Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Oxford Manor,	)	Date: November 09, 2007
(CCN: 34-5291)	)	
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-06-665
	)	Decision No. CR1686
Centers for Medicare & Medicaid	)	
Services.	)	
	)	

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose remedies against Petitioner, Oxford Manor, consisting of: civil money penalties of $3,050 per day for each day of a period that began on April 26, 2006 and which continued through June 21, 2006; and $50 per day for each day of a period that began on June 22, 2006 and which continued through July 22, 2006.

I. Background

Petitioner is a skilled nursing facility in North Carolina. It participates in the Medicare program. Its participation in Medicare is governed by sections 1819 and 1866 of the Social Security Act and by federal regulations at 42 C.F.R. Parts 483 and 488. Its right to a hearing in this case is governed by federal regulations at 42 C.F.R. Part 498.

On June 21-22, 2006 Petitioner was surveyed to determine whether it was complying with Medicare participation requirements (June survey). The surveyors determined that Petitioner was noncompliant. The deficiencies identified by the surveyors included failures by Petitioner to comply that were so egregious as to comprise immediate jeopardy for Petitioner's residents.[1] CMS accepted the surveyors' findings and determined to impose the remedies that I describe above.

Petitioner requested a hearing and the case was assigned to me for a hearing and a decision. I held an in-person hearing in Raleigh, North Carolina, on August 14, 2007. I received into evidence exhibits from CMS which I identified as CMS Ex. 1 - CMS Ex. 39. I received into evidence exhibits from Petitioner which I identified as P. Ex. 1 - P. Ex. 36. Additionally, I heard the cross-examination and redirect testimony of the two surveyors who conducted the June survey.[2] Each party filed a post-hearing brief. The parties received a copy of the hearing transcript. (Tr.)

II. Issues, findings of fact and conclusions of law

A. Issues

The issues in this case are whether:

1. Petitioner failed to comply substantially with one or more Medicare participation requirements;

2. Petitioner proved that CMS's determination of immediate jeopardy was clearly erroneous;

3. Petitioner proved that CMS's determination of duration of noncompliance was incorrect;

4. CMS's determination to impose civil money penalties against Petitioner in amounts of $3,050 and $50 per day was reasonable.

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[1] The term "immediate jeopardy" is defined at 42 C.F.R. § 488.301 to mean:

> a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

[2] The written direct testimony of the two surveyors is in evidence as CMS Ex. 38 and CMS Ex. 39.

B. Findings of fact and conclusions of law

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

1. Petitioner failed to comply substantially with Medicare participation requirements.

The June survey report alleges that Petitioner failed to comply substantially with three distinct Medicare participation requirements. P. Ex. 1, at 1-47.[3] Two of the deficiencies cited in the report were at the immediate jeopardy level. These were alleged failures by Petitioner to comply with the requirements of 42 C.F.R. §§ 483.25(h)(1) and (h)(2). In this decision I find that Petitioner failed to comply substantially with each of these two regulations.

I do not address the third deficiency cited in the June survey report, an alleged non-immediate jeopardy level failure by Petitioner to comply substantially with the requirements of 42 C.F.R. § 483.15(g)(1), because CMS failed to provide me with any argument about it in its brief. However, the remedies that I sustain in this decision do not depend on the presence of this third alleged deficiency.

a. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h)(1).

The regulation that is at issue here requires that a facility ensure that its residents' environment remain as free of accident hazards as is possible. It has been the subject of much litigation. It is settled that the regulation requires that a facility take all reasonable measures to protect its residents against accident hazards that are known or are foreseeable.

CMS's allegations of noncompliance with the regulation center around the care that Petitioner gave to a resident who is identified as Resident #10 in the June survey report. CMS alleges, specifically, that Petitioner failed to protect its residents from accident

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[3] CMS did not introduce the actual June survey report as evidence in the case. Instead, it offered a document which appears to be a restatement of two of the deficiencies that were identified in the June survey report. CMS Ex. 2. Petitioner introduced the June survey report as P. Ex. 1. The portions of the two documents that state the allegations of deficiencies do not appear to differ materially. For purposes of clarity I cite to P. Ex. 1 as the June survey report.

hazards in that it failed to remove a cigarette lighter from the resident's possession after the staff discovered that a wander guard that had been attached to the resident had been burned off. P. Ex. 1, at 4.[4]

The facts establishing Resident #10's physical and mental condition are not in dispute. Petitioner's records show that the resident was, as of his admission to Petitioner's facility and thereafter, an individual suffering from dementia and memory problems. The resident was first admitted to Petitioner's facility at the end of November 2005 and his diagnoses upon admission included a diagnosis of Alzheimer's Disease. P. Ex. 1, at 5. In June 2006, only weeks prior to the June survey, Petitioner's staff assessed the resident as having an unsteady gait and having mental deficits which included short and long term memory problems and poor decision making ability. *Id.* The staff concluded that the resident needed cues and supervision to compensate for his mental deficits. *Id.*

CMS bases its case for noncompliance on the undisputed facts that I have just described and on the following additional facts. At the June survey a surveyor interviewed members of Petitioner's staff concerning the care that was given to Resident #10. Among those interviewed was a nurse's aide who avowed to the surveyor that, about two months prior to the survey, he found a burned wander guard under the resident's bed. The aide asserted that, previously, the resident had worn the wander guard around his ankle, and he concluded that the resident had burned the device off. P. Ex. 1, at 5.

Interviews with other members of Petitioner's staff revealed that the resident was a heavy smoker who was supplied cigarettes and smoking materials by members of his family. According to the staff the resident would go into the facility's courtyard independently and smoke several times during each work shift at the facility. P. Ex. 1, at 6. A nurse's aide averred that the resident had his own cigarette lighter up until about two weeks prior to the June survey. *Id.* Another nurse's aide told the surveyor that the resident's room smelled of cigarette smoke and that there were cigarette butts on the resident's table. *Id.* Another member of Petitioner's staff averred that the resident always kept cigarettes and a lighter on his bedside table. *Id.*, at 9.

During the survey a surveyor visited the resident's room. She discovered smoking materials on the resident's night stand. Tr. at 14. The room smelled of smoke. *Id.*

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[4] A wander guard is a bracelet that a resident wears around his or her wrist or ankle. It contains an electronic device that triggers an audible alarm if a resident who is wearing the wander guard attempts to walk through a doorway containing a sensor that responds to the device.

Petitioner's business manager averred in an interview that the staff had brought the burned wander guard to him/her on the date that it had been discovered and that he/she brought the matter to the attention of Petitioner's director of nursing. P. Ex. 1, at 6. Petitioner's director of nursing, however, claimed no independent memory of having been told about the burned wander guard. *Id*. at 7. Petitioner's administrator stated in an interview that he was unaware before June 20, 2006, that Resident #10's wander guard had been burned off. *Id.*

Nothing in Petitioner's records show that Petitioner's staff documented the wander guard incident. *See* P. Ex. 1, at 9. Furthermore, Petitioner's staff did not perform an assessment between his admission to the facility on November 30, 2005 and the June survey of the need to supervise Resident #10 while he smoked. *See Id.*

Petitioner has a policy governing smoking by its residents. Among other things, this policy states:

> 1. The IDT (Interdisciplinary Team) shall make a determination as to the competency of residents who smoke, *based on a written assessment, on admission and at least quarterly thereafter*.
>
> 2. A care plan that outlines appropriate interventions to ensure the safety of residents who smoke will be completed with the assessment.
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> 3. Residents who are determined by assessment to be incompetent smokers will not be permitted to smoke without the direct supervision of a staff member, family, visitor or volunteer who has been trained in their responsibilities for this task.
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> 4. Residents who are determined by assessment to be competent will be permitted to smoke in designated areas without direct supervision. They may be permitted to retain cigarettes, *but lighters or matches must be secured by staff members when not in use by the resident. In no event is any f[l]ame-producing device to be left in resident rooms or common areas, including the designated smoking areas. . . .*

P. Ex. 13, at 1-2 (emphasis added). Petitioner's smoking policy also instructs staff to "check bedside area[s] and throughout room routinely for lighting materials." *Id.* at 2.

The evidence offered by CMS concerning Petitioner's care of Resident #10 establishes a strong prima facie case that Petitioner's staff failed to protect residents from accident hazards. Resident #10 is a demented individual suffering from memory and judgment problems. Petitioner's staff knew that he was a habitual smoker and knew that the resident kept smoking materials in his room including a cigarette lighter. The resident's

possession of a lighter was an obvious hazard given his dementia and, in fact, was in violation of Petitioner's own smoking policy. Yet, Petitioner's staff failed to take the lighter away from the resident even after the staff discovered that the wander guard that the resident wore had been burned off and placed under the resident's bed. Indeed, the evidence supports a finding that the resident continued to smoke in his room, unsupervised, up until the June survey. Tr. at 14.

The failure to protect Resident #10 is a basis for me to infer a lack of understanding by Petitioner's staff of their obligation to protect residents – not just Resident #10 – from known hazards. The failures documented by CMS with respect to the resident are evidence of a systemic problem. That is because the evidence shows that Petitioner's staff failed consistently to provide necessary protection to the resident. Based on this evidence the staff failed to: conduct requisite assessments of the resident; prevent the resident from keeping and using prohibited smoking materials in unsafe areas; take away these materials after being made aware of an incident that illustrated the danger of leaving the resident with them unsupervised; and, investigate the incident itself.

Petitioner makes several arguments in opposition to CMS's case for noncompliance. I find them to be unpersuasive.

Petitioner asserts that "neither the Statement of Deficiencies [the June survey report] nor CMS's arguments and its witnesses' testimony make clear exactly what the purported noncompliance was in this case." Petitioner's post-hearing brief at 2. I do not understand this argument. As I discuss above, CMS's allegation of noncompliance with the accidents hazard prevention regulation is precise. The June survey report states explicitly that Petitioner failed to remove a cigarette lighter from Resident #10 after the staff discovered that a wander guard worn by the resident had been burned off.

Perhaps related to this assertion is Petitioner's contention that:

> the regulatory bar now is so low that the [Departmental Appeals] Board will sustain virtually any CMS allegation of wrongdoing, whether the evidence actually supports a surveyor's allegations or not . . . .

Petitioner's post-hearing brief at 4. That complaint is, of course, meaningless when uttered in the context of a specific case unless it relates to the evidence and arguments that are made in that case. The evidence that I describe above "actually supports" the allegations of noncompliance made by CMS. It is incumbent on Petitioner, if it wishes to prevail, to do more than to carp about the Departmental Appeals Board's standards of review. Petitioner must rebut CMS's evidence with credible evidence of its own. As I discuss below, Petitioner failed to meet that obligation.

Petitioner asserts that there is no evidence that Resident #10 habitually and consistently smoked without adequate staff supervision over a period of months. Petitioner's post-hearing brief at 2. Indeed, according to Petitioner, its witnesses denied that assertion. But, Petitioner's assertions to the contrary, there is very strong evidence to support a finding that the resident smoked consistently without staff supervision. That evidence includes interviews with facility staff who averred that they found cigarette butts in the resident's room and that the resident's room smelled of smoke. P. Ex. 1, at 6. Additionally, the resident's wife, who was also the resident's roommate, told a surveyor that Resident #10 frequently smoked in the bathroom of his room. *Id.* at 8-9. And, the surveyor found evidence that the resident was still smoking in his room consisting of cigarette butts and the odor of cigarette smoke.

Petitioner's assertions aside, it presented no testimony to show that Resident #10 was supervised adequately by Petitioner's staff. Petitioner presented no testimony to show that the staff acted to remove prohibited items from the resident in the face of knowledge that he possessed them.

Petitioner supported its case with the written direct testimony of four witnesses. P. Ex. 33 - P. Ex. 36. These individuals include Petitioner's director of nursing, Petitioner's administrator, a licensed practical nurse, and a nursing assistant. *Id.* Only one of these witnesses makes any reference to Resident #10's smoking behavior. That witness is Rhonda Foster, R.N., Petitioner's director of nursing. P. Ex. 33. In her testimony she avers that she was "unaware that the Resident ever smoked in a way that was dangerous to himself or others." *Id.* at 4. But, this conclusion aside, Ms. Foster does not deny the reported statements of various staff and the resident's wife that Resident #10: kept a cigarette lighter in his possession in express violation of Petitioner's smoking policy; and smoked in his room also in violation of that policy. Nor does Ms. Foster explain why the resident was allowed to retain possession of the lighter after his wander guard had been discovered by staff to have been burned off. Her only testimony about that is that her "understanding is that the Resident was counseled about the matter, and he never attempted to do so again." *Id.*

Ms. Foster's testimony fails to address the very specific allegations made by other staff members and the resident's wife concerning Petitioner's failure to supervise the resident. She does not testify that she personally supervised Resident #10 and she does not detail the supervision that allegedly was provided to the resident. Moreover, she does not explicitly deny the surveyor's reported conversation with her in which she stated that she did not remember being told about the burned wander guard. P. Ex. 1, at 7. And, the alleged supervision that Ms. Foster testifies to is inadequate on its face given the obvious hazard that the staff was aware of concerning Resident #10's smoking. She provides no explanation for the staff's failure – in contravention of facility policy – to assess the resident's ability to smoke after his initial admission to the facility despite the staff's

knowing that the resident was demented and had significant memory and judgment problems.[5] She does not explain why the resident continued to be allowed to smoke in his room after the staff became aware that he was doing so. She offers no explanation for the staff's failure to take away the resident's cigarette lighter after the staff discovered that he possessed one. And, she offers no explanation for the staff's failure to take more aggressive action to protect the resident after the staff discovered that the resident's wander guard had been burned off.

Petitioner suggests, without offering any evidence to support its speculation, that there is no basis to conclude that the resident burned off his wander guard. The reasonable inference, of course, is that he *did* burn off his wander guard given that it was found under his bed and given further his dementia and his unsupervised use of a cigarette lighter. But, it really is not important to my conclusion that Petitioner was non-compliant to establish that Resident #10, as opposed to someone else, burned off the wander guard. The fact that the wander guard was burned off, whether by the resident or by some unknown individual, was a graphic reminder to Petitioner's staff that the resident possessed a cigarette lighter. That event, in addition to the staff's knowledge of the resident's dementia and Petitioner's own policy which expressly prohibited *even competent residents* from possessing lighters, should have galvanized the staff into taking action to protect the resident.[6]

Petitioner also seems to suggest that the cigarette butts that were present in the resident's room are unreliable evidence that he smoked in his room. Petitioner speculates, again without offering any supporting evidence, that the resident may have collected the butts elsewhere and brought them back to his room. This unsupported suggestion notwithstanding, the reasonable inference that I draw from the presence of those butts in

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[5] Petitioner attempts to make a silk purse out of a sow's ear by asserting that, although its staff failed to make requisite quarterly assessments of the resident's ability to smoke, it is possible to "infer that the resident's cognitive status was stable." Petitioner's post-hearing brief at 8. But "stable" does not mean "safe." Resident #10 had obvious judgment problems, recognized by Petitioner's staff, which made assessing his ability to smoke safely mandatory. The discovery of the burned wander guard only served to underscore the extent of those problems.

[6] The possibility – raised by Petitioner – that someone other than Resident #10 may have burned off the wander guard is highly disturbing. Petitioner, in effect, argues that some individual besides the resident, clearly capable of taking actions that might have caused great harm to residents, was acting undetected in the facility. Yet, despite that possibility, Petitioner's staff did *nothing* to investigate the circumstances surrounding the burned wander guard. Indeed, Petitioner's administrator was unaware of the incident until shortly prior to being interviewed by a surveyor.

the resident's room is that he smoked in his room. That inference is supported by the unrebutted statement of the resident's wife who averred to a surveyor that the resident smoked in his bathroom. And, it is also supported by staff and surveyor assertions that the resident's room smelled of smoke.

Moreover, whether the resident actually smoked in his room is, in fact, a secondary issue. Petitioner's staff *knew* that the resident – a demented individual – possessed a cigarette lighter in his room. The staff also *knew* that the resident's wander guard had been burned off and they had strong evidence that this incident had occurred in the resident's room given that the wander guard was found under the resident's bed. And, yet, the staff did *nothing* to investigate the incident or even to remove the lighter from the resident's possession after the burnt wander guard was discovered.

Petitioner argues also that the resident's smoking at Petitioner's facility should be considered in context. It asserts that the resident was experiencing adjustment problems while at Petitioner's facility and that smoking was a central part of his life. Petitioner's post-hearing brief at 10-12. Consequently, according to Petitioner:

> Resident #10 was not some academic or hypothetical case study; he was a gentleman whose agitation and adjustment problems were so severe that it would have been cruel for Petitioner's staff to treat him like a child or punish him each time that he smoked indoors during the first few weeks of his stay simply because they feared that a surveyor might second-guess their clinical decisions a few months later.

Id. at 11-12. This argument is a straw man. The evidence offered by CMS and not rebutted by Petitioner establishes that Petitioner's staff allowed the resident to possess prohibited smoking material and to smoke, essentially unsupervised, not weeks, but months after his admission to Petitioner's facility. Furthermore, the choice that Petitioner claims was presented to the staff – to allow a demented resident to possess prohibited materials and to smoke largely unsupervised or to "treat him like a child or punish him indoors during the first few weeks of his stay"– is a false choice. Petitioner's staff never faced the option of treating Resident #10 as a child or punishing him for smoking. Petitioner's own smoking policy established clear guidelines which enabled residents to smoke under adequate supervision given their mental and psychological states. Petitioner could have protected the resident adequately, consistent with respecting the resident's dignity, had it simply followed its own policy.

The concern that Petitioner now expresses for the resident's fragile psychological state is ironic given that Petitioner's staff did not manifest sufficient concern for the resident after his admission to perform the assessments of his psychological and mental capacity to smoke that Petitioner's policy required. It is ironic also given that Petitioner's staff failed to express much concern for the resident's physical safety.

b. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h)(2).

The regulation that I address here is closely related to the regulation that I discuss in the previous subsection. It mandates a facility to provide each of its residents with adequate supervision and assistance devices to prevent accidents. The standards for complying with this regulation are well-established and closely track the compliance requirements of 42 C.F.R. § 483.25(h)(1). A facility must provide all reasonable supervision and assistance to a resident in order to protect that resident from any foreseeable accident.

CMS premises its contention that Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h)(2) on three allegations that Petitioner inadequately supervised or assisted residents. These are that Petitioner's staff failed to:

> • supervise Resident #10's possession of a lighter after the resident's wander guard had been discovered burned off;
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> • monitor Resident #10's wandering sufficient to prevent him from eloping Petitioner's premises; and
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> • monitor another resident, identified in the June survey report as Resident #5, sufficiently to protect her from eloping Petitioner's premises.

P. Ex. 1, at 14.

I have discussed in detail at subpart a. of this Finding the failure of Petitioner's staff to protect Resident #10 against the hazards caused by his possessing prohibited smoking materials. I do not need to discuss this failure again in detail here to conclude that the staff failed to supervise Resident #10 as is required by 42 C.F.R. § 483.25(h)(2). Petitioner's staff knew that the resident was demented. The staff knew also that the resident had a propensity to smoke constantly, they knew that he possessed a lighter contrary to facility policy, and they had reason to conclude that he was smoking, unsupervised in locations where smoking was prohibited, including his room. Tr. at 14. But, in the face of that knowledge, the staff did essentially nothing to protect the resident. The staff failed to conduct smoking safety assessments required by Petitioner's own policy. They failed to remove a lighter from the resident's possession after they learned

that he had it and after they had every reason to believe that he'd used it to burn off a wander guard. And, they continued to allow the resident to smoke unsupervised in locations that included his room. *Id.*

Petitioner argues that its staff supervised the resident effectively. According to Petitioner its staff intervened immediately and effectively after the staff discovered the burned wander guard in that a nursing assistant counseled the resident. Petitioner's post-hearing brief at 13.

This intervention was palpably inadequate. Resident #10 is an individual who was assessed by Petitioner's staff as suffering from memory and judgment problems. Petitioner's staff concluded that the resident needed cuing and supervision to compensate for his mental defects. In light of that, to suggest that mere "counseling" would be sufficient to protect this resident defies common sense.

Moreover, the staff did not remove prohibited smoking materials from the resident after they had discovered the burned wander guard. The resident continued, in violation of Petitioner's own policy, to possess a lighter and to smoke in his room *after* the point in time when the staff allegedly counseled him. Given the staff's failure to remove dangerous items from the resident even the most determined counseling would be an exercise in futility.

Petitioner's failure adequately to supervise Resident #10's smoking activities is, in and of itself, sufficient to establish a failure by Petitioner to comply substantially with the requirements of 42 C.F.R. § 483.25(h)(2). I need not consider other evidence in order to sustain CMS's determination of noncompliance. However, I address also CMS's allegations of Petitioner's failure adequately to supervise another resident, Resident #5, because, and as I discuss below, Petitioner's failure to supervise this resident is as egregious as is its failure adequately to supervise Resident #10's smoking activities. Moreover, CMS's determination that Petitioner's noncompliance began on April 26, 2006, is tied to the care that Petitioner gave to Resident #5.[7]

CMS's allegations of noncompliance concerning the care that Petitioner gave to Resident #5 center around her elopement from Petitioner's facility on April 26, 2006, and the aftermath of that incident. The resident was a long-term resident of Petitioner's facility, having resided there for about 13 years. It is undisputed that the resident suffered from

[7] I find it unnecessary to address CMS's allegations that Petitioner failed adequately to supervise Resident #10 in order to prevent his eloping the premises of Petitioner's facility.

mental impairments and associated memory problems. P. Ex. 1, at 15.[8] It is also undisputed that the resident spent much of her waking hours in a wheelchair but that she could ambulate unassisted if necessary. Petitioner's staff was aware that the resident was able to walk without assistance. According to one staff member: "[Resident #5] can walk and when she is agitated or upset she will get up and take off." P. Ex. 1, at 20.

Petitioner's staff identified the resident as being prone to wandering. A care plan for the resident dated April 26, 2006 noted that the resident exhibited:

> wandering with no rational purpose and is at risk for elopement due to increased confusion.

P. Ex. 1, at 16.

Prior to April 26, 2006, the staff determined that the resident should wear a wander guard so as to alert the staff to any attempt by the resident to leave Petitioner's premises without authorization. However, the resident resisted wearing a wander guard and, so, the staff's solution to her resistance was to attach the wander guard to the resident's wheelchair. The staff's evident intent was that they would be alerted to unauthorized efforts by the resident to leave the facility while she was in her wheelchair.

The resident was observed in her bed at about 8:00 p.m. on the 26th. P. Ex. 1, at 16 - 17. But, at about 9:00 p.m. on that evening, a dietary aide found the resident walking with the assistance of a cane about 1/10 of a mile up the street from Petitioner's facility. *Id.* at 18. The staff retrieved the resident and returned her to the facility. The resident was able to elope because she parked her wheelchair within the facility and simply walked out the door unobserved. *Id.* at 17, 20. The wander guard alarm was not triggered because the wander guard never crossed the threshold of Petitioner's facility.

After the resident returned, the staff attempted to attach a wander guard to her person. The resident resisted that effort strongly by attempting to strike a staff member with her cane, and so, Petitioner's staff abandoned the effort. *See* CMS Ex. 1, at 17.

CMS asserts that there is no evidence to show that Petitioner's staff took meaningful precautions after April 26, 2006, to ensure that the resident would not, at a future date, elope using the same technique that she had used on the 26th. Petitioner's staff continued to attach the wander guard to the resident's wheelchair but not to her person. P. Ex. 1, at 19. There is no evidence that Petitioner's staff comprehensively reviewed the events that

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[8] Petitioner's director of nursing characterized the resident's mental problems as consisting of mental retardation. P. Ex. 33, at 1.

occurred on the 26th for the purpose of determining whether leaving the wander guard attached to the resident's wheelchair provided adequate protection against her eloping again in circumstances similar to those of the night of the 26th.[9] Indeed, Petitioner's administrator was unaware of the episode prior to the June survey. *Id.* Moreover, up until the date of the survey Petitioner's staff continued to allow the resident to sit outdoors in front of Petitioner's facility unsupervised except for periodic checks. *Id.* The staff's practice when the resident desired to go out was to turn off the resident's wander guard so that the facility's door alarm would not be triggered when she exited the premises.

The foregoing evidence, if unrebutted, is ample prima facie support for CMS's assertion that Petitioner failed to comply with the supervision requirements as concerned Resident #5 beginning on April 26, 2006. The evidence establishes that Petitioner's staff knew that the resident was demented and knew that she was prone to wander when left unattended. On April 26 the staff discovered, moreover, that their attempts to assure that the resident did not elope were unavailing and ineffective because on that date the resident simply walked out of Petitioner's facility. The April 26 event put the staff on notice that more needed to be done to protect the resident than simply to attach a wander guard to her wheel chair. But, once the resident was returned to the facility on the 26th, Petitioner's staff failed to augment meaningfully the surveillance and supervision that it had provided the resident previously. The result was that the resident remained a risk for continued elopement.

I do not find to be persuasive the several arguments that Petitioner makes in opposition to that which was offered by CMS.

First – and as it did with respect to CMS's allegations concerning Resident #10 – Petitioner asserts that CMS's allegations of noncompliance concerning the care Petitioner gave to Resident #5 are "incomplete", "misleading" and "unclear." Petitioner's post-hearing brief at 17. These assertions notwithstanding, there is nothing that is incomplete, misleading, or unclear about CMS's noncompliance allegations. As I discuss above, CMS charged explicitly that Petitioner failed adequately to monitor Resident #5 so as to prevent her from eloping Petitioner's facility. And, as I discuss above, CMS backed up this explicit allegation of noncompliance with a persuasive prima facie case.

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[9] On April 26, 2006, either shortly prior to or immediately after the elopement incident, Petitioner's staff amended the resident's care plan to add several additional interventions for Resident #5. P. Ex. 21, at 2. I discuss these in more detail, below. Nothing in the care plan shows that the staff intensively investigated the elopement incident or considered whether leaving the wander guard attached to the resident's wheelchair constituted a flaw in their surveillance of the resident.

The thrust of Petitioner's defense is that during the 13-year period that Resident #5 lived at Petitioner's facility prior to April 26, 2006, she had never attempted to elope. Petitioner asserts that the elopement of April 26 was, therefore, an unexpected and unforeseeable event and Petitioner should not be held accountable for it. Petitioner's post-hearing brief at 18-19.

The elopement of the 26th was an unprecedented event in the narrow sense that the resident had not attempted to elope previously. But it also was foreseeable. Indeed, Petitioner's staff had assessed the resident to be an elopement risk and, for that reason, had affixed a wander guard alarm to the resident's wheelchair.

Even if Petitioner's staff were justifiably lulled by the resident's long history of not attempting to elope into believing the resident not to be a serious risk for elopement, all of that changed on the night of the 26th. Beginning with the moment that the staff discovered the resident to be absent the staff not only was made acutely aware that the resident was an actual elopement risk but they knew also that *all* of their precautions against elopement – especially including relying on a wander guard attached only to the resident's wheelchair – were unavailing. That discovery imposed on Petitioner the obligation to reassess closely all of their previously held assumptions about Resident #5 and to determine what new or additional surveillance and supervision was necessary to protect the resident against future elopement attempts.

Petitioner contends that it protected the resident adequately after her elopement by promptly updating her care plan to address her wandering behaviors, with more than a dozen interventions noted in the plan. Petitioner's post-hearing brief at 20; P. Ex. 21, at 2. But, that care plan contains a glaring defect which should have been apparent to anyone on Petitioner's staff who knew the circumstances of the resident's elopement. The care plan does not address the flaw in Petitioner's surveillance of Resident #5 that enabled the resident to elope. There is literally nothing in the care plan that discusses the possibility that the resident might defeat the wander guard attached to her wheelchair simply by walking out of the facility.

The care plan does mention the resident's use of a wander guard and contains precautions for the staff to follow to assure that the wander guard functioned properly. It states that staff would "Apply wander guard and check for placement . . . [each] shift." P. Ex. 21, at 2. And, it states that the staff would "Check for proper functioning of wander guard each shift." *Id.* But, placement of the wander guard on the resident's wheelchair was known to the staff to be an inadequate protection against elopement. Nor was a wander guard malfunction a contributor to the resident's April 26th elopement. That elopement would have occurred regardless whether the wander guard functioned perfectly or was non-functional.

So, although Petitioner's staff made some efforts at better protecting Resident #5 after her April 26, 2006 elopement, they failed to address the principal problem that enabled the resident to elope. The resident remained vulnerable so long as that problem remained unaddressed.[10]

Petitioner also has not offered a satisfactory explanation for its decision to allow the resident to continue to sit outdoors after April 26, 2006, unsupervised except for periodic checks. Petitioner's director of nursing testified that she did not believe that allowing the resident to continue to sit outdoors was inappropriate, even after the resident had eloped. P. Ex. 33, at 5. According to Petitioner: "Reasonable minds may differ regarding the appropriateness of this professional judgment, or its efficacy, but it does not seem to be objectively unreasonable . . . ." Petitioner's post-hearing brief at 21.

I do not find this decision to be reasonable because it is not supported by the record or by Petitioner's logic. Petitioner asserts that the elopement of Resident #5 came as a complete surprise to it and that its staff would have had no reason to assume the resident to be an elopement risk given her 13-year history at the facility. But, if the April 26, 2006 elopement was a surprise and unpredictable, then how could the staff assume reasonably that the resident would not act unpredictably at future times? By allowing the resident to continue to sit outdoors unsupervised the staff was literally gambling that the April 26th incident was a one-time aberration. There is nothing in the record to show that this gamble was well-founded. For example, Petitioner's staff could not have reasonably decided that the resident should remain free to sit outdoors unattended based on a professional evaluation of the resident's mental status because the resident was not seen by a mental health professional until June 20, 2006. P. Ex. 29.

2. Petitioner did not prove to be clearly erroneous CMS's determination that its noncompliance with 42 C.F.R. §§ 483.25(h)(1) and (h)(2) was at the immediate jeopardy level.

It is Petitioner's burden to prove clearly erroneous a determination by CMS that a deficiency puts residents at immediate jeopardy. 42 C.F.R. § 498.60(c)(2). Petitioner failed to meet that burden.

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[10] Petitioner offers no explanation for its staff's failure to consider alternatives to leaving the wander guard attached to the resident's wheelchair. For example, the staff apparently gave no consideration to substituting a pressure alarm on the wheelchair seat for the wander guard and Petitioner has not explained why such an intervention would not have better protected Resident #5.

There is strong evidence in this case to support the conclusion that Petitioner's noncompliance with 42 C.F.R. §§ 483.25(h)(1) and (h)(2) was at the immediate jeopardy level. The evidence showing that Petitioner's staff failed to protect Resident #10 against accident hazards and failed to supervise Resident #5 adequately also supports a finding that there was considerable likelihood that residents of Petitioner's facility were at risk of serious injury, harm, impairment, or death. The evidence demonstrates that Petitioner's staff failed to comprehend their basic obligation to protect residents against known or foreseeable adverse consequences and also failed to comprehend the probable tragic outcomes of their failure to discharge that obligation.

In the case of Resident #10, allowing him to possess a cigarette lighter was a recipe for catastrophe. This resident was a demented individual with memory deficits and poor judgment. The staff had overwhelming evidence, in the form of the resident's burned wander guard, that this resident was a risk for starting a fire within the facility that could have injured or killed many individuals. And yet, they allowed the resident to continue to possess the lighter well after the burned wander guard was discovered and in violation of Petitioner's own smoking policy.

In the case of Resident #5, Petitioner's staff knew that the resident was mentally limited and had a propensity to wander. Given the resident's mental and physical condition an elopement by her posed grave risks for her safety. But, the staff failed to address the obvious flaw in their surveillance system for the resident for many weeks after the resident had made that flaw evident by eloping Petitioner's facility.

Petitioner offered no evidence to show that the probable consequences for its residents, resulting from its staff's inattentiveness to their obligation to protect and supervise them, were any less than I have stated. Petitioner asserts that there is nothing in the record to show a causal connection between any deficiency in providing care and adverse consequences that residents would likely sustain. I disagree. The evidence strongly points to a likelihood of serious injury, harm, impairment or death emanating from failure by Petitioner's staff to discharge its obligations.

What Petitioner seems to be saying is that it is unreasonable to find immediate jeopardy here because neither Resident #10 nor Resident #5 experienced actual harm as a result of the staff's deficient care. In other words, Petitioner seems to be advocating a kind of "no harm no foul" rule in which jeopardy cannot exist unless there are actual adverse consequences. But, the regulation defining immediate jeopardy doesn't require there to be an adverse consequence of deficient care in order for jeopardy to exist. The regulation is predicated on the *likelihood* of an adverse consequence. In this case, the likelihood that residents eventually would experience serious injury, harm, impairment or death from Petitioner's failure to protect and supervise them was very high.

3. Petitioner did not prove that it eliminated immediate jeopardy, or attained compliance with participation requirements, at dates earlier than those that were determined by CMS.

CMS determined that immediate jeopardy persisted at Petitioner's facility from April 26 through June 21, 2006, and it determined that noncompliance at the non-immediate jeopardy level persisted from June 22 through July 22, 2006. Where noncompliance is established, as in this case, it is presumed to continue until CMS certifies that it has been remedied. A facility has the right to challenge CMS's determination of the date when compliance is achieved but the burden falls on the facility to prove, by the preponderance of the evidence, that it has attained compliance at an earlier date than that which has been determined by CMS.

Petitioner offered no evidence that it corrected its noncompliance at any date earlier than that which was determined by CMS. Indeed, Petitioner does not argue in its post-hearing brief that, if it was noncompliant, its noncompliance had a shorter duration than that which was determined by CMS. Consequently, I sustain CMS's duration determinations.

4. The civil money penalties that CMS determined to impose are reasonable as a matter of law.

Daily penalties for immediate jeopardy level deficiencies may range from $3,050 to $10,000 per day. 42 C.F.R. § 488.438(a)(1)(i). Daily penalties for non-immediate jeopardy level deficiencies may range from $50 to $3,000 per day. 42 C.F.R. § 488.438(a)(1)(ii). The penalties that CMS determined to impose in this case were at the minimum amounts for immediate jeopardy and non-immediate jeopardy level deficiencies. Therefore, they are reasonable as a matter of law.

/s/
Steven T. Kessel
Administrative Law Judge