

**Department of Health and Human Services  
DEPARTMENTAL APPEALS BOARD  
Appellate Division**

Good Shepherd Home for the Aged, Inc., d/b/a  
The Good Shepherd Home  
Docket No. A-17-63  
Decision No. 2858  
March 19, 2018

**FINAL DECISION ON REVIEW OF  
ADMINISTRATIVE LAW JUDGE DECISION**

Title 42 C.F.R. § 483.25(h)(2) (Oct. 1, 2013) requires a Medicare-participating skilled nursing facility (SNF) to provide each of its residents with “adequate supervision and assistance devices to prevent accidents.”<sup>1</sup> At issue in this case is whether Good Shepherd Home for the Aged, Inc. (Petitioner), an Ohio SNF, provided adequate supervision to a resident, known here as Resident 19, to whom it had given a motorized wheelchair.

The Centers for Medicare & Medicaid Services (CMS) determined that, as of June 24, 2014 (the first day of a three-day compliance survey), Petitioner was not in substantial compliance with section 483.25(h)(2) because it had allowed Resident 19 to leave its premises in the motorized wheelchair without the supervision Petitioner had determined he needed. Petitioner requested, and received, an evidentiary hearing before an administrative law judge (ALJ) to challenge that noncompliance determination. Based on the hearing record, the ALJ concluded, in a February 7, 2017 decision, that Petitioner had not violated section 483.25(h)(2). *Good Shepherd Home for the Aged, Inc.*, DAB CR4785 (ALJ Decision). CMS now appeals that conclusion, contending that the ALJ committed legal errors and made findings of fact not supported by substantial evidence.

We hold that the ALJ committed an error of law by failing to address, or adequately address, whether Petitioner met its obligation under section 483.25(h)(2) to provide adequate supervision to Resident 19 when it allowed him to leave Petitioner’s premises in the motorized wheelchair without the supervision it had determined he required. We further hold that Petitioner failed to demonstrate that it met that specific obligation prior

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<sup>1</sup> On October 4, 2016, CMS issued a final rule that amended the Medicare participation requirements for long-term care facilities published in 42 C.F.R. Part 483. Final Rule, *Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities*, 81 Fed. Reg. 68,688 (Oct. 4, 2016). Our analysis and decision are based on the version of the participation requirements in effect during 2014, when the compliance surveys supporting CMS’s enforcement action were performed. *Carmel Convalescent Hosp.*, DAB No. 1584, at 2 n.2 (1996) (applying the regulations in effect on the date of the survey and resurvey).

to the June 2014 survey, and that its violation of section 483.25(h)(2) constituted lack of substantial compliance with the regulation. Based on these holdings, we reverse the ALJ's conclusion that Petitioner was in substantial compliance with section 483.25(h)(2) during the June 2014 survey. In addition, we sustain CMS's determination that Petitioner's noncompliance with section 483.25(h)(2) was at the immediate-jeopardy level of severity on June 24, 2014; that the noncompliance continued from June 25 through August 13, 2014 at a lower level of severity; and that the remedies imposed by CMS for the noncompliance – a \$3,550 civil money penalty (CMP) for one day of immediate jeopardy (June 24, 2014) and a \$100 per day CMP for the remaining days of noncompliance (June 25 through August 13, 2014) – were reasonable. Finally, we summarily affirm the ALJ's conclusion, which has not been challenged on appeal, that Petitioner was noncompliant with a second Medicare participation requirement – 42 C.F.R. § 483.35(i) – from August 14 through August 19, 2014 and that \$100 per day was a reasonable CMP for that period of noncompliance.

### Legal Background

To participate in the Medicare program, a SNF must be in “substantial compliance” with the participation requirements in 42 C.F.R. Part 483, subpart B. 42 C.F.R. §§ 483.1, 488.400. A SNF is not in substantial compliance when it has a “deficiency” – that is, a failure to meet a participation requirement – that creates the potential for more than minimal harm to one or more residents. *See id.* § 488.301 (defining “substantial compliance”). The term “noncompliance,” as used in the applicable regulations, is synonymous with lack of substantial compliance. *Id.* (defining “noncompliance”).

CMS may impose enforcement remedies (such as CMPs) on a SNF that is not in substantial compliance with one or more participation requirements. *Id.* §§ 488.400, 488.402(b), (c), 488.406. When CMS elects to impose a CMP, it sets the CMP amount based on, among other factors, the “seriousness” of the SNF's noncompliance. *Id.* §§ 488.404(b), 488.438(f). “Seriousness” is a function of the noncompliance's scope (whether it is “isolated,” constitutes a “pattern,” or is “widespread”) and severity (whether it has created a “potential for harm,” resulted in “actual harm,” or placed residents in “immediate jeopardy”). *Id.* § 488.404(b). The most severe noncompliance is that which puts one or more residents in “immediate jeopardy.” *See id.* § 488.438(a) (authorizing the highest CMPs for immediate-jeopardy-level noncompliance); *Woodland Oaks Healthcare Facility*, DAB No. 2355, at 2 (2010) (citing authorities).

### Case Background

This background summary draws on undisputed information in the hearing record and the ALJ Decision. The summary is not intended to replace, modify, or supplement the ALJ's findings of fact.

From June 24 through June 26, 2014, the Ohio Department of Health (ODH) performed an onsite compliance survey of Petitioner. Transcript of July 9, 2015 Video Teleconference Hearing (Tr.) 35. The survey was performed by Cathy Wagner, R.N. Tr. 34-35. “On her way to survey Petitioner’s facility around 9:20 a.m. on June 24, Surveyor Wagner observed an individual she suspected might be one of Petitioner’s residents traveling in his motorized wheelchair down the two-lane, two-way, Center Street near the facility.” ALJ Decision at 9. “[T]he suspected resident” – Resident 19 – “was in the middle of Center Street’s southbound lane, and he was traveling north in the direction of oncoming traffic, though [Surveyor Wagner] did not testify that there was any oncoming traffic at the time of the observation.” *Id.* “Surveyor Wagner was traveling to Petitioner’s facility in her car headed east on Walnut Street, waiting to make a right turn on to Center Street.” *Id.* “Surveyor Wagner was stopped for a red light at the intersection of the two streets while the suspected resident, who had the green light, went through the intersection in front of her.” *Id.* According to Surveyor Wagner, “[a]s [Resident 19] crossed the intersection, the resident was talking on his cell phone, and at one point he stopped under the traffic light while talking on the phone.” *Id.* Surveyor Wagner “testified that if she had made a right turn on the red light, she would have hit the resident.” *Id.*

When Surveyor Wagner arrived at Petitioner’s facility to begin the survey, “[s]he reported her observations of the suspected resident” to Petitioner’s director of nursing, Sarah Kerr, R.N., who confirmed that Resident 19 was the person Wagner had seen riding on Center Street in the motorized wheelchair. ALJ Decision at 9. When “Surveyor Wagner suggested [to Kerr] and [Petitioner’s] Administrator that the facility should find Resident 19,” they responded that his daily routine was to leave the facility in his wheelchair without signing out, travel to the grocery store (about three or four blocks away) on public streets, and then return to the facility on his own. *Id.*; *see also* Tr. 43; CMS Ex. 4, at 6. The ensuing compliance survey focused on Resident 19 and his use of the motorized wheelchair, which Petitioner had given him. ALJ Decision at 9; Tr. 78, 217-18.

Resident 19 was 38 years old at the time of the survey. ALJ Decision at 11. He had multiple diagnoses, including human immunodeficiency virus (HIV), syphilis, and multiple pressure ulcers (the worst being in his sacral area). *Id.* at 11-12; Tr. 54. He was first admitted to Petitioner on March 21, 2014, but was hospitalized a few days later. ALJ Decision at 11; Tr. 49-50. He was re-admitted to Petitioner’s facility on March 28, 2014. Tr. 50. On April 3, 2014, he checked himself out of Petitioner’s facility “against medical advice” and “went to live in the community.” Tr. 50; P. Ex. 1, at 499-500. On April 6, 2014, Resident 19 went to the emergency room and was admitted to the hospital. Tr. 49-50; P. Ex. 1, at 16-19. On April 10, 2014, he was readmitted to Petitioner’s facility, displaying impaired strength, endurance, and functional mobility. ALJ Decision

at 12; Tr. 50; P. Ex. 1, at 156, 477-481; CMS Ex. 4, at 4. Although a case manager reported that a hospital physician had determined that Resident 19's prognosis was poor, Petitioner's plan for Resident 19 was to provide him wound care and rehabilitation therapy, to maintain his dignity by giving him as much independence as possible, and to return him to the community to live if possible. ALJ Decision at 12, 14; Tr. 87, 91-92, 126, 133-34, 145-47, 152-54, 204-07; CMS Ex. 13, at 11, 16-17, 19, 21, 23; P. Ex. 1, at 187, 189, 191. Planned occupational and physical therapy was discontinued in late April 2014 because of Resident 19's lack of cooperation or participation, ALJ Decision at 13, and Resident 19 often refused treatment for his pressure sores. *Id.* In addition, he consumed alcohol against his doctor's orders, admitted to using illegal drugs, and smoked in his room in violation of facility policy. *Id.* at 15 n.10.

Resident 19 was using a standard wheelchair when he was readmitted to Petitioner's facility on April 10, 2014, but he lacked strength or stamina to propel himself far. Tr. 153-54, 172-73. On April 15, 2014, an occupational therapist (OT), Ashley Corban, assessed Resident 19's ability to use a motorized wheelchair.<sup>2</sup> ALJ Decision at 12. Corban's "initial assessment was that [Resident 19] needed additional training . . ." *Id.* On April 17, 2014, "[a]fter three 30-minute training sessions, including Resident 19 going through doorways, maneuvering around obstacles such as cones, and moving on gravel and through potholes on the facility parking lot, OT Corban approved his use of the power chair." *Id.* She memorialized that approval in a document titled "Resident Status Change." *Id.* at 12-13; Tr. 47-48, 159, 178-79; P. Ex. 1, at 158; CMS Ex. 11, at 1. That document stated the following conditions on Resident 19's use of the motorized wheelchair:

1. Can only utilize scooter to go outside to smoke and within the facility – ***no where else outside without [supervision].***
2. Must wear seat belt [at] all times.
3. Stay on speed #1.

P. Ex. 1, at 158 (italics and emphasis added)<sup>3</sup>; CMS Ex. 11, at 1. A copy of the Resident Status Change was given to Petitioner's "MDS Coordinator" (the nurse who developed Resident 19's plan of care), to the "charge nurse," and to Petitioner's certified nursing assistants. Tr. 107-08, 160-61, 177-78.

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<sup>2</sup> As we discuss later, Petitioner's policies assign the responsibility for wheelchair safety assessments to its OT. Although Resident 19 did not always cooperate with his planned occupational therapy, there is no dispute that he cooperated during this assessment for the motorized wheelchair.

<sup>3</sup> We note that the Status Change form had an "S" with a circle around it instead of the word "supervision," but the surveyor testified, and it is not disputed, that the symbol was rehabilitation shorthand for "supervision." Tr. 46, 159.

Prior to the survey, an interdisciplinary team assessed Resident 19 as being at risk of harm for falls. ALJ Decision at 12. In light of that risk, his plan of care specified, among other things, that Resident 19 “needed a safe environment with even floors free of spills or clutter[.]” *Id.*; *see also* CMS Ex. 6, at 3; CMS Ex. 7, at 1.

When the June 2014 survey began, Resident 19’s comprehensive care plan did not address his use of a motorized wheelchair or reflect the limitations noted in the April 17, 2014 Resident Status Change completed by the OT and given to the MDS Coordinator. *See* CMS Ex. 4, at 5, 8-9 (noting that the plan of care, as last revised March 24, 2014, was Resident 19’s “current” plan on the date of the survey); Tr. 107 (testimony of Surveyor Wagner that “the motorized wheelchair wasn’t documented in the care plan when I was at the facility”).<sup>4</sup>

During the June 2014 survey, Surveyor Wagner reviewed Petitioner’s then-current written policy governing its provision and resident use of motorized wheelchairs. *See* ALJ Decision at 9; CMS Ex. 4, at 5. The policy stated that Petitioner “balances promotion of resident independence with promotion of safety for all persons who reside, visit, or work in the facility[.]” and that Petitioner “restricts the use of motorized wheelchairs . . . to residents who have shown through assessment, that they can safely operate” them. CMS Ex. 10, at 1. The policy further stated that “[a]ssessments for resident safety in operating” a motorized wheelchair was “the responsibility of the [OT], who may coordinate assessment activity with the MDS coordinator, social services director, care plan coordinator or other qualified designee.” *Id.* In addition, the policy stated that “[i]f a resident is to be off the premises, they are required to have a charged cell phone on their person.” *Id.* at 2.

“Surveyor Wagner’s [survey] notes reflect her conversations with staff, including Petitioner’s Administrator and [the director of nursing], and they forthrightly reported to her that Resident 19 left facility property daily in his wheelchair and without signing out.” ALJ Decision at 13. Those notes also “show that the Administrator and [director of nursing] told [Wagner] that they repeatedly spoke with Resident 19 about leaving the facility grounds and not signing out but [that] he refused to comply.” *Id.* In addition, Surveyor Wagner learned from her survey interviews and document review that Resident 19 was often gone from his unit, or not in the facility, at times when he was scheduled to receive treatment and medication. CMS Ex. 4, at 7; CMS Ex. 6, at 2.

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<sup>4</sup> The copy of the plan of care submitted by Petitioner has an entry stating that staff had identified a “[p]otential safety concern” that Resident 19 “may not exhibit sound judgment when utilizing motorized wheelchair off the premises as evidenced by the fact that he rides his chair in the street.” P. Ex. 1, at 192-93. The date just below this entry is March 24, 2014. *Id.* at 193. However, the entry must actually have been made on the care plan *after* March 24, 2014 because Petitioner did not receive the motorized wheelchair any sooner than April 2014 (the month in which he underwent a wheelchair safety assessment by the OT). Petitioner does not allege that the entry was made any earlier than the June 2014 survey.

Based on the information gathered by Surveyor Wagner, ODH determined that, as of June 24, 2014, Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h)(2) because it had allowed Resident 19 to leave its property in his motorized wheelchair without supervision, contrary to the limitation stated in the OT's April 17, 2014 Resident Status Change. *See* CMS Ex. 4, at 1-2 (stating that Petitioner failed to provide "adequate supervision, based on the safety assessment"); Parties' Joint Stipulations and Statement of Issues (Jt. Stip.) ¶ 2. ODH further determined that Petitioner's noncompliance with section 483.25(h)(2) was at the immediate-jeopardy level of severity as of 9:20 a.m. on June 24, 2014 (the day Surveyor Wagner observed Resident 19 riding his motorized wheelchair on a public street); that Petitioner abated the immediate jeopardy condition later that day by instituting "one-on-one" supervision of Resident 19 whenever he left Petitioner's property in the motorized wheelchair; and that Petitioner remained out of substantial compliance (below the immediate-jeopardy level) after June 24, 2014 pending implementation of a "long term plan" for supervising Resident 19's use of the motorized wheelchair and completion of staff "education." CMS Ex. 4, at 2-3; Jt. Stip. ¶ 3.

By letter dated July 17, 2014, CMS notified Petitioner that it concurred with ODH's determination of noncompliance, including a day of noncompliance at the immediate-jeopardy level, and that CMS had decided to impose enforcement remedies on Petitioner, including: a \$3,550 CMP for the one day of immediate jeopardy on June 24, 2014; and a \$100 per day CMP beginning June 25, 2014 and remaining in effect until Petitioner came back into substantial compliance. CMS Ex. 1, at 5-6. CMS also notified Petitioner that because Petitioner had been subjected to an extended survey as a result of a finding of substandard quality of care, it would be prohibited from offering or conducting a Nurse Aide Training and Competency Evaluation program (NATCEP) for two years from June 26, 2014. CMS Ex. 1, at 8 (citing the statutory requirements in sections 1819(f)(2)(B) and 1919(f)(2)(B) of the Social Security Act (Act)).<sup>5</sup>

On August 14, 2014, ODH performed another survey of Petitioner. Jt. Stip. ¶ 5. That survey found that Petitioner had corrected its noncompliance with section 483.25(h)(2) as of that date but was not in substantial compliance with another participation requirement – namely, 42 C.F.R. § 483.35(i). *Id.*; CMS Ex. 5.

On September 3, 2014, ODH conducted a revisit survey and determined that Petitioner was back in substantial compliance with all requirements as of August 20, 2014. CMS Ex. 1, at 1; Jt. Stip. ¶ 6.

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<sup>5</sup> As the ALJ noted (ALJ Decision at 4 n.4), Petitioner did not have a NATCEP program at the time of the survey, and the prohibition against starting one had expired by the time of the ALJ's decision. The NATCEP prohibition is not an issue on appeal.

On October 6, 2014, CMS notified Petitioner that it concurred with the deficiency citation from the August 2014 survey; that the \$100 per-day CMP had stopped accruing on August 20, 2014; and that certain other non-CMP remedies would not be imposed or take effect. CMS Ex. 6, at 1-2; Jt. Stip. ¶ 7.

Petitioner then filed a timely request for hearing to challenge the determination that it was not in substantial compliance with section 483.25(h)(2) from June 24 through August 13, 2014. Jt. Stip. ¶ 10. Petitioner did not contest the determination that it was noncompliant with section 483.35(i). *Id.* ¶ 11.

The ALJ conducted an evidentiary hearing (by videoconference) on July 9, 2015. Surveyor Wagner testified on behalf of CMS. The following persons testified on behalf of Petitioner: Mehrdad Tavallae, M.D., Petitioner's medical director and Resident 19's attending physician (Tr. 123-40); Sarah Kerr, R.N., Petitioner's director of nursing (DON) (Tr. 142-68); Ashley Corban, the OT who performed wheelchair safety assessments of Resident 19 during April 2014 (Tr. 169-97); and Lorie White, a licensed social worker and Petitioner's director of social services (Tr. 198-221).

At the hearing, Surveyor Wagner testified that she learned from Petitioner's staff that "Resident 19 had his own agenda and he pretty much did what he wanted to do," and that the staff was generally aware of Petitioner's unsupervised offsite trips in the motorized wheelchair and was not concerned about them. Tr. 44. Surveyor Wagner further testified that Resident 19 exercised poor judgment by possessing drug paraphernalia in the facility, smoking in his room in violation of facility policy, and failing to comply with Petitioner's sign-out policy. Tr. 59-60, 64-65, 96.

Dr. Tavallae testified that his office practice had many "outpatients" who use motorized wheelchairs in order to maintain their independence and be "more active in life," and that most of those patients used their wheelchairs on public streets daily. Tr. 126-27. Dr. Tavallae further testified that he does not limit a patient's use of a motorized wheelchair, or require the patient to be supervised when using that equipment, as long as the patient is alert, oriented, and able to use his or her hands. Tr. 126-28. Dr. Tavallae testified that he had no concerns about Resident 19's safety awareness or competence to operate a motorized wheelchair, and that Resident 19 was "alert and oriented" and "able to make his own decisions" and for those reasons did not need to be supervised when off of Petitioner's property. Tr. 128-29, 133, 135-36. While he was aware of Resident 19's history of (alleged) illicit drug use and poor or questionable judgment, Dr. Tavallae stated that these circumstances did not make Resident 19 "incompetent" to control his own care. Tr. 129. In addition, Dr. Tavallae testified that Resident 19 understood that he had a life-shortening illness and therefore did what made him happy. Tr. 130.

Petitioner's director of nursing, Sarah Kerr, testified that Resident 19 was given a motorized wheelchair so that he had freedom to do what he "wanted to do for himself," and when he wanted, without having to rely upon staff, and to provide him with some privacy and personal dignity. Tr. 145-46, 152. Kerr further testified that Resident 19 lived in a private home prior to his hospitalization and that his intention was to return to that (or a similar) living arrangement in the community. Tr. 145, 147, 151-52. In addition, Kerr testified that staff "routinely," and "nearly every day," reminded Resident 19 of the need to sign out of the facility but that he did not always do so; that this problem was frequently discussed in morning staff meetings; that Resident 19 took a cell phone with him when he left Petitioner's property; that the cell phone number was in his nursing chart; and that staff "were always able to reach him by his cell phone." Tr. 147-48, 148-50, 155. Kerr also testified to morning discussions in which staff discussed Resident 19's comings-and-goings in the motorized wheelchair and felt that because he was "alert and oriented" and appeared to use the wheelchair safely, the team "felt that he had a right to make that choice and decision for himself[.]" Tr. 149, 163.<sup>6</sup> According to Kerr, Resident 19 was not a "typical resident," and the nursing staff were always trying to "work with him, and [with] his nuances, and his wants and needs." Tr. 149.

Ashley Corban, the OT, was questioned about her instruction on the April 17, 2014 Resident Status Change that Resident 19 could use the motorized wheelchair in the designated outdoor smoking area but "no where else outside without [supervision]." Corban testified that she incorporated that limitation because she had not actually assessed Resident 19's ability to operate the wheelchair off of Petitioner's property. Tr. 173-75, 179-80, 184. She testified that she included the "no where else outside without supervision" clause in all of her written recommendations – and irrespective of the resident's abilities – because she did not, as a matter of policy or practice, assess a resident's ability to use a motorized wheelchair off of Petitioner's property. Tr. 179-80. When asked by the ALJ what instruction "the Director of Nursing or any of the other staff . . . are supposed to take from [the instructions on the April 17, 2014 Resident Status Change]," Corban responded, "They're going to take from that that my recommendation is that he have supervision outside the facility due to me not personally treating him outside the facility." Tr. 184.

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<sup>6</sup> In her testimony on page 163, DON Kerr referred to the "morning meetings" in response to a question as to whether the "interdisciplinary team ever met [to] have a discussion about safety concerns or [Resident 19's] need for supervision . . ." However, on page 149, she referred to the morning meetings in response to a question as to whether Resident 19's non-compliance with sign-out procedures "was an issue that was discussed in morning rounds?" Accordingly, it is not clear from the transcript whether the discussions were in meetings of the interdisciplinary team, as opposed to meetings of only nursing staff.



## The ALJ Decision

The ALJ held that CMS made a prima facie showing that Petitioner was noncompliant with 42 C.F.R. § 483.25(h)(2) based on: (1) the assessment and recommendation of the OT in the April 17, 2014 Resident Status Change (which the ALJ found was the facility's plan of care for Resident 19's use of his motorized wheelchair) that Resident 19 could operate the motorized wheelchair on Petitioner's property (including the designated outdoor smoking area) but nowhere else outside unless supervised; and (2) Surveyor Wagner's observation of Resident 19 operating his motorized wheelchair on a public street without supervision, observations the ALJ found "unrebutted, not disputed, and fully credible." *See* ALJ Decision at 9, 22-26.<sup>7</sup>

However, the ALJ ultimately concluded that Petitioner had rebutted CMS's prima facie case and demonstrated that it was, at all relevant times, in substantial compliance with section 483.25(h)(2). *Id.* at 26-30. The ALJ based his conclusion largely on Dr. Tavallae's "credible testimony" that because Resident 19 was alert, oriented, and able to use his hands and make his own decisions, he was capable of taking care of himself and did not need to be supervised while off of Petitioner's property in the motorized wheelchair. *Id.* at 26-28. The ALJ also relied heavily on testimony by Dr. Tavallae that he was aware, prior to the June 2014 survey, that Resident 19 left the facility unsupervised in the motorized wheelchair, that the matter had been discussed by the resident's interdisciplinary team, and that no changes had been made to the resident's plan of care because he (Dr. Tavallae) had no safety concerns about the resident's practices. *Id.* at 27-28. The ALJ emphasized that "[u]nder the [Medicare statute], the Secretary's regulations, and Ohio law, it is the attending physician who is responsible to determine if and how to limit a resident's freedom for the treatment and safety of the resident." *Id.* at 28.

The ALJ acknowledged that Petitioner "was responsible . . . for ensuring [that Resident 19] was prepared to be as safe as possible when he departed" its property in the motorized wheelchair. *Id.* at 18. But the need to minimize risks of harm, said the ALJ, must be balanced against the resident's right to "dignity" and self-determination. *Id.* at 18-19, 21, 27. The ALJ held that Petitioner reasonably balanced Resident 19's needs and rights by allowing him to leave the facility without supervision while making reasonable efforts to "enforce its sign-out policy" so that Petitioner's staff knew where he was going and when he was expected to return. *Id.* at 29-30. The ALJ stated that "any

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<sup>7</sup> The ALJ also concluded that CMS had made a prima facie showing of noncompliance based on evidence that Petitioner had failed to follow its care plan, to reassess Resident 19's risk for falls, or to "updat[e]" the "interventions" that it had instituted to mitigate that risk, in light of Resident 19's "unsupervised departure[s]" from Petitioner's property in the motorized wheelchair. ALJ Decision at 24-25. We do not address this conclusion since we, contrary to the ALJ, have concluded that CMS lawfully found noncompliance with section 483.25(h)(2) based on Petitioner's failure to adequately supervise Resident 19's use of his motorized wheelchair.

shortcomings” in that area “were offset by [Petitioner’s] policy requiring residents to take a charged cell phone with them when they left the facility – a policy that Resident 19 obeyed.” *Id.* at 29.

Having concluded that Petitioner was in substantial compliance with section 483.25(h)(2) in its care of Resident 19, the ALJ determined that CMS had no basis to impose a CMP (or other enforcement remedy) for the period June 24 through August 13, 2014. ALJ Decision at 30. However, the ALJ sustained CMS’s determination that Petitioner was not in substantial compliance with section 483.35(i) from August 14 through August 19, 2010 as well as the \$100 per day CMP imposed by CMS for that noncompliance. *Id.* at 30-33.

### The Parties’ Contentions on Appeal

CMS then filed its request for review, contending that Petitioner had failed to rebut the prima facie case or prove that it had taken “meaningful steps” to mitigate a documented “risk of harm” to Resident 19 when he rode his wheelchair in the road facing oncoming traffic. CMS’s Request for Review of Decision No. CR4785 (RR) at 11, 15, 17-18. In support of that contention, CMS asserted that the ALJ ignored, or failed to adequately consider, evidence of the safety risks posed by Resident 19’s unsupervised trips off of Petitioner’s property or take “meaningful steps” to mitigate those risks (*id.* at 11, 13-15, 17-18, 23-25); misstated CMS’s position concerning the nature of the violation of section 483.25(h)(2) and what would constitute “adequate supervision” under the circumstances (*id.* at 15-18); erroneously found that the “the only options presented to address [Resident 19’s] frequent unsupervised travel off of Good Shepherds’ grounds were either providing R19 with absolute autonomy or locking R19 in the facility” (*id.* at 18); made unsupported or “internally inconsistent” findings about whether Petitioner adequately enforced its sign-out policy; overstated Resident 19’s “level of independence” (*id.* at 21-23); erroneously gave “controlling weight” of Resident 19’s physician and the director of nursing (*id.* at 26-28); ignored “inconsistencies” in the OT’s testimony (*id.* at 28-29); improperly interwove the requirements in paragraphs (1) and (2) of section 483.25(h) in deciding the case, rather than directly applying paragraph (2)’s adequate-supervision requirement (*id.* at 30-31); misapplied or failed to apply relevant Board case law (*id.* at 31-34); and improperly focused on Petitioner’s complaints about the conduct of the surveyor (*id.* at 34-35).

Petitioner responds that CMS has not established a basis, factual or legal, to overturn the ALJ’s decision under the applicable standard of review. Pet.’s Response to CMS’s Request for Review (Response Br.) at 3-5. Petitioner submits that the ALJ drew reasonable inferences from the evidence and made supportable and internally consistent findings of fact (*id.* at 25-26, 32); properly credited the testimony of Resident 19’s

physician, its director of nursing, and the OT (*id.* at 34); and correctly applied the regulations and relevant Board case law (*id.* at 36). Petitioner contends that if the Board reverses the ALJ's decision and concludes that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h)(2), then it should remand the case to the ALJ to decide whether CMS's immediate-jeopardy determination regarding that noncompliance was clearly erroneous and, if there was no clear error, whether the CMP imposed for the one day of immediate jeopardy (June 24, 2014) is unreasonable. *Id.* at 4-5, 21.

### Standard of Review

The Board's standard of review on a disputed conclusion of law is whether the ALJ's decision is erroneous. The Board's standard of review on a disputed finding of fact is whether the ALJ's finding is supported by substantial evidence in the record. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs (Guidelines)*, accessible at <http://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/index.html?language=en>.

### Discussion

A. *The ALJ erred in concluding that Petitioner had rebutted what he correctly concluded was a prima facie showing of noncompliance.*

1. The ALJ erred in focusing on testimony about Resident 19's ability to operate his wheelchair safely off facility premises rather than requiring evidence that Petitioner, contrary to the ALJ's finding, had actually followed the OT's assessment and wheelchair usage limitations or that Petitioner's failure to do so was because Petitioner had reassessed and changed those limitations.

Section 483.25(h)(2) "obligates the facility to provide supervision and assistance devices designed to meet the resident's assessed needs and to mitigate foreseeable risks of harm from accidents" and to "provide supervision and assistance devices that reduce known or foreseeable accident risks to the highest practicable degree, consistent with accepted standards of nursing practice." *Century Care of Crystal Coast*, DAB No. 2076, at 6-7 (2007) (citations omitted), *aff'd*, *Century Care of Crystal Coast v. Leavitt*, 281 F. App'x 180 (4<sup>th</sup> Cir. 2008); *see also Woodstock Care Ctr. v. Thompson*, 363 F.3d 583, 589-90 (6<sup>th</sup> Cir. 2003) (a SNF must take "all reasonable precautions against residents' accidents").<sup>8</sup>

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<sup>8</sup> Several pages of the ALJ Decision discuss the requirements of section 483.25(h)(1), but the noncompliance was not based on that section of the regulation, and the ALJ's discussion of it tended to confuse the issues. *See* ALJ Decision at 16-20.

Consistent with CMS’s Guidance to Surveyors for Long Term Care Facilities,<sup>9</sup> the Board has held that, in order to comply with section 483.25(h)(2), a SNF must identify and assess foreseeable accident risks; determine what, if any, interventions are necessary and appropriate to mitigate the assessed risks; and take timely and effective steps to implement the chosen interventions.<sup>10</sup> *Crawford Healthcare & Rehab.*, DAB No. 2738, at 5 (2016); *see also Van Duyn Home and Hosp.*, DAB No. 2368, at 7-13 (2011) (holding that the ALJ had properly focused on whether a SNF had “actually identified risk factors that would plainly impact the resident’s health and safety when away and then developed and offered interventions to mitigate those risks” (internal quotation marks omitted)); *Del Rosa Villa*, DAB No. 2458, at 19 (2012) (stating that “whether a SNF complied with section 483.25(h)(2) depends on whether it took all ‘reasonable’ and ‘practicable’ measures . . . to identify, evaluate, and reduce or eliminate the foreseeable ‘risk’ of an accident”), *aff’d*, *Del Rosa Villa v. Sebelius*, 546 F. App’x 666 (9<sup>th</sup> Cir. 2013); *Libertywood Nursing Ctr.*, DAB No. 2433, at 7 (2011) (stating that “ensuring” adequate supervision involves identifying and minimizing safety risks).

The Board has also held that the quality-of-care requirements in section 483.25 obligate the SNF to furnish the care and services set forth in a resident’s care plan, to implement doctors’ orders, to monitor and document the resident’s condition, and – as pertinent here – to follow its own resident care policies. *Life Care Ctr. of Bardstown*, DAB No. 2479, at 22 (2012) (citing cases), *aff’d*, *Life Care Ctr. of Bardstown v. Sec’y of Health & Human Servs.*, 535 F. App’x 468 (6<sup>th</sup> Cir 2013). A resident care policy intended to ensure compliance with Medicare participation requirements “may reflect [the] facility’s own judgment about how best to achieve compliance [with those requirements] and hence failure to comply with its own policies can support a finding that the facility did not achieve compliance with the regulatory standard.” *Bivins Memorial Nursing Home*, DAB No. 2771, at 9 (2017); *see also Sheridan Health Care Ctr.*, DAB No. 2178, at 32 (2008) (holding that a SNF’s failure to follow its own meal-monitoring policies “constituted a deficiency under section 483.25” and stating that a facility’s adoption of a resident care policy supports an inference that the policy was “necessary to attain or maintain resident well-being”).

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<sup>9</sup> The Guidance to Surveyors for Long Term Care Facilities is published in Appendix PP to CMS’s State Operations Manual (CMS Pub. 100-07). Appendix PP is available at [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_pp\\_guidelines\\_ltcf.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf).

<sup>10</sup> CMS’s Surveyor Guidance explains that a SNF’s obligations under section 483.25(h) entail: (1) “[i]dentifying hazard(s) and risk(s)”; (2) “[e]valuating and analyzing hazard(s) and risk(s)”; (3) “[i]mplementing interventions to reduce hazard(s) and risk(s)” that are “consistent with [the] resident’s needs, goals, plan of care, and current standards of practice”; and (4) “[m]onitoring for effectiveness and modifying interventions when necessary.” *Crawford Healthcare & Rehab.* at 5 (quoting State Operations Manual, Appendix PP (internal quotation marks omitted)).

In this case, surveyors found that Petitioner had a resident care policy that addressed the provision and use of motorized wheelchairs. CMS Ex. 10. That policy made the OT responsible for assessing a resident's capacity to operate a motorized wheelchair safely. *Id.* at 1. The policy stated that Petitioner would allow a resident to use a motorized wheelchair only if the resident "show[ed] through assessment" that he could "safely operate" that equipment. *Id.* As noted in our background, Petitioner's OT concluded a motorized wheelchair safety assessment of Resident 19 on April 17, 2014. *See* P. Ex. 1, at 151; Tr. 45, 118, 194. Based on that assessment, the OT issued a Resident Status Change document on April 17, 2014. *Id.* at 158; Tr. 159, 178-79; CMS Ex. 10, at 11; CMS Ex. 11, at 1. That document, which she gave to nursing staff, including the MDS Coordinator, stated that Resident 19 should not be allowed to operate the motorized wheelchair outside the facility (other than in the facility's smoking area) without supervision. P. Ex. 1, at 158; CMS Ex. 11, at 1; Tr. 178-79. When asked what the nursing staff was "supposed to take from" the April 17, 2014 Resident Status Change she completed, the OT stated that staff would "take from that that my recommendation is that [Resident 19] have supervision outside the facility due to me not personally treating him outside of the facility." Tr. 184.

The ALJ found that the OT's assessment was Petitioner's plan of care addressing the level of supervision needed by Resident 19 when he used his motorized wheelchair outside the facility and that CMS made a prima facie case of noncompliance with section 483.25(h)(2) by showing that Petitioner's staff failed to provide the supervision required by that care plan when it allowed Petitioner to leave Petitioner's premises without supervision. The ALJ stated in part:

Surveyor Wagner observed Resident 19 on the street off facility grounds, not smoking and without supervision. Surveyor Wagner's observation of Resident 19 off the facility grounds operating his power wheelchair and the assessment from OT Corban are sufficient evidence to support Surveyor Wagner's finding that Petitioner planned for the risk of Resident 19 going outside other than to smoke and that plan required that Resident 19 receive supervision in that circumstance. Accordingly, I conclude that, in the absence of rebuttal evidence, CMS has made a prima facie showing of a violation of 42 C.F.R. § 483.25(h) because the evidence reviewed by Surveyor Wagner in Resident 19's clinical record showed that Petitioner planned for an accident hazard for Resident 19 and Surveyor Wagner's observation showed Petitioner failed to follow the care plan.

ALJ Decision at 25-26.<sup>11</sup> The ALJ also acknowledged that, once CMS had established a prima facie case of noncompliance with section 483.25(h)(2), it was Petitioner's burden to rebut that case by a preponderance of the evidence. *Id.* at 6 (citing multiple Board decisions). The ALJ concluded that Petitioner had met that burden, but we find that conclusion erroneous. The ALJ erred because he misframed the legal issue and relied on evidence which, while credible in his view, was not relevant or material to the resolution of that issue. The issue on rebuttal was whether Petitioner had shown (by a preponderance of the evidence) that the reason staff had not followed the care plan – as the ALJ had found they did not – was because they had reassessed Resident 19 in consultation with the OT and replaced her recommendation with one allowing Resident 19 to leave facility grounds unsupervised. The issue was not, as the ALJ framed it, whether Petitioner's staff or Resident 19's physician opined, without any documented reassessment or change in his care plan, that Resident 19 did not need the supervision the OT had assessed him as requiring. Thus, while we defer to the ALJ's credibility determinations regarding the testimony on which he relied, that testimony does not alter the material fact that Petitioner's plan of care for Resident 19's use of his motorized wheelchair based on the OT's assessment remained in place and should have been followed.<sup>12</sup>

The Board has held that a SNF violates section 483.25(h)(2) if it fails, without “justifiable reason,” to implement accident precautions that its own staff has determined to be necessary to mitigate foreseeable accident risks. *NHC Healthcare Athens*, DAB No. 2258, at 13 (2009); *Burton Healthcare Ctr.*, DAB No. 2051, at 9 (2006); *see also Del Rosa Villa* at 9 (noting prior holdings that “accident precautions contained in a resident's plan of care represent a SNF's judgment about what measures are necessary to keep the resident safe, and that failure to implement such precautions supports a conclusion that the SNF did not meet its obligation under section 483.25(h)(2) to provide adequate supervision”); *id.* at 10 (holding if an assessment identifies a risk of harm requiring supervision, then the staff must determine the “level of supervision . . . required[,]” develop a plan to provide that supervision, and communicate to staff their responsibilities

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<sup>11</sup> Petitioner asserts that CMS misstated the ALJ's finding “in its multiple assertions that Resident #19's care plan included the . . . [OT's] written recommendation, which it did not.” Response Br. at 26. However, as our quote from the ALJ Decision shows, the ALJ did find that the OT's assessment and recommendation was Petitioner's plan of care for Resident 19's use of his wheelchair even though that assessment and recommendation existed in a written document separate from the comprehensive care plan for Resident 19 that existed prior to the survey. We agree with the ALJ's finding since there is no dispute that the OT's written assessment and recommendation functioned as a care plan developed in accordance with the facility's motorized wheelchair policy. Arguably Petitioner should have referenced the OT's assessment and recommendation in the resident's comprehensive care plan, but the fact that it did not do so would be a failing on its part, not something that affects the stature or role of the OT's assessment and recommendation.

<sup>12</sup> We also note that the opinions stated in the testimony were all after-the-fact. There is no contemporaneous evidence to support the existence of such opinions during the time period in question.

under the plan). Here, Petitioner's OT – the staff member responsible for assessing a resident's safety when operating a motorized wheelchair – issued a written recommendation that Resident 19 be supervised if he operated the motorized wheelchair anywhere outside the facility except the designated smoking area. Petitioner's nursing staff, as the ALJ found, did not follow that recommendation but, instead, permitted Resident 19 to leave its property in the motorized wheelchair without supervision whenever he wished. Tr. 161. Contemporaneous records reveal no reason, much less a "justifiable" one, for the nursing staff's failure to provide the recommended supervision. Because the OT issued the recommendation in order to implement a resident care policy whose evident purpose was to prevent accidents involving motorized wheelchairs, Petitioner's unexplained failure to follow the recommendation violated its obligation under section 483.25(h)(2) to provide "adequate supervision."

2. The evidence on which the ALJ relied is immaterial, indeed largely irrelevant to the properly framed legal issue.

In light of Petitioner's failure to implement the motorized wheelchair care plan developed by the OT based on her assessment, the testimony which the ALJ cited or relied upon is largely irrelevant and fails to show that Petitioner met its regulatory obligations. The ALJ relied heavily on the testimony of DON Kerr and Dr. Tavallae, who were on Petitioner's interdisciplinary team. ALJ Decision at 8, 27-28. Kerr testified that staff discussed Resident 19's daily offsite excursions in the motorized wheelchair in "morning meetings." Tr. 149. Later, when asked whether the interdisciplinary team ever met to discuss safety concerns or the resident's need for supervision, Kerr once again referred to the "morning meetings." Tr. 163. The essence of those discussions, she testified, was that staff felt that Resident 19 had the "right to make [the] choice" to leave the facility's property without supervision because he was "alert and oriented" and "seemed to be" using the motorized wheelchair in a safe manner both on and off Petitioner's property. Tr. 163. However, Kerr admitted that the discussions were not documented in Resident 19's nursing records. Tr. 166. Furthermore, Kerr did not say that these discussions involved or led to consultation with the OT or were based on review of the results of the OT's April 17, 2014 safety assessment or the facility's own assessment of potential risk factors (such as Resident 19's documented alcohol and drug use) that might have compromised Resident 19's safety while operating the motorized wheelchair beyond Petitioner's property. Tr. 158, 163. DON Kerr also failed to explain the basis for her statement that Resident 19 seemed to be operating the motorized wheelchair safely when

he was off of Petitioner's property and acknowledged she had never personally observed him doing so.<sup>13</sup> Tr. 158. In addition, there is no evidence that the staff interviewed Resident 19 to understand how and where he was operating the motorized wheelchair in order to better understand the risks that he may have been encountering when he was off of Petitioner's property.

With respect to Dr. Tavallae, the ALJ stated that he was "clear in his testimony that he was not bound to follow the recommendation of OT Corban . . . ." ALJ Decision at 27, citing Tr. 138-39. However, that is not an accurate statement of Dr. Tavallae's testimony. Dr. Tavallae testified with respect to patients generally that when the "rehab unit" assesses a patient and makes a recommendation regarding the use of a wheelchair, "it usually gets approved" by him. Tr. 138. When asked whether he "would agree that whatever the recommendations are based on that assessment is what should be followed with that particular patient," he responded, "No. The reason is, sometimes their recommendation is something that can be fixed very easily, and sometimes I don't agree with the recommendation, so I have to question that." Tr. 138-39. Thus, Dr. Tavallae did not specifically address whether he was bound to follow the OT's recommendation for Resident 19, and even with respect to patients generally stated only that he reserved the right to question the recommendations made by those assessing the patient for wheelchair usage.

Dr. Tavallae's response also suggested he would communicate his concerns to the person making the recommendation with an eye to fixing any problems, and he answered "Yes" when asked whether in a case where he disagreed with the recommendation he would document his disagreement. Tr. 139. Yet, there is no evidence in the record before us that Dr. Tavallae documented any disagreement with the OT's recommendation for Resident 19 or discussed the matter with the OT or the interdisciplinary team prior to the June 2014 survey. Petitioner cites no documentary evidence of pre-survey consultation. While Dr. Tavallae testified that he was "aware of" discussions by the interdisciplinary team about Resident 19's habit of operating the motorized wheelchair off facility grounds, he did not say that he had participated in them. *Id.* And when asked what the "upshot" of the interdisciplinary team's discussions was, Dr. Tavallae replied that he "didn't make any specific decisions" and did not state that he took any other action based on those discussions. *Id.* While the doctor added that he was "okay with that" – presumably meaning the information that Resident 19 was using his wheelchair off the premises – he did not explain why he and the interdisciplinary

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<sup>13</sup> A June 19, 2014 nursing note states that a "[v]isitor reported seeing [the] resident riding his electric w/chair in the street facing traffic" and that "[a]ttempts to re-educate resident [were] ineffective." P. Ex. 1, at 289. The fact that staff sought to "re-educate" Resident 19 on that occasion strongly suggests it had concerns, or reason to know, that Resident 19 was operating the wheelchair in an unsafe manner.



team left the OT's care plan requiring supervision intact if he did not think the supervision was necessary. Tr. 139-40. As long as the care plan was in place, under the facility's policies, federal regulations and this Board's decisions, staff were required to supervise Resident 19 when he used his wheelchair off facility grounds.

The ALJ's reliance on Dr. Tavallae's testimony also did not give proper consideration to Petitioner's resident care policy addressing "use of motorized wheelchairs." That policy said the use of such wheelchairs was restricted to residents "who ha[d] *shown through assessment*[ ] that they [could] safely operate" them. CMS Ex. 10, at 1 (italics added). The policy designated the OT, not the resident's physician, as the person responsible for making that safety assessment. Indeed, Dr. Tavallae acknowledged that he did not do wheelchair tests and did not conduct a wheelchair skills test for Resident 19. Tr. 137. Dr. Tavallae was Petitioner's Medical Director as well as Resident 19's treating physician. The Board has held that the role of a Medical Director "is to implement the facility's resident care policies, not to override them." *Golden Living Center – Superior*, DAB No. 2768, at 21 (2017). The Board explained that while the Medical Director's "professional judgment might well be a factor in developing or amending the facility's policy . . . [,]" once the policy is adopted, "the facility must follow it unless and until it is changed." *Id.* As a member of the interdisciplinary team, Dr. Tavallae presumably was in a position to have had input into the motorized wheelchair policy and could have recommended amending it if he disagreed with it. Absent any amendment, Dr. Tavallae, as Petitioner's Medical Director, was required to follow it just as staff were required to follow it. He was also required to follow the OT's assessment for Resident 19 since it was adopted as prescribed in that policy, unless that assessment was revisited and changed. The ALJ cited no evidence, testimonial or otherwise, that Petitioner's motorized wheelchair policy, Resident 19's assessment, or the care plan the OT developed based on that assessment was ever replaced or amended. Indeed, the ALJ seems to have accepted that there was no further assessment until the OT reassessed the resident during the survey. *See* ALJ Decision at 27.

Thus, Petitioner violated its motorized wheelchair policy when it repeatedly allowed Resident 19 to use the motorized wheelchair off of its property without supervision even though he had not "shown through assessment" (performed by the OT, in coordination with other staff as appropriate) that he was capable of doing so without substantial risk of harm to himself. Such a violation is evidence of noncompliance with section 483.25(h)(2) because that provision's clear purpose is to prevent accidents, including those caused by unsafe use of a motorized wheelchair. *Cf. Heritage Plaza Nursing Ctr.*, DAB No. 2829, at 20 (2017) ("Once a facility adopts a policy that incorporates the measures that are appropriate to assure that residents receive adequate supervision and assistance devices to prevent accidents, . . . the facility is held to follow through on them.").

3. The ALJ erred in concluding, in effect, that Petitioner was not required to follow the care plan developed by the OT because that plan, in the ALJ's view, conflicted with Resident 19's right to be independent.

As discussed above, the ALJ erroneously focused on after-the-fact opinions about Resident 19's ability to operate the wheelchair safely outside the facility that were not corroborated by any contemporaneous evidence rather than on the resident's care plan. The ALJ also appears to have concluded that a facility may invoke resident rights as a reason for not following its care plan designed to protect that resident. ALJ Decision at 21-22. This too was error. The State Operations Manual (SOM), as the ALJ noted, instructs surveyors that "[i]t is reasonable to accept some risks as a trade[-]off for the potential benefits, such as maintaining dignity, self-determination, and control over one's daily life." ALJ Decision at 19 (quoting SOM Appendix PP). However, in the context of the regulation (and instructions) as a whole, both of which focus on the facility's responsibility to develop a plan for protecting the resident against accidents, this means the facility's plan should address that balance. It does not mean that CMS should excuse a facility's failure to follow a resident's care plan that unambiguously requires a particular level of supervision based on an assertion by the facility that it could not do so without unduly restricting the resident's independence. *See* 42 C.F.R. § 483.20(k)(1)(ii) (providing that a care plan must describe "any services that would otherwise be required under § 483.25 but are not provided due to the resident's exercise of rights" to refuse treatment under section 483.10(b)(4)).

In this case, the surveyor properly relied on the care plan developed by the OT, which stated that Resident 19 should not be allowed to operate his wheelchair off facility premises without supervision to find a violation of section 483.25(h)(2) given undisputed evidence that staff repeatedly failed to follow that plan and did not amend the plan based on a reassessment of the resident consistent with its policies. As Petitioner notes (Response Br. at 12), the whole premise behind the OT's assessing Resident 19 for use of a motorized wheelchair was that the chair, if she concluded he could operate it safely, would enhance the resident's mobility. The assessment itself (which took place over several days prior to the OT's issuing the care plan document) was done to determine whether he could safely operate the wheelchair. Thus, in developing the care plan, the OT had the responsibility to balance the resident's desire for more independence in his mobility against the risks associated with operating the wheelchair. The OT's instruction to restrict unsupervised use of the wheelchair to the facility's premises, including the smoking area outside, reflects that balance, and staff were required to follow the OT's instruction unless it was replaced by another assessment and care plan allowing the resident to leave the facility's premises without such supervision.

Petitioner points to the OT's testimony that her assessment restricted Resident 19's unsupervised use of the wheelchair to the facility's premises because, following her customary practice, she had not evaluated his ability to use the wheelchair safely off the premises, not that she had formed an opinion that he could not safely do so. Response Br. at 13, citing Tr. 180, 184. Petitioner suggests that because the OT's restriction on the resident's unsupervised use of the wheelchair was based not on an opinion on her part as to Resident 19's ability to use the wheelchair safely off Petitioner's premises (because she had not formed an opinion on that issue) but, rather, on the fact that she had not assessed him for that use, staff was somehow relieved of the need to implement the restriction. We reject that suggestion. The OT's after-the-fact testimony as to why she wrote the instruction restricting the resident's use of the wheelchair to the facility premises is not supported by any contemporaneous documentation and, in any event, is immaterial. The material fact is that she issued a written instruction that unambiguously restricted the resident's unsupervised use of the wheelchair to the facility's premises. That instruction served as Petitioner's care plan for the resident's use of his wheelchair which Petitioner's staff members were required to follow regardless of why the OT issued the instruction.

Moreover, Petitioner's suggestion undercuts rather than supports its argument that it was in substantial compliance. Petitioner's duty under section 483.25 was to comprehensively assess any risks posed by the resident's use of the wheelchair wherever staff allowed him to use it. Since staff allowed the resident to come and go from the facility premises, indeed, pretty much at will, it was required to assess whether he could do so safely without supervision. There is no evidence Petitioner did any assessment and care plan for Resident 19's use of his wheelchair other than the one done by the OT, and her admission that she did not assess for that use simply compounds the noncompliance. If Petitioner knew, as it claims, that the OT did not routinely include safe operation off premises in her assessments and, specifically, that she did not do so for Resident 19, then it needed to do a reassessment that included this dimension before allowing the resident to leave the premises in the wheelchair. Petitioner's responsibility in this regard was enhanced by the fact that they knew Resident 19 was repeatedly leaving the grounds and repeatedly left the facility and often did so without even signing out.<sup>14</sup>

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<sup>14</sup> Petitioner suggests that because staff could contact Resident 19 by cell phone when he was off the premises, it was providing adequate supervision. See Response Br. at 25. The record provides no support for this suggestion. The DON admitted that even though staff could call the resident, they could not verify that he was where he said he was. Tr. 158. She also testified that the sign-out sheets, which Resident 19 routinely did not use, despite nearly daily reminders (Tr. 148), did not provide information about where a resident was going (Tr. 156). Moreover, there is evidence that having a cell phone may actually have enhanced the risk of Resident 19 harming himself since the surveyor observed him in the street crossing an intersection while talking on his cell phone. CMS Ex. 4, at 3-4; see also ALJ Decision at 9 (discussing the surveyor's observations and finding them "unrebutted, not disputed, and fully credible").

Petitioner asserts that Resident 19 had the right to refuse care and to leave its facility when he wanted, and that his frequent absences from the facility revealed his desire for autonomy and independence. Response Br. at 4. In *Venetian Gardens*, the Board stated that “a resident’s choice to leave the facility may, in a sense, be considered a refusal of the care and supervision the facility would otherwise provide.” DAB No. 2286, at 22 (2009). Here, it is unclear that Resident 19 actually refused supervision because although Petitioner allowed the resident to leave the facility despite the OT’s limitation of his use of the motorized wheelchair to the facility’s premises, there is no evidence that Petitioner developed a plan to supervise that offsite use, much less communicated the plan to him.

Even if it is accurate to say that Resident 19 refused such supervision, Petitioner “ha[d] an obligation to make sure that the refusal [was] informed, to attempt to address the cause of the resident’s refusal, and to look for alternatives . . . that would not violate the resident’s rights.” *Venetian Gardens* at 22. Petitioner did not establish that it met these obligations either. Petitioner alleges that it “specifically advised [Resident 19] of concerns associated with leaving the Facility without assistance, and he stated that he understood the safety risks involved, which is documented in his records.” Response Br. at 29. In support of that allegation, Petitioner cites an April 30, 2014 social services note which indicates that Petitioner planned to leave the facility that day to visit with family. *Id.*, citing P. Ex. 1, at 431. But Resident 19 did not plan to leave the facility in the motorized wheelchair on that occasion; instead, he had arranged to leave in a taxi, accompanied by his brother. P. Ex. 1, at 431. The staff did not talk with him that day about the safety risks of operating the motorized wheelchair beyond the confines of Petitioner’s property, or about the potential health risks associated with his frequent wheelchair-assisted absences from the facility.

Petitioner asserts that the Board’s decision in *Venetian Gardens* “is a case with very similar facts” and “set[s] forth several principles that were properly applied by the ALJ in this case.” Response Br. at 28. The ALJ did not cite or discuss that case, however – and for good reason. While *Venetian Gardens* concerned a “competent resident who repeatedly chose to leave the facility in his motorized wheelchair,” as well as a claim by CMS that the SNF violated section 483.25(h)(2) by allowing the resident to leave without supervision, *see* DAB No. 2286, at 1, 5-6, the Board did not decide the case’s merits but, rather, vacated a grant of summary judgment in favor of CMS and remanded for further proceedings because it concluded that *Venetian Gardens* had raised a dispute about the facts on which CMS had relied in its summary judgment motion and that the ALJ had not provided any analysis for his reading of section 483.25(h)(2). Furthermore, unlike this case, *Venetian Gardens* did not involve a failure by staff to implement a recommendation of supervision issued pursuant to an unambiguous written resident care policy.

In sum, the issue before us is not whether supervising Resident 19's motorized wheelchair use would have unduly restricted his autonomy or freedom of movement, but whether Petitioner met its obligation under section 483.25(h)(2) to provide Resident 19 with the supervision that its own staff thought necessary to prevent accidents. *Cf. Van Duyn Home* at 8-9 (stating that the administrative law judge had correctly explained that the case "was not about restricting residents' freedom of movement" but about whether the SNF "actually identified factors that would plainly impact the resident's health and safety when away" (internal quotation marks omitted)); *Eastwood Convalescent Ctr.*, DAB No. 2088, at 12 (2007) (stating that the "issue" for decision was not whether a resident had the right to leave the facility with her husband but what the SNF did, or did not do, to "mitigate the foreseeable risk of" harm to the resident "once the administrator decided to let her leave with her husband").

Based on the foregoing analysis, we conclude that substantial evidence does not support the ALJ's conclusion that Petitioner rebutted CMS's prima facie showing of noncompliance by any standard, much less by a preponderance of the evidence. Accordingly, we reverse that conclusion and hold that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h)(2) as of June 24, 2014. Petitioner does not contend that it corrected its noncompliance with section 483.25(h)(2) any earlier than August 14, 2014. We therefore sustain CMS's determination that Petitioner was not in substantial compliance with that regulation from June 24, 2014 through August 13, 2014.

*B. CMS's immediate-jeopardy determination is not clearly erroneous.*

As noted in the background narrative, CMS determined that Petitioner's noncompliance with 42 C.F.R. § 483.25(h)(2) was at the immediate-jeopardy level of severity on June 24, 2014 until Petitioner instituted "one-on-one" supervision of Resident 19's offsite use of the motorized wheelchair. "Immediate jeopardy" is defined as a "situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's immediate-jeopardy determination must be upheld unless it is clearly erroneous. *Id.* § 498.60(c)(2). Under that standard of review, the immediate-jeopardy determination is presumed to be correct, and the SNF has a "heavy burden" to overturn it. *Crawford Healthcare & Rehab.* at 14-15.

Petitioner suggests that we remand the case for the ALJ to decide whether CMS's immediate-jeopardy determination is clearly erroneous. Response Br. at 21. However, the Board is authorized to resolve the issue in the first instance. 42 C.F.R. §§ 498.88(a) (stating that the Board may "either issue a decision or remand the case . . .") and 498.88(f)(1)(iii) (stating that the Board may reverse or remand an administrative law judge's decision – or modify it); *Lake City Extended Care Ctr.*, DAB No. 1658, at 17

n.20 (1998); *Golden Living Ctr. – Riverchase*, DAB No. 2314, at 19 n.10 (2010), *aff'd*, *Golden Living Ctr.-Riverchase v. U.S. Dep't of Health & Human Servs.*, 429 F. App'x 895 (11<sup>th</sup> Cir. 2011). Petitioner does not say why a remand is necessary or preferable in these circumstances,<sup>15</sup> and we see no reason why the issue cannot, or should not, be resolved at this level.

Petitioner asserts that the immediate-jeopardy determination is clearly erroneous “because there is no connection between the undefined supervision requirement espoused by CMS here and the likelihood of serious harm or death to a resident who decides to lawfully use a motorized wheelchair on a residential street, as opposed to the sidewalk.” Response Br. at 22. Petitioner offers no argument to back up that assertion. In addition, the assertion presupposes, without factual foundation, that Resident 19 possessed sufficient physical and motor abilities, safety awareness, and behavioral stability to operate a motorized wheelchair on a public street without substantial risk of an accident. Petitioner never assessed Resident 19 as having those capacities. Moreover, a wheelchair safety re-assessment performed *during the survey* revealed that Resident 19 was deficient in key areas. Although he “passed safety checks for 18 out of the 27 relevant [wheelchair] skills assessed” on that day, Resident 19 was, as the ALJ accurately noted, found to be “easily distracted, very lethargic, and slow to respond at times”; to have “difficulty turning and rolling backwards”; and to be “at increased risk for hitting someone.” ALJ Decision at 12 n.8; P. Ex. 1, at 161. CMS could reasonably infer from that information that Petitioner’s noncompliance (that is, its failure to provide “adequate supervision,” in accordance with the instruction issued by its occupational therapist) was likely to cause, or to be a contributing cause of, a traffic or road-related accident resulting in serious harm to Resident 19. We therefore conclude that the immediate-jeopardy determination was not clearly erroneous.

*C. The penalty amounts imposed by CMS for Petitioner’s noncompliance with 42 C.F.R. § 483.25(h)(2) are reasonable.*

In light of our conclusions in the previous two sections, we must address any issues relating to the amount of the CMPs imposed by CMS for Petitioner’s noncompliance with 42 C.F.R. § 483.25(h)(2). Those CMPs are \$3,550 for the single day of immediate jeopardy on June 24, 2014, and \$100 per day for the 56 days of non-immediate-jeopardy-level noncompliance from June 25 through August 19, 2014. Petitioner does not challenge, and we thus affirm, the penalty imposed for the non-immediate-jeopardy period of noncompliance. Only the \$3,550 penalty for June 24, 2014 is at issue here.

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<sup>15</sup> Petitioner does not, for example, suggest that ALJ must make additional credibility findings with respect to testimonial assertions that bear upon the merits of the immediate-jeopardy determination.

During an appeal of a determination of noncompliance, a SNF may challenge the reasonableness of the amount of any CMP imposed. *Crawford Healthcare & Rehab.* at 2. In deciding whether the CMP amount is reasonable, the Board may consider only the factors specified in 42 C.F.R. § 488.438(f). 42 C.F.R. § 488.438(e)(3); *Crawford Healthcare & Rehab.* at 19. Those factors are: (1) the SNF's history of noncompliance; (2) the SNF's financial condition – that is, its ability to pay the CMP; (3) the “seriousness” of the noncompliance; (4) the SNF's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety; and (5) the relationship of one deficiency to other deficiencies resulting in noncompliance. 42 C.F.R. §§ 488.438(f), 488.404(a)-(c).

Petitioner asserts that \$3,550 is an “unreasonable” CMP for the one day of immediate jeopardy, but it does not argue that the penalty is excessive based on the applicable regulatory factors. Response Br. at 4-5, 38. The Board has held that the CMP amount selected by CMS is presumptively reasonable based on those factors, and that the burden is on the SNF “to demonstrate, through argument and the submission of evidence addressing the regulatory factors, that a reduction [in the penalty amount] is necessary to make the CMP amount reasonable.” *Crawford Healthcare & Rehab.* at 19 (internal quotation marks omitted). Because Petitioner has not attempted to carry that burden, we sustain the \$3,550 CMP imposed by CMS for June 24, 2014 without further discussion. *Bivins Memorial Nursing Home* at 13 (affirming a CMP against a SNF that failed to present an argument based on the regulatory factors).

*D. The ALJ's findings of fact and conclusions of law concerning the noncompliance identified by the August 14, 2014 survey are summarily affirmed.*

Following his discussion of the noncompliance involving Resident 19, the ALJ determined that: (1) Petitioner was in violation of 42 C.F.R. § 483.35(i) during the August 14, 2014 revisit survey; (2) the violation of section 483.35(i) constituted lack of substantial compliance; (3) Petitioner's noncompliance with section 483.35(i) continued from August 14 through August 19, 2014; (4) CMS validly imposed a \$100 per-day CMP for that noncompliance; (5) Petitioner did not question the reasonableness of the CMP amount; and (6) “Petitioner received adequate notice of the CMS initial determination to impose an enforcement remedy based on the noncompliance cited by the survey completed on August 14, 2014.” ALJ Decision at 30-33. Petitioner does not challenge any of these findings or conclusions in this appeal. We therefore summarily affirm them.

Conclusion

For the reasons discussed above, we: (1) reverse the ALJ's conclusions of law in II.C.1 and II.C.2 of the ALJ Decision (on pages 3-30) and hold that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h)(2) from June 24 through August 13, 2014; (2) uphold CMS's determination that Petitioner's noncompliance with section 483.25(h)(2) was at the immediate-jeopardy level on June 24, 2014; (3) sustain the CMPs imposed by CMS for the period June 24 through August 13, 2014; and (4) summarily affirm the ALJ's findings of fact and conclusions of law in section II.C.3-II.C.7 (on pages 30-34) relating to the noncompliance found during the August 2014 revisit survey.

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*/s/*

Susan S. Yim

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*/s/*

Constance B. Tobias

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*/s/*Sheila Ann Hegy  
Presiding Board Member