August 20, 2005. She was 87 years old, suffering from Type II diabetes, hypertension, osteoporosis, Alzheimer's disease, and dementia. She had a history of cancer and was legally blind in one eye. She was able to walk with the assistance of a cane. Her gait was unsteady and she was at risk for falls. P. Ex. 7, at 57, 254.[15] She was not placed in a secure unit. P. Ex. 28.

At the time of her admission, R11 had apparently fallen twice in the preceding three months. P. Ex. 7, at 253. A care plan, probably dated August 20, 2005, identifies R11 as at risk for falls related to her dementia, decreased mobility, and psychotropic medications. P. Ex. 7, at 191. Setting a goal of minimizing the risk for falls, the plan calls for PT/OT evaluations, assistance with transfers and with ambulation, as well as keeping her bed low and call light in reach. P. Ex. 7, at 191; *see also* P. Ex. 7, at 202 ("ambulation/ transfer assist: X 1 asst."), 216 (1-person assist with ambulation), 224, 231, 235, 237, 255, 267, 270, 284. Subsequent notes describe her gait as unsteady, and say that she was encouraged to ask for assistance with ambulation. *See, e.g.*, P. Ex. 7, at 61.

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[15] The record contains an elopement risk assessment dated August 17, 2005, three days prior to R11's admission to the facility, that suggests R11 was not then at risk for elopement. P. Ex. 7, at 218. Neither the assessment nor anything else indicates who filled it out or for what purpose. According to the assessment, the resident had not wandered in the last 90 days. Notably, according to the assessment tool, even in the absence of other risk factors, wandering alone puts a resident at a high risk for elopement.

According to a nurses note dated August 26, 2005, at 10:00 p.m., R11 was "found" sitting on the floor beside her bed. P. Ex. 7, at 60. A note dated August 27, 2005, states that she "has been getting up at night [by] herself, and not using her walker," resulting in an increased number of falls at night. Her daughter asked that a bed alarm be installed. P. Ex. 7, at 60. The alarm was installed, although a note dated August 28 indicates that she "has been pushing the reset button when [the] bed alarm sounds." P. Ex. 7 at 61, 466, 474. CMS has not cited this incident as evidence of any deficiency, so I assume that it considers adequate the facility's action. I mention the incident here because it shows that facility staff well knew about, or should have recognized, R11's vulnerability when attempting to walk unsupervised.

A psychiatric evaluation dated October 6, 2005 found that R11 had a severe cognitive impairment and concluded that she needed a guardian as she was not able to understand her situation nor to make decisions regarding healthcare and finances. According to the evaluation, staff reported that "episodically she will pack up her belongings [and] head up to front door as if she is leaving here, forgetting that she is living here in the facility." P. Ex. 7, at 720.

A wander/elopement risk assessment dated November 22, 2005 inconsistently assesses R11 as at risk for wandering and elopement, based on her "confusion and wanting to go home," but elsewhere checks "no" risk for wandering or elopement. P. Ex. 7, at 240, 241.

A care plan dated November 29, 2005, identifies R11 as at risk for elopement related to Alzheimer's and wandering. The document is a typed form with additional hand-written entries, some of which are dated and some not, so it is again difficult to tell exactly when each entry was made. The printed form sets as a goal that R11 will remain in the facility unless supervised by staff or family. Approaches include: observe location and re-direct as needed; maintain on secured unit if indicated; provide diversional activities, staff interventions to redirect when wandering is observed, staff/companion walking approach. Someone hand wrote (without dating) "need to make everyone know who can take resident out of facility," and "make sure resident is safe with all exits secure." P. Ex. 7, at 195.

A risk assessment dated February 7, 2006, places R11 at high risk for wandering, but no risk for elopement. According to the summary, R11 frequently "walks halls without knowing where she is or where she is going." P. Ex. 7, at 196; *see also* P. Ex. 7, at 273 ("ambulates throughout building. . . on go all time."). From February 2006, her mood and behavior assessments identify wandering as an exhibited behavior. P. Ex. 7, at 269, 272, 286.

On March 4, 2006, at 11:45 a.m., R11 was standing in the hallway when another resident, who was in a motorized wheelchair, came up behind her and ran into her. She fell forward on to her knees, catching her right foot under the wheelchair. P. Ex. 7, at 35. Again, CMS does not suggest any fault on the facility's part with respect to this incident; however, it offers another example of R11's vulnerability.

An assessment dated March 6, 2006, again identifies R11 as at risk for wandering but not for elopement: "Res. paces hallways. Makes no attempts to leave facility." P. Ex. 7, at 196. In written statements dated May 28, 2006, staff members confirm that R11 would frequently pace the hallways and wander into other units, but they were not aware of her ever attempting to leave the facility. P. Ex. 26, at 3, 5, 6.

On **April 4, 2006**, R11 left the facility. In a note written at 6:45 p.m. on April 4, 2006, the Director of Nursing (DON) states that a staff member found R11 at a shopping center down the street. P. Ex. 7, at 33. Petitioner's records are vague as to how R11 was discovered at the shopping center. Citing the survey report form and surveyor notes, CMS asserts that an off-duty employee happened to be driving by at about 6:30 p.m. when he spotted R11's red walker. CMS Cl. Br. at 12; CMS Ex. 22, at 7. Again, without declarations from the surveyors who gathered this information, I would tend to afford relatively little weight to the survey report form and surveyor notes. But, since this is the only evidence in the record that explains how R11 was found, and Petitioner has not challenged it nor offered any evidence to the contrary, I accept CMS's explanation. As with R17, the circumstances surrounding R11's discovery are not, in any event, critical to the outcome of this case.

According to the DON's note, R11 ambulated to the shopping center, using her walker, and, after she was discovered, she was returned to the facility uninjured. When asked what she had been doing, R11 said that she was going home. According to the note, staff reported that R11 left the dining room after eating supper (although it does not specify what time that was). P. Ex. 7, at 33, 287. A nurse aide reported that R11 had a habit of making a wrong turn when leaving the dining room, and ambulating throughout the facility. CMS Ex. 22, at 13. R11's care plan adds, without further explanation, "followed family member out." *Compare* P. Ex. 7, at 195, *with* P. Ex. 7, at 197.

In order to get to that shopping center, R17 had to cross a road. CMS Ex. 27, at 3 (Willhite Decl. ¶ 7).

An incident report dated April 4, 2006, adds that R11 went out the front door, behind a visitor.[16] CMS Ex. 22, at 12. Surveyors apparently asked the DON how she determined this and she said that the resident told her. Although a group of visitors had been sitting on the stoop, no one interviewed them as part of the investigation. CMS Ex. 22, at 11-12.

R11 was placed on 5-minute checks until bedtime, followed by 15-minute checks through the night, and then 30-minute checks for 24-hours. P. Ex. 7, at 33, 142-145, 195, 547. In addition, her care plan indicates "memo to front door for visitors/family not to let residents out [without] checking [with] staff." P. Ex. 7, at 195.

Apparently the following day, R11 tried to leave the unit "several times," but was redirected. P. Ex. 7, at 36-37. Notes dated April 8, 2006 report that she again tried to leave the unit following her daughter's visit. According to the note the resident "is unable to redirect [related to] forgetfulness." P. Ex. 7, at 38. A note dated April 22, 2006 says that R11 "wanders and gets lost [at] times," but staff encourages her to stay on the unit. P. Ex. 7, at 40. An April 27 entry in her care plan says "green arm band" and a May 5, 2006 entry says "wanderguard alarm watch." P. Ex. 7, at 195, 289, 291.

The parties argue about whether the facility should have recognized that R11 was an elopement risk. The facility's assessments on the question are obviously inconsistent. P. Ex. 7, at 195, 196, 218, 240, 241, 720. However, without regard to whether she posed an elopement risk, staff were supposed to be supervising R11 closely because she was at risk for falls. According to her care plan, she was supposed to be provided "one-person assist" with ambulation. P. Ex. 7, at 191, 202. She was not supposed to be wandering through the units – often lost – without assistance and without supervision. Yet, her records suggest that she did so regularly, and that the staff knew it and allowed it. Even though she walked with the assistance of a walker, so she could not have been moving either rapidly or surreptitiously, she managed to leave the facility undetected, make her way down a busy street and across a cross-street to the parking lot of a shopping center. The facility offers no evidence establishing when – or even if – its staff realized that she was missing, and, if so, what steps they were taking to find her. That she was found uninjured was fortunate, but not attributable to any facility action.

Thus, the situation involving R11 also, by itself, justifies a finding of substantial noncompliance with the quality of care regulation, 42 C.F.R. § 483.25(h)(2).

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[16] Again, there were several steps outside of the front door that could pose a danger to an individual with dementia or at risk for falls. P. Ex. 25 (DVD).

Resident 3 (R3)

R3 was an 88-year-old woman, admitted to the facility January 11, 2006, with diagnoses of dementia, hypertension, vertigo, and depression. She had muscle weakness and difficulty walking. P. Ex. 3, at 20, 256. She frequently required oxygen because she had episodes of hypoxia. CMS Ex. 10, at 22, 35. At the time of her admission, a wandering/elopement risk assessment put her at risk for wandering and for elopement, noting, "Resident attempts to ambulate out into hallway [without] assistance. [She] has stated, 'I want to leave. I don't want to stay here.'" CMS Ex. 10, at 43. Nevertheless, she was placed in a non-secure unit. P. Ex. 28, at 1.

From early in her stay, R3 attempted to transfer and walk without assistance. P. Ex. 3, at 21 (January 12 – attempts to transfer without assistance); P. Ex. 3, at 24 (January 17 – she will attempt to ambulate by herself at times). On January 19, 2006, she attempted to get out of bed by herself, and fell on the floor, her head hitting the side of the bed. P. Ex. 3, at 26. An assessment dated January 24, 2006 notes her diagnoses, her use of psychotropic medications, her unsteady gait, and her attempts to ambulate without assistance, which resulted in a fall. The summary notes that bed alarms are used, but that she is "at risk for untoward side effects and serious injury, so will proceed with plan of care." CMS Ex. 10, at 22-24. Although a bed alarm was purportedly in place on January 30, 2006, she was found wandering in the halls without assistance. A note says that she "continued to be noncompliant [with the] call bell and bed alarm system." P. Ex. 3, at 32. As with R11, CMS does not charge the facility with failure to prevent falls. However, these incidents establish that staff recognized that R3 was at significant risk whenever she attempted to walk, unsupervised and without assistance. In fact, on January 31, 2006, R3's care plan includes as listed problems "risk for serious injury related to recent falls – attempts to ambulate without assistance;" the listed approaches are limited to explaining the call light, keeping it within reach, keeping her bed in the lowest position, and PT/OT as ordered. CMS Ex. 10, at 32-33. The plan says nothing about wandering or elopement.

On **March 1, 2006**, R3 wandered to another unit, and asked a staff member how she could open the door to the outside. She was returned to her assigned unit. P. Ex. 3, at 45; CMS Ex. 10, at 50. On **March 4, 2006**, at 4:00 p.m., a staff member found R3 standing "on front walkway" without her walker. P. Ex. 3, at 50; CMS Ex. 10, at 51. She said that she "wanted some fresh air." P. Ex. 3, at 50; CMS Ex. 10, at 51. She was assisted back to the facility. At 5:30 p.m., however, visitors reported that a "little woman just went out the front door. Is she allowed?" P. Ex. 3, at 50; CMS Ex. 10, at 51. The visitors reported

that she had pushed the code buttons and gone out.[17] When staff went out, she was "standing down on [the] ramp [without her] walker." P. Ex. 3, at 50; CMS Ex. 10, at 51. She insisted that she wanted to stay out "for the fresh air." P. Ex. 3, at 50; CMS Ex. 10, at 51. Eventually, "with reluctance," she went back inside, and staff closed a door between the lobby and the hall. P. Ex. 3, at 50; CMS Ex. 10, at 43, 51.

A wander/elopement risk assessment dated March 4 says that R3 "pushed code buttons and went out front door [twice] today," and was "very reluctant to come back inside . . . ." She was again assessed as at risk for wandering and elopement, although no changes were made to her care plan. CMS Ex. 10, at 45.

On **March 5, 2006**, R3 woke up at 3:00 a.m. and wandered into the rooms of other residents and off the unit. She became upset with the staff member who attempted to explain that she couldn't go into other rooms or off the unit by herself. The note says, "She needs to be on Magnolia." P. Ex. 3, at 52. At some point that morning, she packed her belongings and said that she was going home. P. Ex. 3, at 50; CMS Ex. 10, at 51.

On March 6, 2006, R3 was moved to Magnolia, where she twice attempted to walk out the fire exit and became "agitated" when redirected. P. Ex. 3, at 50; CMS Ex. 10, at 21, 51.

Monitoring sheets dated March 6 through 8, 2006 identify R3 as an elopement risk, and show 15-minute checks beginning at 5:15 p.m. on March 6, and ending at 7:15 a.m. on March 9, 2006. P. Ex. 3, at 49, 54, 55; CMS Ex. 10, at 28-30.

But on March 10, 2006, R3 was transferred back to her original room, apparently at the insistence of her family. A note says that the family was "very satisfied" with the transfer. P. Ex. 3, at 51. At that time, the Director of Nursing drafted a Risk/Benefit Statement explaining that after she had exited the building, R3 was moved to the Magnolia unit, away from the front entrance. However, the resident and her family asked

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[17] The DVD that Petitioner offered into evidence shows portions of the facility and provides some explanation of what is shown in each scene. P. Ex. 25. However, I was not always sure what a particular scene portrayed. For example, the DVD seems to show that the exit code was posted on a sign directly above the key pad in one of the units (presumably the Magnolia unit). If so, this might explain the apparent ease with which some of the residents managed to leave this purportedly secure unit.

that she be moved back. The DON notes that R3 risks "falling, having injury, and/or even death." Her family responds that she was happier in the old room, that her mental health outweighed other considerations, and the family promised to work on redirecting her to the courtyard outside the activity room. CMS Ex. 10, at 34.

At 12:30 a.m. on **March 11, 2006**, R3 was found on the floor, with an injury to her left forearm. According to the nurses note, she was ambulating from the bathroom to bed when her footwear slipped off. P. Ex. 3, at 51.

On March 13, 2006, R3 again packed her clothes and bed linens and told staff she was going home. With much encouragement, she finally agreed to return to her room. CMS Ex. 10, at 54.

A note written at 8:30 p.m. on March 29, 2006, reports that R3 was up at the fire door, punching in the code buttons, attempting to open the door, saying that she wanted fresh air. Staff redirected her to the activities room and allowed her to go outside to the courtyard. P. Ex. 3, at 58; CMS Ex. 10, at 53.

R3's February 2006 CNA Care Plan contains no wandering precautions, but, under the comments section, directs staff to "chart any incident of [patient] ambulating unassisted." It notes that she is at high risk for falls and requires bed and chair alarms. P. Ex. 3, at 351. In the March 2006 CNA Care Plan, however, someone has struck out the instruction that staff chart incidents of unassisted ambulation, and written in that R3 is independent in ambulation. With respect to wandering precautions, someone has written in "redirect to activity room when res[ident] states wants to go for breath of fresh air." P. Ex. 3, at 354. The entry is not dated.

But R3's April 2006 CNA Care Plan again includes no wandering precautions, and, although the plan acknowledges her high risk for falls, it includes no interventions to prevent them. CMS Ex. 10, at 42. It appears that on April 17, 2006, "elopement risk" was added, and an entry dated April 27 says that the "elopement – mood care plan updated." P. Ex. 3, at 457.

On **April 20, 2006**, R3 was again found sitting on the bathroom floor. She could not explain how she fell, but said that she hit her head on the door. Her walker was not in the room. She was confused, and had bruises at both knees, although she could not say whether they were old. P. Ex. 3, at 64.

It seems that the facility began to appreciate R3's vulnerability after the survey began. On April 27, 2006 – nearly eight weeks after she had first exited the building, and after the start of the survey – it developed a care plan acknowledging that R3 "liked to go out for fresh air [and to] feed the birds." Interventions included applying a green arm band, redirecting the resident to "activity exit for safe outside enjoyment," and "assist the resident outside for fresh air and for feeding the birds." Staff were to sit with her if she sat out front. P. Ex. 3, at 368. An entry dated May 5, 2006, identifies R3's risk for injury related to her history of wandering and elopement. "Likes to go out for fresh air and feed the birds." P. Ex. 3, at 368. Approaches included: monitoring her whereabouts; redirecting her to safe area, including the activity exit, when wandering; encouraging her to attend activities; and diverting her during periods of wandering. Someone was to sit with her when she went out for fresh air or to feed the birds. She wore a green arm band and a wander guard to the wrist. P. Ex. 3, at 368.

The May 2006 CNA Care Plan identifies her as an "Elopement Risk!" and she is provided a green arm band and electronic monitoring bracelet. Staff are also instructed to chart any incident of her ambulating unassisted. CMS Ex. 3, at 359.

CMS asks why, prior to the survey, this acknowledged elopement risk, a woman who was cognitively impaired, with chronic hypoxia that required oxygen, and, most significantly, was a very high fall risk, had no care plan to address her wandering outside the building without staff knowledge or supervision. CMS Cl. Br. at 17.

Notwithstanding the facility's own assessment (CMS Ex. 10, at 43) Petitioner now insists that R3 was not at risk for elopement, and that she never eloped. P. Cl. Br. at 14. In support, Petitioner points to statements from Dr. Richards, who says of R3's March 4 excursion, she "made no attempt to leave the porch or premises." P. Cl. Br. at 14; P. Ex. 34, at 3; P. Ex. 41, at 2. Petitioner provides no foundation for Dr. Richard's conclusion, which seems to be at odds with the facility's documents.[18] Nurses notes place R3, not on the porch, but on the "front walkway" and later "on the ramp." P. Ex. 3, at 50; CMS Ex. 10, at 51.

Petitioner also relies on the declaration of Nancy J. Stiles, M.D., a physician who specializes in geriatrics, who reviewed R3's records and also concludes that R3 did not elope. Dr. Stiles concedes that R3 exited the facility on March 4, but opines that because her exit was "purposeful, it does not support that she wandered out of the facility." P. Ex. 40, at 1 (Stiles Decl. ¶ 5). I don't see how the "purposefulness" of R3's departure

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[18] No matter how credentialed the expert, his opinion has weight only if supported. Conclusory statements, offered without foundation or support, are entitled to no weight.

made it any safer for this elderly, frail woman – at risk for falls, suffering from dementia, and in need of oxygen for her hypoxia – to be out of the facility, unsupervised and without her walker. I flatly reject any suggestion that R3 could safely leave the facility unsupervised.

Dr. Stiles also says that CNA care plans were "appropriately updated for this behavior," although she does not specify when that happened. I agree that eventually the plans were updated, but the documents establish that those updates occurred late in April, after the surveyors had raised their concerns.

Again, the situation involving R3, by itself, justifies a finding of substantial noncompliance with 42 C.F.R. § 483.25(h)(2).

Resident 26 (R26)[19]

Resident 26 was admitted to the facility on March 14, 2005. She was 50 years old and had recently suffered a cerebrovascular accident (stroke), which left her with weakness and paralysis on her right side, aphasia (inability to speak), and a multitude of related problems, including a seizure disorder. P. Ex. 9, at 8, 41-45, 54, 55, 57. At the time of her admission, she was not considered at risk for wandering or elopement, and she was not placed in a secure unit. P. Ex. 9, at 305, 332, 334.

She was subsequently assessed as at risk for falls due to her decreased mobility, incontinence, and psychotropic medications. CMS Ex. 21, at 15.

On September 27, 2005, R26 suffered a gran mal seizure. P. Ex. 9, at 62, 518-519, 1060; CMS Ex. 21, at 66.

R26 propelled herself around the facility in a wheelchair. *See, e.g.*, P. Ex. 9, at 45, 49, 51. On **October 3, 2005**, she pushed visitors out of the way and forced her way out the front door three times. When a staff member brought her back into the facility, she immediately wheeled herself back to the front door and, when someone enter or exited,

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[19] R26's medical records are most confusing. Petitioner makes largely unsupported assertions and then string cites to pages in the 1,158 page exhibit. P. Cl. Br. at 16-17. But the pages listed seem unrelated to any of the arguments proffered. In fact, it is difficult to fathom why some of the pages have been cited at all. *See, e.g.*, P. Ex. 9, at 58-59, 71, 85-86, 92, 94, 391. Among other problems, cited pages include documents dated after the relevant time period. P. Ex. 9, at 127, 278-279 (June 2006); P. Ex. 9, at 290, 294 (October 2006); P. Ex. 9, at 745, 746 (July 2006).

she forced her way out. Staff were unable to redirect her. P. Ex. 9, at 64; CMS Ex. 21, at 70. On **October 5, 2005**, she tried to go out through the emergency doors. Staff redirected her each time. P. Ex. 9, at 65; CMS Ex. 21, at 71. On **October 7, 2005**, she tried again, first pushing past visitors and staff to get out the front door, and then attempting to go out the fire exits. P. Ex. 9, at 67.

A social service note dated October 7, 2005, indicates a conversation with R26's husband, who agreed to a room change. CMS Ex. 21, at 43.

R26's care plan, dated October 3, 2005, added to her problem list "risk for elopement" related to her attempts to exit the facility and her aggressive behavior, which was not easily altered. CMS Ex. 21, at 18. The approaches listed include: one-to-one visits; assess reasons for anxiety, social withdrawal, crying; call by name each time approached; if identified, attempt to reduce causal factor; provide diversional activities; observe location and redirect as needed; observe closely, if resident is exhibiting anxiety. Someone subsequently wrote in by hand: locked unit; picture in wander book; inservice staff. CMS Ex. 21, at 18-19. The entry is not dated, but seems to have been entered on April 1, 2006.

But the October care plan instructions were not added to R26's subsequent SRNA care plan, which says nothing about her efforts to exit the facility. P. Ex. 9, at 427.

A social service note dated October 19, 2005, indicates that R26's husband agreed to a room change, but an October 26, 2005 note says that the room change was "on hold." P. Ex. 9, at 726.

Notes dated November 4, 2005 indicate that R26 continued trying to get out the doors, crying and yelling loudly, and staff were not able to redirect. P. Ex. 9, at 74; CMS Ex. 21, at 54. On **November 7, 2005**, according to the note, she was found at 7:30 a.m. with the exit door open, attempting to go out. At 8:10 a.m., the exit door was open and she was leaving. She was escorted back into the facility and transferred to another room, but still in an unsecured unit, Maple Leaf II. P. Ex. 9, at 74; CMS Ex. 21, at 54. Social Service Progress notes dated November 7, 2005 indicate that the facility's social worker discussed with R26's husband staff concerns about R26's efforts to get out of the building, suggesting another room change. The husband refused to consider a room on the Magnolia Unit.[20] R26 was moved, but the note does not say where. P. Ex. 9, at 725.

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[20] The Magnolia Unit housed residents with significant behavior problems (*see* discussion *infra*), which may explain the reluctance of families and residents to agree to a placement on that unit. A family's refusal to agree to such placement, however, does not

The following day, November 8, the social services notes indicate that R26 continued to wander the front of the building, that she was increasingly anxious, and hit at a staff member. P. Ex. 9, at 725.

Nurses notes document that on **November 9, 2005**, R26 managed to leave her new unit multiple times. She was escorted back "many times by her nurse, her CNAs, and other staff members from other units." At one point, the admissions nurse found her in the parking lot.[21] P. Ex. 9, at 77-78; CMS Ex. 21, at 41-42. An incident report dated November 9 provides minimal information about the incident: at 2:15 p.m., it "was reported" to the nurse that the resident had been found in the parking lot by the admission nurse. No injuries were noted. CMS Ex. 21, at 11. I do not consider this evidence of an adequate investigation.

Perhaps relying on the otherwise unsupported declaration from Administrator Larmour, Petitioner again claims that R26 exited to the front porch and was "immediately retrieved by staff." P. Cl. Br. at 16; *see also* P. Ex. 37, at 17 (Larmour Decl. ¶20Ei).[22] But this claim is at odds with the contemporaneous record, which puts her in the parking lot.

The Social Service notes indicate that R26 was to be moved to the Magnolia Unit. P. Ex. 9, at 725. Petitioner provides a sheet containing some 15-minute safety checks, but they only cover one hour, from 2:20 p.m. until 3:20 p.m. on November 9. P. Ex. 9, at 140.

A summary of the care conference held November 15, 2005 says nothing about R26's efforts to leave the facility. P. Ex. 9, at 438-440.

A social service note dated November 21, 2005 indicates that R26's husband again agreed to a room change. P. Ex. 9, at 726.

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relieve the facility of its obligation to ensure that the resident receives adequate supervision to prevent accidents.

[21] P. Ex. 25 (DVD) seems to show that the code to exit the unit was posted on a sign directly above the key pad. *See supra* note 17.

[22] Petitioner's closing brief says that R26 exited on the 19th, but I am assuming this was a typographical error and Petitioner intended to say the 9th.

R26's subsequent CNA Care Plan identifies R26 as an elopement risk and calls for checks every 30 minutes. P. Ex. 9, at 452.[23] The January and February 2006 CNA Care Plans also identify her as an elopement risk, and call for hourly checks. P. Ex. 9, at 456, 459, 461. Notwithstanding its submission of voluminous (and sometimes irrelevant) records, Petitioner has not provided evidence that these checks were carried out.

R26's April 2006 CNA Care Plan says that she sits at doors and is at risk for wandering and elopement, and says that she wears a green armband. It no longer calls for periodic checks. An entry dated April 28, 2006, however, says that R26 may leave the locked unit unsupervised per her husband's request. P. Ex. 9, at 476. The plan still does not include most of the interventions listed in R26's care plan: one-to-one visits; assess reasons for anxiety, social withdrawal, crying; call by name each time approached; if identified, attempt to reduce causal factor; provide diversional activities; observe location and redirect as needed; observe closely, if resident is exhibiting anxiety. Someone subsequently wrote in by hand, but did not date (although it seems to have been entered on April 1, 2001): locked unit; picture in wander book; inservice staff.

CMS charges that surveyors observed R26 at the time of the survey, and her care plan was not being followed. Specifically, at 5:00 p.m. on April 26, 2006 she was sitting in the dining room unsupervised. No staff were present. Surveyors purportedly asked R26's nurse where she was. The nurse replied that R26 "usually" sits at the door, and, if not there, she might be in her room. A CNA suggested that R26 might have gone to an activity. At 5:10 p.m., a member of the activity staff admitted leaving R26 alone in the dining room. According to the survey report form, the staff member did not know that R26 was an elopement risk; she thought that such at-risk residents wore green wrist bands. In fact, according to the report, the Administrator two days earlier told the surveyors that she would implement the green wrist bands. The surveyor spoke to the administrative staff at 5:50 p.m. on April 26, and was told that staff had been inserviced a few days prior, but the green wrist band program had not been implemented. CMS Ex. 1, at 123-124; CMS Ex. 21, at 4.

CMS again relies solely on the survey report form and surveyor notes, without a declaration from any surveyor establishing, first hand, these observations and conversations. Had Petitioner denied the allegations, or come forward with any shred of contrary evidence, I would have been compelled to discount CMS's evidence. But Petitioner has not denied the allegations. In fact, Petitioner responds that it thereafter updated R26's care plan was "to indicate [her] wandering behavior and elopement risk."

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[23] The plan is probably dated December 2005, although the date is difficult to read.

P. Reply at 7 (citing P. Ex. 9, at 474, 476). The pages Petitioner cites, establish that the facility ultimately updated R26's care plan, but not until April 27, 2006, the day after the surveyors reported the care plan not being followed.[24]

R26's May 2006 CNA Care Plan identifies her as at risk for wandering and elopement, and indicates that she wears a green armband and wanderguard alarm bracelet at all times. P. Ex. 9, at 489.

Although the facility was more responsive to R26's behaviors than it had been to the behaviors of other residents, its actions did not satisfy the regulation. The facility recognized early in October that R26 had become a wandering/elopement risk. But appropriate interventions were not included in her CNA Care Plan until December. Moreover, Petitioner does not dispute that, at the time of the survey, staff were not following the care plan. I am also concerned about the inadequacy of the facility's investigation following R26's November 9, 2005 exit to the parking lot. Because of these problems, the facility was not in substantial compliance with 42 C.F.R. § 483.25(h)(2) with respect to its treatment of R26.[25]

Resident 53 (R53)

R53 had a short but memorable stay at the facility. He was an 83-year-old man admitted to the Magnolia Unit on February 22, 2006, suffering from organic brain syndrome and a variety of other impairments. He was paranoid and confused, and assessed as high risk for wandering, although not for elopement. P. Ex. 12, at 2, 25, 47, 106.

The facility well understood the challenge R53 presented. In asking whether the facility could accommodate him, his prior placement warned that he is "a high wandering risk and needs to be on a locked unit." P. Ex. 12, at 104. According to his most recent records from the Veterans Administration Medical Center, he had been living at his daughter's house, but was becoming acutely paranoid. On the night of his VA admission, he had awakened, dressed, and run out of his daughter's house. He threatened to kill her when she attempted to take him to the hospital. His daughter was no longer able to care

[24] P. Ex. 9, at 474 is a note dated April 27, 2006, that says the care plans were updated, and P. Ex. 9, at 476 is the CNA care plan.

[25] R26's records include multiple instances of falls, some with serious results. Since neither party addresses these incidents, I assume the facility's responses were considered appropriate. P. Ex. 9, at 70, 104, 107, 113, 516-517, 609.

for him at home because of his wandering behaviors and confused mental state. P. Ex. 12, at 97. According to his assessment, he required "constant monitoring." P. Ex. 12, at 114, 115. Treatment records for the period immediately prior to admission document a history of wandering "all day and all night." He could not easily be redirected. P. Ex. 12, at 100, 107-117. Records dated February 17, 2006 indicate that he tried to leave the institution out the back door. P. Ex. 12, at 112.

Notwithstanding these warnings, R53's CNA Care Plan says nothing about wandering precautions. P. Ex. 12, at 67; CMS Ex. 9, at 20.

According to a February 22, 2006 nurses note, R53 was wandering the unit and "slipped out [the] door behind a visitor or staff member." Staff redirected him back to the Magnolia Unit. P. Ex. 12, at 25; CMS Ex. 9, at 25. At 7:15 that evening, he was again wandering and attempted to enter the code so that he could leave the unit. Staff redirected, writing in the nurses note, "will monitor." P. Ex. 12, at 25. Apparently, staff did not monitor sufficiently because, even though he was put on 15-minute checks (P. Ex. 12, at 27-29), the following day R53 twice went into the special care unit. According to a note, at 2:00 p.m., he went outside to the parking lot by the maintenance shed. P. Ex. 12, at 26; CMS Ex. 9, at 27. According to Petitioner, he was found by maintenance staff and "immediately" returned to the unit. P. Cl. Br. at 12. He may have been returned as soon as he was discovered, but this does not tell us how long he was gone. Again, the record contains no adequate investigation of the incident.

R53 was discharged the following day because the facility was "unable to confine [him] in lockdown unit." P. Ex. 12, at 16, 61.

Petitioner suggests that R53 was not at the facility long enough to merit appropriate care planning. This does not excuse the facility's failure to supervise him properly while he was there. Prior to accepting him, staff were warned that he required "constant monitoring" and they should have been prepared to do so. I also find disturbing the apparent ease with which he managed to exit this purportedly secure unit, and the facility's failure to investigate his actions in order to correct the weaknesses in its systems. These failings establish that the facility was not in substantial compliance with 42 C.F.R. § 483.25(h)(2) with respect to its treatment of R53.

Resident 52 (R52)

R52 was admitted to the facility on February 8, 2006. She was 80 years old, and diagnosed with schizophrenia. P. Ex. 4, at 2. According to a February 8, 2006 wander/elopement assessment, she was at high risk for wandering and elopement. CMS Ex. 14, at 16; P. Ex. 4, at 219, 220. Nevertheless, she was not care-planned for either behavior.

She was very confused. *See, e.g.*, P. Ex. 4, at 43. She seems to have spent her time wandering, talking to herself, and yelling at other residents. P. Ex. 4, at 30 *et seq*. A typical entry reads: "Ambulates continuously from room to nursing station, demands staff to walk back to room [and] cover her." P. Ex. 4, at 44. Although she wandered daily, and often behaved in a socially inappropriate or disruptive manner, the facility did not amend her care plan to address the wandering. P. Ex. 4, at 155, 157, 164, 167, 170, 193, 200, 206, 308.

Her February and March 2006 CNA care plans say nothing about wandering precautions. P. Ex. 4, at 160, 162.

Finally, her April 27, 2006 care plan recognizes that she is at risk of injury related to wandering and at risk for elopement. P. Ex. 4, at 148, 149-150, 168. The plan calls for monitoring her whereabouts, redirecting her to a safe place when she is wandering, encouraging her to attend activities, offering her a snack or other diversion, administering her medication as ordered, and, someone handwrote in "green arm band." Wandering and elopement were also added to the CNA Care Plan in April, although the only intervention listed there is "green arm band." P. Ex. 4, at 172.

Here, the facility identified a risk of injury from wandering/elopement but did not plan for that risk. Its treatment of R52 therefore contravened the regulation. 42 C.F.R. § 483.25(h)(2).

Resident 27 (R27)

R27 was admitted to the facility on February 16, 2006. She was 76 years old, suffering from Parkinson's disease, syncope, and dementia. P. Ex. 8, at 2, 114; CMS Ex. 16, at 15. She had severe burns to her chest and shoulder, having been found in her bathtub with scalding water running over her. She had a history of repeated falls. P. Ex. 8, at 121, 123, 126, 231; CMS Ex. 16, at 15. A wander/elopement risk assessment dated February 16, 2006 places her at risk for wandering, but not for elopement. CMS Ex. 16, at 22. A February 27, 2006 entry in her behavior assessment form notes that "[resident] is at risk for wandering, oblivious of possible harm of self and others." CMS Ex. 16, at 4.

From early on, wandering was an obvious problem for R27. A note dated February 19 at 2:00 a.m. indicates that she came into the hallway with her bags packed, and announced that she was going home. P. Ex. 8, at 232. Another note dated February 19 at 9:00 p.m. describes R27 as walking up and down the hallway, crying, asking, "please, take me home." When staff took her back to bed, she said, "No, I'm going home." P. Ex. 8, at 234. Her February and March 2006 mood and behavior assessment charts document that she exhibited wandering almost daily. P. Ex. 8, at 190, 191.

At 5:00 a.m. on February 24, she was out of bed wandering the halls. An alarm sounded and she was found sitting on her roommate's bed urinating. She then walked down the hallway into another room and defecated on an empty bed. P. Ex. 8, at 233. That afternoon, she was transferred to the Magnolia Unit. P. Ex. 8, at 233. On February 26, at 2:00 a.m., she was up walking, going into the rooms of other residents, picking up their things, and refusing to return to bed. P. Ex. 8, at 235.

Yet R27's February 2006 CNA Care Plan does not identify wandering as a problem, and lists no precautions. P. Ex. 8, at 196, 198.[26] Not surprisingly, the behavior continued, virtually unchecked. A nurses note dated **March 3, 2006**, says that the resident followed her family off the unit. They brought her back, but she went back out because the family did not shut the door. She was "on another unit." The note says that family will be reminded to shut the door completely and return her to the nurses station when visiting. P. Ex. 8, at 238; CMS Ex. 16, at 7. A notation on the mood/behavior/memory comments sheet is dated March 3, 2006, and says that R27 had a visitor, they went off the Magnolia Unit, and the visitor did not bring her back. She "was found" on another unit. P. Ex. 8, at 269; CMS Ex. 16, at 8.

The March 2006 CNA Care Plan includes a note dated March 3, 2006, "will wander off unit behind visitors/family," and "Remind family to completely shut the door when they exit unit [and] walk her back to desk." P. Ex. 8, at 200; CMS Ex. 16, at 20.

A note on the mood/behavior/memory comments sheet dated March 5 states:

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[26] For some reason, which has not been explained, R27 had two not wholly consistent February 2006 CNA Care Plans. One contains CNA signatures attesting to their having implemented the plan, from February 23-29. P. Ex. 8, at 196-197. The other contains CNA signatures, attesting to their having implemented the plan on February 16 and 17, and then from February 24 thorough 29. P. Ex. 8, at 198-199.

> When I went [into the resident's] room, she was naked from the waist down and in bed [with] her roommate, [name deleted]. She also had urinated in the bed. [R27] didn't want to get out of [name deleted's] bed. Finally got her up and put clothes on her.

P. Ex. 8, at 271; CMS Ex. 16, at 10. Yet, nothing in the record suggests any changes to R27's care plan.

The facility identified R27 as an elopement risk on March 6, 2006. P. Ex. 8, at 171-172. Thereafter, she continued "ambulating throughout the facility," and wandering in and out of the rooms of other residents. At 3:30 a.m. on March 22, 2006, she "was found" lying on the floor. She was checked for injuries, and walked back to bed. P. Ex. 8, at 240-243. A note dated March 23 reports that R27 "tends to carry all her belongings with her." She is described as "paranoid" because she claims that "someone is taking her belongings." But she was also observed rummaging through the belongings of others. P. Ex. 8, at 243.

A note dated April 2 at 6:40 a.m. indicates that R27 was up walking the hallways the entire shift, attempting to enter the rooms of other residents. "1:1 redirection" was given several times, and was successful for short periods, but she would then repeat the behavior. P. Ex. 8, at 244. Notes dated April 3 indicate that she continued to carry multiple items with her. On April 4, she was again described as going into resident rooms, but was redirected. P. Ex. 8, at 244.

An April 11, 2006, a wander/elopement risk assessment again places R27 at risk for both wandering and elopement. CMS Ex. 16, at 22. An April 11 entry to her care plan states "locked unit." P. Ex. 8, at 171. On April 27, the facility added green arm band and wander guard to its approaches. P. Ex. 8, at 171-172.

The April 2006 CNA Care Plan notes that she wanders the hallway, and is an elopement risk. The sole precaution listed for this behavior is green armband. P. Ex. 8, at 194; CMS Ex. 16, at 18.

According to Petitioner, placement on the Magnolia Unit was sufficient for these at-risk residents without further care planning. I disagree. First, the Magnolia Unit could hardly be considered secure since its residents were able to leave so regularly.[27] Second, R27

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[27] Again, P. Ex. 25 (DVD) seems to show that the unit's exit code was posted directly above the key pad for one of the doors leading outside. The DVD also seemed to show that the exit code was posted at the doors leading from the Magnolia Unit to the rest

needed close supervision, not just because she was an elopement risk; she was also at risk for falls, and her bizarre behaviors put others at risk as well. These issues should have been addressed in a care plan.

R27 eloped from her purportedly secure unit; she fell; she subjected others to her bizarre behavior. Yet, aside from the minimal information provided in the nursing notes, the facility offers no evidence of an investigation. There are no incident reports, no contemporaneous statements from staff. Interventions were minimal. The facility provided no systematic care planning. Its treatment of R27 therefore violated 42 C.F.R. § 483.25(h)(2).

Resident 28 (R28)

R28 was admitted to the facility on April 12, 2006. She was 79 years old and had suffered an intracranial hemorrhage. She had congestive heart failure, multiple meningiomas (tumors), seizures and confusion. P. Ex. 2, at 2, 24, 215. An April 12, 2006 note describes her sitting in her room crying, asking why her family left her, and saying that she feels lost. P. Ex. 2, at 25. She was at risk for falls related to her unsteady gait and antidepressant medications. P. Ex. 2, at 68. She walked using a walker. P. Ex. 2, at 69.

An assessment dated April 13, 2006, indicates that she was at risk for wandering and for elopement. She displayed all of the risk factors, except that she had not actually eloped. CMS Ex. 8, at 20; P. Ex. 2, at 73. CMS provides a copy of the April 2006 CNA Care Plan that includes a note dated April 18, 2006 that identifies R28 as an elopement risk and notes that she wanders the building; it mentions no interventions or precautions. CMS Ex. 8, at 27.

Thus, notwithstanding its assessment of R28 as an elopement risk, the facility again failed to care plan for the problem until after the survey. Elopement and wandering care plans were developed on April 27, 2006, and included instructions that her whereabouts be monitored, and that she be redirected to a safe area when wandering (instructions not included on the CNA Care Plan). At some point the green arm band was added to the plans, and, an entry dated May 5 adds the wanderguard bracelet. P. Ex. 2 at 75, 135.

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of the facility. *See supra* notes 17, 21.

CMS asserts that the facility's social worker told the surveyors that she was responsible for developing care plans for residents assessed as at risk for elopement, but that she had not been aware of R28's assessment. CMS. Cl. Br. at 20 (citing CMS Ex. 1, at 128; CMS Ex. 8, at 6; CMS Ex. 27, at 7 (Willhite Decl. ¶ 18)). Further, CMS says that the DON told the surveyors that she did not know why R28 had not been care planned for elopement; "the Unit Coordinator didn't follow through." CMS. Cl. Br. at 20 (citing CMS Ex. 1, at 128; CMS Ex. 26, at 2). Petitioner does not challenge the assertions, and, in any event, the reasons underlying the facility's failure to care plan are peripheral to the undisputed fact that R28 had no care plan to address her assessed need, which is another circumstance demonstrating the facility's substantial noncompliance with 42 C.F.R. § 483.25(h)(2).

Petitioner points out that, in fact, R28 did not attempt to leave the facility. P. Cl. Br. at 18. Petitioner also claims that R28 did not display any exit seeking or wandering behaviors, and staff knew that, contrary to her assessments, she was a low risk for potential elopement. P. Cl. Br. at 19. But according to the CNA Care Plan, R28 wandered the building. P. Ex. 8, at 27. Further, as the record in this case amply demonstrates, an attempt to elope does not determine whether an individual is an elopement risk. R11, for example, was identified as an elopement risk even though she never attempted to leave the facility – until her successful departure in April 2006. *Compare* P. Ex. 26, at 3, 5, 6 (R11 wandered but had not attempted to leave the facility) *with* P. Ex. 7, at 33 (R11 left the facility); *see also Weatherford Health Care Center*, DAB CR1139, at 11 (2004) (Resident with no history of wandering and no wandering incidents nevertheless identified as at risk based on his confusion and dementia). Moreover, if the assessment was inaccurate, it was incumbent on the facility to amend it, rather than to ignore it.

In contrast, Petitioner's reply brief, citing P. Ex. 2, at 73 and 78, claims that the facility, in fact, care planned for potential elopement. P. Ex. 2, at 73 is an assessment; it identifies the problem but offers no interventions. P. Ex. 2, at 78 is a portion of a care plan dated April 25, 2006, which was after the start of the survey. Petitioner also points out that the facility provided a green arm band. P. Reply at 9. It did – but not until April 27, 2006.

<u>Resident 16</u> (R16)

R16 was admitted to the facility on June 3, 2005, and assessed as a probable elopement risk. He was housed in the Magnolia unit. He was 48 years old, suffering from dementia, seizure disorder, and mental retardation. He was at high risk for falls. P. Ex. 5, at 11, 85, 176, 211, 862.

R16 was initially in a wheelchair, with a lap buddy, and, almost immediately after his admission, nurses notes record his wheeling up and down the halls in his wheel chair, repeatedly trying to stand and walk, even though he was very unsteady, and unable to balance. A note dated June 4, 2005, says that a CNA was assigned to him for safety. P. Ex. 5, at 12-13. By June 7, 2005, however, he was allowed out of the chair because his gait was steadier. P. Ex. 5, at 14. He was then up and walking around at all hours. P. Ex. 5, at 14 (at 1:15 a.m. R16 was up and walking, refusing to go to bed).

At 10:00 a.m. on June 9, R16 exited through the door as staff entered, and refused to return. Two staff members followed him down the hallway to the Mapleleaf I unit. Although the nurses note is ambiguous, I assume he returned to Magnolia unharmed. P. Ex. 5, at 15. At 4:55 p.m. on June 11, he followed a visitor out the door into the hallway near the dining room. He was returned and 15-minute checks initiated, according to the nurses note. P. Ex. 5, at 15. A note dated June 12 describes him as restless and persistent in attempting to go out onto the patio. But a tornado watch was in effect and it was raining. The note says "CNA or nurse 1:1 for safety." P. Ex. 5, at 15-16.

On July 20, at 9:00 a.m. R16 "was noted" standing in the hallway outside the unit, refusing to return. He was escorted back in. At 10:45 a.m., he "was noted to be swiftly walking down the hallway to the front lobby." He refused to return, but after 20 minutes, was brought back to the unit. P. Ex. 5, at 19.

On the morning of August 28, 2005, R16 experienced a gran mal seizure, falling to the floor and convulsing. P. Ex. 5, at 25. That evening, he fell in the middle of the hallway, attempting to sit where there was no chair. P. Ex. 5, at 26. A note dated September 1, 2005, describes him as pleasant, but notes that he "does wander." At 11:40 that morning, he is described as "agitated" and "wanting to leave." He was redirected back into the unit. P. Ex. 5, at 27. A note dated September 21 describes him as agitated and "trying to leave unit doors." P. Ex. 5, at 32. The following day, September 22, at 1:30 p.m., a note describes him as "continuously" trying to get out the door and off the unit. At 7:00 p.m. that evening, he is wandering in and out of rooms and up and down the hallway, but makes no elopement attempts. P. Ex. 5, at 33.

His September, October and November 2005 SRNA Plans of Care mention "wanders" but suggest no interventions, and say nothing about R16 being an elopement risk. P. Ex. 5, at 243, 249, 253, 255.

At 2:00 p.m. on September 23, R16 is again described as ambulating and "continuously" trying to get out the door. P. Ex. 5, at 33. On the night of September 28, he became violent, attacking a female CNA. The facility called 911 and he was taken to the emergency room. P. Ex. 5, at 33; P. Ex. 5, at 861.

On October 3, R16 was again up wandering the hallways, and entering the rooms of other residents. P. Ex. 5, at 35. At some time that day, he walked to the gazebo, and would not come back in. He is described as "walking into doorway repeatedly." P. Ex. 5, at 35. He was again taken to the hospital and returned on October 6. P. Ex. 5, at 36.

A note dated October 21, 2005, describes R16 as standing at the courtyard door, with his right hand holding the door closed, his left hand a fist, mumbling and refusing to allow staff inside the door. P. Ex. 5, at 35.

A care plan dated November 2, 2005 identifies R16 as at risk for elopement related to his wandering and "ambulation ad lib." Among other approaches the plan calls for staff to observe location and redirect as needed, maintain on secured unit, redirect when wandering is observed (nurses notes document wandering, without suggestion of redirection). P. Ex. 5, at 281. Neither elopement nor any of these approaches are mentioned in his SRNA Plan of Care, however. P. Ex. 5, at 255.

R16's November 17, 2005 Care Conference Summary mentions neither wandering nor elopement. P. Ex. 5, at 293-294. His December 2005 CNA Care Plan offers no wandering precautions. P. Ex. 5, at 178.

On December 5, he "was found" sitting upright on the floor in front of the nurses station, apparently uninjured. P. Ex. 5, at 41. At 8:15 on December 13, he was observed having another seizure. P. Ex. 5, at 42. A social service progress note dated December 21, 2005, indicates that he had suffered a cognitive decline and "roams around more than usual," and has become more combative. P. Ex. 5, at 864.

Yet, his January 2006 CNA Care Plan does not mention wandering or elopement. P. Ex. 5, at 309.

On January 9, 2006, he again appeared to be sitting down but no chair was there, so he fell in the hallway. P. Ex. 5, at 50. His care plan was then amended to note the behavior, and add the approaches "assist in ambulation as needed," and "monitor [for signs and symptoms] of being tired [and] assist to chair for rest periods." P. Ex. 5, at 267.

His February 2006 CNA Care Plan does not mention wandering, elopement, or any related interventions. P. Ex. 5, at 335.

On February 20, 2006, a CNA reported that R16 "was found" on the floor and was changing color. He had a bruise on the right side of his forehead. He was taken to the hospital and returned later in the day. P. Ex. 5, at 52-53.

His March 2006 CNA Care Plan does not mention wandering or elopement. P. Ex. 5, at 371.

On March 27, 2006, after a series of altercations with other residents, staff, and some behavioral outbursts, the facility suggested that R16 be transferred to a psychiatric hospital. P. Ex. 5, at 57. Apparently, the facility then agreed to allow him to remain so long as he did not exhibit uncontrollable behavior. P. Ex. 5, at 58. By April 18, after another series of altercations, staff determined to place him elsewhere. P. Ex. 5, at 62.

Petitioner submits records of 30-minute safety checks for April 18-21, 2006. P. Ex. 5, at 62-67.

A plan of care dated April 2006 finally identifies wandering and risk for elopement as problems. Among the interventions are: monitor whereabouts of resident; redirect to safe areas when wandering, encourage activities, offer snack or provide diversional activities during periods of wandering.[28] Handwritten into the plan are: locked unit, picture in elopement book, and inservice staff. A final entry, dated April 27, 2006 adds "green arm band when returns from hospital." P. Ex. 5, at 397.

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[28] It appears, however, that the facility was not equipped to provide the "diversional activities" that R16 needed. In a letter to Dr. Richard, dated March 28, 2006, R16's neurologist, Dr. Gerald Eichhorn, opines that "environmental modifications that allow him enough activity during the daytime are not possible at the facility . . . . There also does not seem to be any kind of stimulating activity that he can participate in . . . ." P. Ex. 5, at 501. Dr. Eichhorn's opinion is buttressed by the nurses notes that do not suggest R16's having been diverted at any time by any activity other than his wandering the halls and his occasional inappropriate interaction with other residents. Although the record contains some activity assessments, and suggestions that R16 was taken to activities (P. Ex. 5, at 846, 850-852), nothing in the records of his safety checks suggests his having attended any organized activity during those periods.

Moreover, a document dated April 7, 2006, titled Care Plan of R16, signed by the facility's social worker, Sarah Hill, describes the recommendations for R16's care made by social worker, Marie Smart, who was affiliated with R16's consulting neurologist. Her assessment and recommendations include adding structure and routine to his day, offering him a physical activity, and other activities to fill his time. She opines that the unit had declined since her first visit, and observes that all of its residents need activities. P. Ex. 5, at 446, 490.

R16's April CNA Care Plan identifies, for the first time, his wandering and elopement risk. A green arm band is listed as a precaution. P. Ex. 5, at 443.

Thus, again, the facility identified a risk of injury from wandering/elopement, but did not plan for that risk. Its treatment of R16 therefore contravened the regulation. 42 C.F.R. § 483.25(h)(2).

Resident 48 (R48)

R48 was a 78-year-old woman admitted to the facility on October 7, 2005, suffering from dementia, Alzheimer's disease with behavioral disturbance, and a variety of other ailments. P. Ex. 10, at 5.

At the time of her admission, she was assessed as at high risk for elopement (scoring 15 on a scale that places any score of 8 or higher indicates risk for elopement). P. Ex. 10, at 44.[29] She was apparently housed in Magnolia. *See, e.g.*, P. Ex. 10, at 206. Nursing notes record her wandering through the unit, and in and out of resident rooms. P. Ex. 10, at 48, 49, 53, 57, 60. She was discharged on November 1, 2005, because she was combative and sexually aggressive. P. Ex. 10, at 14-15, 59, 206.

CMS asserts that R48 was also assessed as an elopement risk, but the facility failed to formulate an intervention to prevent elopements. CMS Cl. Br. at 21. Petitioner denies this, pointing to P. Ex. 10, at 170. P. Cl. Br. at 20. That document says nothing about elopement. It is a care plan dated October 7, 2005 that identifies as problem areas a wide range of behaviors, including refusing medication, combative behavior, and wandering related to Alzheimers dementia. Interventions include: administering her medication; approach at a different time if she refuses care; call by name; approach calmly; encourage rest periods; offer diversional activities; allow choices; re-direct from potential areas of conflict with other residents; use simple, direct commands; refer to NP as needed; contact social services, as needed; 1:1 as indicated; offer toileting assistance every two hours; and when she is wandering, assess for pain or need for toileting. P. Ex. 10, at 170.

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[29] A second, undated, assessment also identifies R 48 as at risk for wandering. P. Ex. 10, at 40.

Neither of the SRNA Care Plans offered, whose dates are illegible, say anything about wandering or elopement or any of the listed interventions. P. Ex. 10, at 186, 188. I consider this sufficient to establish substantial noncompliance.[30]

B. The facility's deficiencies posed immediate jeopardy to resident health and safety.

I next consider whether CMS's immediate jeopardy finding was "clearly erroneous." 42 C.F.R. § 498.60(c)(2). Immediate jeopardy exists if the 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.

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) (citing *Florence Park Care Center*, DAB No. 1931, at 27-28 (2004) (citing *Koester Pavilion*, DAB No. 1750 (2000)). Here, the facility has not satisfied its burden.

Although Petitioner points out that no actual harm befell any facility resident (an assertion CMS challenges, at least with respect to R11), the regulation does not require a showing of actual harm; immediate jeopardy exists if the facility's noncompliance "is likely to cause" serious injury or harm. *Hermina Traeye Memorial Nursing Home*, DAB No.1810, at 10 (2002), *aff'd sub nom, Sea Island Comprehensive Healthcare Corp. v. CMS*, 2003 WL 22451772 (4th Cir. Oct. 29, 2003). Recognizing the very real and serious dangers inherent to the unsupervised wandering and elopement of frail and demented individuals, the Board has found facilities accountable for their failures even though their residents have been fortunate enough to avoid harm.

> The likelihood of serious harm is weighed not merely by the fortuitous sequence of events that actually resulted from lack of supervision in the instance discovered by the surveyor, but by considering what the episode reveals about dangers to which residents in the facility were exposed by the identified problems and how likely such dangers were to result in

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[30] Because I find that the deficiencies involving the residents discussed above justify the penalty imposed, I do not discuss every resident CMS identifies as at risk under 42 C.F.R. § 483.25(h)(2).

> serious harm. . . . [T]he fact that someone who was severely mentally impaired and unable to care for her own safety could wander off entirely unnoticed and not be sought until strangers rescued her presents significant likelihood that vulnerable residents might encounter the very dangers which [the facility] calls the "usual hazards of wandering away," such as falls, traffic, etc.

Century Care of Crystal Coast, DAB 2076, at 24 (2007).

Here, the facility housed many vulnerable, wandering residents who were not safe unsupervised even within the facility, and who were at even greater risk if they managed to leave. They were demented; they were at risk for falls; some posed significant dangers to others. Yet these residents were able to exit their purportedly secure unit and/or the building on a fairly regular basis. And vulnerable residents exiting this facility faced particular risks. Many seemed to have little difficulty finding their way to the parking lot, and, for them, a parking lot can be a very dangerous place. Further, the driveway running along the side of the facility connects the parking lots to Waller Avenue. CMS Ex. 27, at 3-4 (Willhite Decl. ¶ 8). Waller Avenue is a busy street, with active railroad tracks within several hundred feet. CMS Ex. 27, at 3 (Willhite Decl. ¶ 7).

I am therefore not able to find clearly erroneous CMS's determination that the facility's noncompliance with 42 C.F.R. § 483.25(h)(2) posed immediate jeopardy to resident health and safety.

C. I find reasonable the imposition of a $4050 per day CMP.

Because the facility was not in substantial compliance with program requirements, CMS has the authority to impose a remedy, and I have no authority to review CMS's choice, in this case, a per day CMP. 42 C.F.R. § 488.438(e)(2); 42 C.F.R. § 498.3(b)(13); *see also* 42 C.F.R. § 488.408(g)(2).

CMS based the CMP on incidents that occurred over an extended period of time, which resulted in a sizeable total CMP. However, I consider whether the per day amount – not the total amount – imposed is reasonable. *Century Care of Crystal Coast*, DAB No. 2076, at 26. CMS has imposed a penalty of $4050 per day, which is at the lower end of the range ($3050 to $10,000) for situations that pose immediate jeopardy. 42 C.F.R. § 488.438(a)(i). To determine its reasonableness, I apply the factors listed in 42 C.F.R. § 488.438(f): 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 factor. 42 C.F.R. § 488.438(f). The factors in section 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.

It is well-settled that, in reaching a decision on the reasonableness of the CMP, I may not consider CMS's internal decision-making processes. Instead, I consider whether the record evidence concerning the relevant regulatory factors supports the finding that the amount of the CMP is at a level "reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found and in light of the other factors involved" (facility history, financial condition, culpability). *Barn Hill Care Center*, DAB No. 1848, at 21 (2002); *Community Nursing Home*, DAB No. 1807, at 22 *et seq*. (2002); *Emerald Oaks* DAB No. 1800, at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1683, at 7-8 (1999).

The facility has a significant history of noncompliance. Petitioner acknowledges that, prior to May 1, 2004, when it "assumed responsibility for providing services" the facility's record of compliance was sufficiently dismal to mandate its closure and removal of all residents. The State Agency thereafter allowed for their gradual readmission. P. Cl. Br. at 43.[31] Citing Administrator Larmour's declaration, Petitioner seems to suggest that it has been in substantial compliance with all Medicare requirements since May 2004. P. Reply at 24 (citing P. Ex. 37, at 3 (Larmour Decl. ¶ 5)).[32] But CMS's computer profile of the facility's compliance history (OSCAR Report) says otherwise. CMS Ex. 25. In May 2004, the facility was not in substantial compliance with at least six requirements,

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[31] Petitioner has not explained the circumstances under which it "assumed responsibility" nor its relationship to the prior managers, but, so long as it operates under the same provider agreement (and Petitioner does not suggest otherwise), it is subject to all applicable statutes and regulations and to the terms and conditions under which it the agreement was originally issued. Among other consequences, this means that the facility's compliance history remains a consideration in determining whether a CMP is reasonable. *See CarePlex of Silver Spring*, DAB No. 1683 (1999), and DAB No. 1627 (1997).

[32] I found very confusing Petitioner's claims as to its history. Elsewhere it admits to "only 7 minor deficiencies" during the prior annual survey. P. Reply at 25.

with its most serious deficiency at a G level of scope and severity. In 2005, it was not in substantial compliance with four requirements, the most serious at scope and severity level F. The profile also shows that many of the deficiencies cited during the 2006 survey had been cited previously:

- In its two prior surveys, May 2003 and May 2004, the facility was found not in substantial compliance with Tag F157, notification of changes (42 C.F.R. § 483.10(b)(11)), at a D level of scope and severity;

- In May 2003, it was found not in substantial compliance with Tag F225, staff treatment of residents (42 C.F.R. § 483.13(c), at a D level of scope and severity;

- In May 2003, it was found not in substantial compliance with Tag F250, social services (42 C.F.R. § 483.15(g)(1)), at a D level of scope and severity;

- In May 2003, and May 2004, it was found not in substantial compliance with Tag F282, comprehensive care plans, at a D level of scope and severity;

- In May 2004, it was found not in substantial compliance with Tag F314, pressure sores (42 C.F.R. § 483.25(c)), at scope and severity level G;

- In May 2003 and May 2004, it was found not in substantial compliance with Tag F315, urinary incontinence (42 C.F.R. § 483.25(d)), at scope and severity levels of D and E, respectively;

- In May 2003, it was found not in substantial compliance with Tag F323, accidents (42 C.F.R. § 483.25(h)(1)), at an E level of scope and severity;

- In May 2004, it was found not in substantial compliance with Tag F353, sufficient staff (42 C.F.R. § 483.30(a)), at an E level of scope and severity;

- In May 2005, it was found not in substantial compliance with Tag F371, sanitary conditions (42 C.F.R. § 483.35(i)(2)), at an F level of scope and severity.

Many of these earlier deficiencies – the facility's failure to develop and implement comprehensive care plans; the deficiencies of its social services department; its failure to keep the facility free of accident hazzards; and its deficiencies in staffing – were not only repeated here (see pages 2-4 *supra*), but the problems they described were closely related to the facility's immediate jeopardy deficiencies cited here. CMS Ex. 25.

With respect to the facility's financial condition, Petitioner bifurcates the "stand-alone, limited liability company" from the corporate entity that manages the facility, and argues, without citation to any authority, that I may consider only the financial condition of the "limited liability company." Petitioner characterizes as "completely irrelevant" the financial condition of its management. P. Cl. Br. at 45. I find this a strange result, considering that the management company is probably largely responsible for the deficiencies cited here. But inasmuch as Petitioner offers no underlying evidence 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.

I have no doubt that the size of the CMP will have an impact on Petitioner's bottom line. However, even severe financial losses may not be sufficient to establish a provider's inability to pay. *Wellington Specialty Care & Rehabilitation Center*, DAB CR548 (1998). Although the Board has not definitively addressed the issue, I accept the careful analysis set forth in *Ridge Terrace,* DAB CR938 (2002). There, Judge Kessel observed that a facility's profits or losses may rise and fall over short periods of time depending on a host of other factors, but short-term profits and/or losses may not accurately describe the facility's overall financial health. Profits and losses must be considered in the context of other factors, including the facility's financial reserves, its credit-worthiness, and other long-term indicia of its survivability. *Ridge Terrace* at 4-5. Here, even if I were to consider the declaration of Chief Financial Officer Turner (which I do not for the reasons discussed elsewhere), Petitioner has simply not presented sufficient evidence to justify lowering the CMP based on its financial condition. *See Mercy Health Care & Rehabilitation Center*, DAB CR955 (2002); *Wellington Specialty Care & Rehabilitation Center*, DAB CR548 (1998). CFO Turner, who apparently worked for the management entity, declares that the CMP will affect profits and losses, but provides none of the other types of information described in *Ridge Terrace*. Petitioner has simply provided insufficient information upon which to determine its survivability.

Even if Petitioner had established that its financial condition should be factored into the final amount, other compelling factors preclude lowering the CMP below $4050 per day. The CMP must be a minimum of $3050 per day. Considering the facility's dismal history, and the scope and severity of the deficiencies cited here, raising it to $4050 or more per day is reasonable. By itself, the widespread scope of the immediate jeopardy deficiency merits an increase in the per day amount beyond the minimum. The circumstances surrounding virtually any one of the residents discussed justifies an immediate jeopardy finding. The number and circumstances of incidents suggest serious systematic problems in care planning, investigating incidents, and ultimately protecting residents from injury, for which the facility must be considered culpable. Moreover, the complete list of deficiencies cited is formidable, and includes multiple instances of

deficiencies that are widespread and deficiencies that caused actual harm.[33] Even absent a finding of immediate jeopardy, considering these deficiencies with the other factors (history, etc.) would have justified a penalty at the high end of the lower range ($50 to $3000).

In light of all of these factors, the $4050 per day CMP is reasonable.

IV. Conclusion

Thus, because the facility did not adequately supervise its residents, placing them at significant risk of suffering an accident and potentially serious injury, it was not in substantial compliance with 42 C.F.R. § 483.25(h)(2) from September 15, 2005 through May 12, 2006. Its deficiencies posed immediate jeopardy to resident health and safety. I find reasonable the $4050 per day CMP.

/s/

Carolyn Cozad Hughes
Administrative Law Judge

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[33] In addition to the immediate jeopardy findings, the facility was not in substantial compliance with at least 19 other regulations, three at scope and severity level E (pattern of noncompliance with potential for more than minimal harm), four at level F (widespread noncompliance with potential for more than minimal harm), and three were at level G (actual harm).