Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Owensboro Place and Rehabilitation Center
Docket No. A-11-39
Decision No. 2397
June 30, 2011

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Owensboro Place Care and Rehabilitation Center (Owensboro or Petitioner), appealed the November 22, 2010 decision of Administrative Law Judge Carolyn Cozad Hughes, *Owensboro Place Care and Rehabilitation Center*, DAB CR2286 (2010) (ALJ Decision). The ALJ sustained the Centers for Medicare & Medicaid Services's (CMS's) determinations that Owensboro was not in substantial compliance with a requirement for participation in the Medicare program and that the noncompliance was at the immediate jeopardy level, and sustained the imposition of a civil money penalty (CMP) of $3,050 per day for the 50-day period of December 25, 2008 through February 12, 2009.

For the reasons explained below, we sustain the ALJ Decision as supported by substantial evidence and free from legal error.

Applicable Law

The Social Security Act (Act) and federal regulations provide for state agencies to conduct surveys of nursing facilities that receive Medicare and Medicaid funds to evaluate their compliance with the participation requirements of those programs. Act §§ 1819, 1919; 42 C.F.R. Parts 483, 488, and 498.[1] A facility's failure to meet one or more participation requirements, set forth at 42 C.F.R. Part 483, subpart B, constitutes a "deficiency." 42 C.F.R. § 488.301. "Noncompliance" is defined as "any deficiency that causes a facility to not be in substantial compliance." *Id*. "Substantial compliance" means a level of compliance such that "any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." *Id*. Surveyor findings are reported in a statement of deficiencies (SOD), which identifies each deficiency under its regulatory requirement. 42 C.F.R. § 488.404; CMS State Operations Manual (SOM), CMS Pub. 100-07, App. P – Survey Protocol for Long Term Care Facilities (available at http://www.cms.hhs.gov/Manuals/IOM/list.asp).

[1] The current version of the Social Security Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssact.htm.

A facility determined to be not in substantial compliance is subject to enforcement remedies, including CMPs. 42 C.F.R. §§ 488.402(c), 488.406, 488.408. A per-day CMP may accrue from the date the facility was first out of compliance until the date it achieved substantial compliance. 42 C.F.R. § 488.440(a)(1), (b). For noncompliance determined to pose less than immediate jeopardy to facility residents, CMS may impose a per-day CMP ranging from $50-$3,000 per day. 42 C.F.R. § 488.408(d)(1)(iii). For noncompliance determined to pose immediate jeopardy to facility residents, CMS may impose a per-day CMP ranging from $3,050-$10,000 per day. 42 C.F.R. §§ 488.408(e)(1)(iii), 488.438(a)(1)(i). "Immediate jeopardy" is defined as "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301.

The regulation at issue here, 42 C.F.R. § 483.25(h), requires facilities to "ensure that . . . (1) The resident environment remains as free of accident hazards as is possible" and that "(2) Each resident receives adequate supervision and assistance devices to prevent accidents."[2] It is part of the quality of care regulation at 42 C.F.R. § 483.25 that requires that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." Numerous Board decisions have explained the requirements of 42 C.F.R. § 483.25(h)(2). *See, e.g.*, *Liberty Commons Nursing and Rehab - Alamance*, DAB No. 2070, at 3 (2007), *aff'd, Liberty Commons Nursing and Rehab Ctr. - Alamance v. Leavitt*, 285 F. App'x 37 (4th Cir. 2008), citing *Golden Age Skilled Nursing & Rehabilitation Center*, DAB No. 2026 (2006); *Woodstock Care Center*, DAB No. 1726, at 9 (2000), *aff'd, Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 (6th Cir. 2003). Although section 483.25(h)(2) does not make a facility strictly liable for accidents that occur, it "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 the Crystal Coast v. Leavitt*, 281 F. App'x 180 (4th Cir. 2008). In doing so, "[f]acilities have the 'flexibility to choose the methods of supervision' to prevent

[2] While the SOD and the ALJ cited both paragraphs (1) and (2) of section 483.25(h), the ALJ and the parties focused, as do we, on the requirement in paragraph (2) to ensure that each resident receives adequate supervision and assistance devices to prevent accidents. *See, e.g.*, ALJ Decision at 8 (finding that facility staff "failed to take reasonable steps to ensure that the resident received the supervision necessary to mitigate foreseeable risks of harm from accidents"); RR at 11-12 (discussing facility's burden to "take reasonable steps to ensure that a resident receives supervision and assistive devices designed to meet his assessed needs and to mitigate foreseeable risks of harm from accidents.").

accidents so long as the methods chosen are adequate in light of the resident's needs and ability to protect himself or herself from a risk." *Liberty Commons Nursing and Rehab - Alamance* at 3, citing *Golden Age* at 11 and *Woodstock*, 363 F.3d at 590.

Case Background

This case involves the elopement from the facility on December 25, 2008 of an 81-year-old woman, designated to protect her privacy as Resident 1 (R. 1), whose diagnoses included vascular dementia, peripheral vascular disease, and Alzheimer's disease. ALJ Decision at 4, citing CMS Ex. 8, at 2, 13, 61, 88, 111, and P. Ex. 4, at 1, 2. The minimum data set (MDS) completed October 22, 2008 states that she engaged in wandering behavior, defined on the MDS form as "moving with no rational purpose, seemingly oblivious to needs or safety," that her behavior was not easily altered, and that she suffered from moderately impaired decision making, requiring supervision and cues. CMS Ex. 8 at 19, 26, 30. The facility had identified R. 1 as an elopement risk because of her wandering, fitted her with a WanderGuard bracelet, and instructed staff via R. 1's care plan to redirect the resident if the WanderGuard alarm sounded or if she attempted to leave the unit or the building. ALJ Decision at 4, citing CMS Ex. 8 at 75; P. Ex. 4, at 32, 80.

The following facts from the ALJ Decision about the elopement are not disputed. R. 1 exited the facility, without the knowledge of staff, through a locked, alarmed door on the "E" wing or unit. The door was designed to sound an alarm if pushed and to open if the pushing continued for 15 seconds.[3] The alarm sounded at the door and at a nurse's station on the D wing, and would sound until the alarm was reset at the door. Staff accounts indicate that when R. 1 eloped, the alarm sounded for some 15 to 30 minutes, and the licensed practical nurse (LPN) at the D wing nurse's station paged staff in the south hall of E wing to check the door three times, and then sent three people to check on the alarm. Although "seven employees . . . assigned to the E wing . . . acknowledge[d] hearing a door alarm sound," the resident's departure was discovered only because one staff member later happened to see her outside through a window and retrieved her. ALJ Decision at 5-6, R. 1 was wearing a sweatshirt, sweatpants, socks, and no shoes, and the

[3] While the resident was equipped with a WanderGuard bracelet, the door through which she exited was not part of the WanderGuard system. Only three of the facility's 14 doors, none on the E wing, were part of the WanderGuard system whereby an alarm would sound if a resident wearing a WanderGuard bracelet approached the door. ALJ Decision at 5, citing Tr. at 32-33, 102. The three doors in the WanderGuard system were described as commonly used by members of the public to come and go from the facility, such as the front door in the lobby, and were WanderGuard-equipped to alert staff if a resident attempted to leave the facility with a member of the public. Tr. at 145-46. The other 11 doors were the type of locked, alarmed door through which the resident exited, which would sound an alarm and then open if pushed for 15 seconds. Tr. at 103.

outside temperature was 32 degrees Fahrenheit. *Id*. Staff accounts show the course of events beginning sometime around 11:00 a.m. and ending around 12:20 p.m. *Id*. at 6-8.

The Kentucky Cabinet for Health and Family Services (State agency) conducted an abbreviated survey of Owensboro's facility from January 26 through February 3, 2009. CMS Ex. 16 (SOD Feb. 3, 2009). The State agency determined that Owensboro was not in substantial compliance with four regulatory requirements for participation in the Medicare program, including the requirement addressed in the ALJ Decision (42 C.F.R. § 483.25(h)), and that the noncompliance was at a level of less than immediate jeopardy. *Id*. Owensboro submitted a plan of correction on the SOD form on March 3, 2009. P. Ex. 2, at 4, 10-11. The SOD contains a column for the facility to specify the completion date of its corrective actions. The facility put "2/13/09" in that column; in the preceding column, the facility referred to that date as a "compliance date." *Id*. at 11.

The State agency "reopened" the abbreviated survey "for investigation" on April 2, 2009 and conducted a partial extended survey of the facility on April 2 and 3, 2009. CMS Ex. 18, at 1 (SOD Apr. 3, 2009). The State agency determined that Owensboro had been out of substantial compliance with section 483.25(h) and another regulation at the immediate jeopardy level for the period December 25, 2008 through February 12, 2009, and that the facility had "abated the Past Immediate Jeopardy, corrected the deficient practice, and was back in compliance effective 02/13/09." *Id*. at 13. CMS notified Owensboro by letter dated May 15, 2009, that CMS was imposing a CMP for the immediate-jeopardy level noncompliance of $3,050 per day for the period December 25, 2008 through February 12, 2009. CMS Ex. 1.

Owensboro appealed CMS's imposition of the CMP, and the case was assigned to ALJ Alfonso J. Montaño, who convened an in-person hearing on April 14, 2010. ALJ Montaño subsequently left the Department, and the case was reassigned to ALJ Hughes, who closed the record without objection from either party and issued the ALJ Decision based on the written record and the transcript of the hearing.

The ALJ Decision

The ALJ found that R. 1's elopement on December 25 triggered an alarm that was reported to have sounded for some 15 minutes and was heard by multiple staff members, one of whom made several announcements from the D wing nurse's station asking staff to check the door. ALJ Decision at 7. Yet, as the ALJ found, "[j]ust one employee wrote [in her December 25, 2008 statement] that she responded to the alarm." *Id*. at 8, citing CMS Ex. 5, at 5 and P. Ex. 5, at 2 (statement of CNA Lewis). That employee, a medication aide, wrote that she returned to the E wing from the restroom on another wing to find the door alarm sounding, went outside to look for any resident who might have

gone out, saw no one, and returned to the facility and reset the door. *Id*. The resident was spotted in the parking lot purely by happenstance: a registered nurse (R.N.) "happened to spot" R. 1 in the facility parking lot and "returned her to the facility before any harm came to her." ALJ Decision at 5, 6.

The ALJ concluded that the facility was not in substantial compliance with the requirement in section 483.25(h) because "staff ignored facility policy regarding elopements when they failed to respond to a door alarm, allowing a vulnerable, unsupervised resident to leave the facility." *Id*. at 4. It is undisputed that the facility's elopement policy "dictated that, upon hearing a door alarm, 'all staff must secure the resident that they are working with and go to visually check the door that is sounding.'" *Id*. at 5, citing CMS Ex. 6, at 15. The elopement policy informed staff that "'[y]ou must check that door and the surrounding areas outside as well,'" meaning that "[i]n checking the door, staff were required to open it, go outside, and look around the vicinity to make sure that a resident had not left." *Id*. citing CMS Ex. 6 at 15, P. Ex. 11 at 8, and Tr. at 129-30. The ALJ found that "[t]he undisputed evidence establishes that the nurses and most of the nurse aides on the E unit failed to respond to the sound of a door alarm, in contravention of the facility policy, which allowed R1 to elope." *Id*. at 8. "This alone," she concluded, "means that facility staff failed to take reasonable steps to ensure that the resident received the supervision necessary to mitigate foreseeable risks of harm from accidents." *Id*. The ALJ concluded that the facility, therefore, was not in substantial compliance with 42 C.F.R. § 483.25(h).

The ALJ also concluded that CMS's immediate jeopardy determination was not clearly erroneous, noting that "a vulnerable resident was able to leave the facility without staff intervention and remain outside in a parking lot for an unknown period of time" while "inappropriately dressed for the freezing temperature, having no shoes and no coat." *Id*. at 9. She also found that the staff's failure to follow "the policy in place to prevent elopements created a 'significant likelihood' that vulnerable residents could encounter the significant dangers related to elopement." *Id*.

Standard of Review

We review a disputed finding of fact to determine whether the finding is supported by substantial evidence on the record as a whole, and a disputed conclusion of law to determine whether it is erroneous. *Guidelines-Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs*, www.hhs.gov/dab/divisions/appellate/guidelines/prov.html; *Batavia Nursing and Convalescent Inn*, DAB No. 1911, at 7 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 143 F. App'x 664 (6th Cir. 2005). Substantial evidence is "more than a mere scintilla. It means such relevant evidence as a reasonable mind

might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971), quoting *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938). Under the substantial evidence standard, the reviewer must examine the record as a whole and take into account whatever in the record fairly detracts from the weight of the evidence relied on in the decision below. *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 488 (1951).

Analysis

1. The ALJ's conclusion that the facility was not in substantial compliance with 42 C.F.R. § 483.25(h) is supported by substantial evidence and free of legal error.

a. *Owensboro was not in substantial compliance with the regulation.*

Owensboro does not challenge the ALJ's factual findings about the circumstances of R. 1's elopement from the facility on December 25, 2008. Owensboro does not challenge, for example, the ALJ's finding that "[t]he undisputed evidence establishes that the nurses and most of the nurse aides on the E unit failed to respond to the sound of a door alarm" that was reported to have sounded for at least 15 minutes. ALJ Decision at 7, 8. Owensboro also does not dispute the ALJ's finding that although seven staff members heard the alarm and/or the LPN's pages to check the door, none responded in time to prevent the elopement or retrieve the resident, who was found to have eloped and was returned to the facility only because a staff member "happened to spot R. 1 in the facility parking lot and returned her to the facility before any harm came to her." *Id*. at 5; s*ee also*, Tr. at 138 (DON testimony). Owensboro concedes that "Resident #1 eloped from the facility and although the door alarm sounded, the resident was not caught until she was in the parking lot." RR at 1.

Owensboro instead disputes the ALJ's finding that the elopement was caused by a "contravention of the facility policy" that all staff were to respond to an alarm. ALJ Decision at 8. Owensboro disputes this finding on the ground that one staff member, Medication Aid Karen Lewis, apparently responded to the alarm triggered by R. 1's elopement on December 25, 2008. As the ALJ noted, Ms. Lewis reported that she heard the alarm upon returning to the E wing from a restroom on another wing, went outside through the E wing door where the alarm was sounding to look for residents, saw no one, returned to the facility and reset the door. Tr. at 107-113; ALJ Decision at 8, citing CMS Ex. 5, at 5 and P. Ex. 5, at 2. Ms. Lewis's actions do not demonstrate compliance with the facility's elopement policy. That policy required that *all* staff respond to alarms, and Owensboro does not dispute the ALJ's determination that seven staff members heard but

did not respond to the alarm that was triggered by R. 1's elopement. CMS Ex. 6, at 15; ALJ Decision at 5.

Owensboro also asserts that other staff who heard the alarm could not respond because they were unable to secure the residents with whom they were working, as required by the elopement policy, but the facility fails to support that assertion. Owensboro states only that an LPN who heard the alarm while in the dining room could not respond because she had to remain with the residents in case of a choking incident. Owensboro does not address the ALJ's observation that the LPN made no effort to send any of "the four to five nurse aides [who] were with her in the dining room . . . out in response to the alarm." ALJ Decision at 7. Owensboro also does not dispute the ALJ's finding that six of seven staff assigned to the E wing did not respond to the sounding alarm.[4] *Id*. at 9. We note here that the staff member who eventually spotted the resident outside, an R.N., reported to the surveyor that he heard an alarm go off, and it is not disputed that he did not respond to or check the alarm. CMS Ex. 7, at 9; Tr. at 48 (surveyor). He told the surveyor that sometime later, when the alarm was not sounding, he happened to see R. 1 in the parking lot while he was taking residents to the dining room. *Id*. Written statements of facility staff and the surveyor's notes of interviews with staff further reveal that several staff members who were not on the E wing heard the alarm or the pages issued by the LPN at the D wing nurse's station, where the alarm sounded as well. CMS Ex. 5; P. Ex. 5. The LPN at the D wing nurse's station had paged staff in the south hall of E wing to check the door three times during the 15 minutes that the alarm sounded and then sent three people to check on the alarm. CMS Ex. 5, at 7; P. Ex. 5, at 9.

In addition, Owensboro states that R. 1's elopement on December 25, 2008 was "due, in all probability[,] to the staff's failure to respond to the door alarm fast enough to catch the resident before she reached the parking lot." RR at 4. The suggestion that the resident was retrieved because staff responded to the alarm, albeit too late to prevent her from reaching the parking lot, is not supported by the record. The record clearly shows that the resident was retrieved only because an R.N. fortuitously observed her outside while doing work unrelated to the alarm or her elopement. We also note that the ALJ rejected, as unsupported by the evidence, a statement in a two-page form report of the incident,

[4] Owensboro asserts that the ALJ "was unable to evaluate the credibility of the witnesses" at the hearing as conveyed in each witness's "presentation and body language" and alludes to "the potential effect the change in ALJ had on the case." P. Reply at 6. While the ALJ discussed conflicts between various statements and/or testimony by facility staff (and explained why she discounted testimony by one nurse about whether another nurse had heard the alarm), the ALJ ultimately determined she did not need to resolve the conflicts, in light of the "undisputed evidence [that] the nurses and most of the nurse aides on the E unit failed to respond to the sound of a door alarm, in contravention of the facility policy, which allowed R1 to elope." ALJ Decision at 8. Thus, the absence of in-person observation of the witnesses was immaterial to her decision. Accordingly, we find no grounds for Owensboro's assertion and do not address it further.

"Allegation of Violation of Policy," that R. 1 had been "brought back into [the] facility [in] less than 5 minutes by [a] staff member." ALJ Decision at 11, citing P. Ex. 14, at 2. The ALJ found that this statement was "most charitably described as inaccurate." *Id*. Owensboro does not dispute this finding.

The fact that the alarm triggered by the resident's departure sounded for such a prolonged period of time before the door was checked, and the fact that the resident was discovered to have eloped only by chance, by an R.N. who did not respond to the alarm, support the ALJ's finding that the staff were either unaware of their obligations under that policy, chose to ignore them, or did not follow the policy in a timely fashion. *Id*. at 5. Even accepting Owensboro's explanation that the intent of its elopement policy "is to insure that someone makes it to the door, not that every staff member drops what he or she is doing" (RR at 16), substantial evidence supports the ALJ's determination that staff did not follow the facility's policy.

There was thus no error in the ALJ's conclusion that Owensboro was not in substantial compliance with 42 C.F.R. § 483.25(h) "because staff ignored facility policy regarding elopements when they failed to respond to a door alarm, allowing a vulnerable, unsupervised resident to leave the facility." ALJ Decision at 4; *see Desert Lane Care Center*, DAB No. 2287, at 10 (2009) ("A facility's failure to fully employ those measures as intended in its policies may thus be evidence that the facility failed to provide residents with the services required by specific subsections of section 483.25."). As the ALJ correctly found, the failure of staff to respond to the alarm as required by facility policy "means that facility staff failed to take reasonable steps to ensure that the resident received the supervision necessary to mitigate foreseeable risks of harm from accidents. The facility was therefore not in substantial compliance with 42 C.F.R. § 483.25(h)." ALJ Decision at 8.

b. *Assigning Owensboro the burden to demonstrate substantial compliance was not contrary to the Administrative Procedure Act.*

Owensboro argues that requiring it to establish that it was in substantial compliance violates the requirement in the Administrative Procedure Act (APA), 5 U.S.C. § 556(d), that the burden of proof in an administrative proceeding lies with the proponent of a rule or order, which Owensboro says is CMS. RR at 20-23. The Board has addressed and rejected this APA argument and "has consistently held, based on analysis of the applicable statutory and regulatory provisions, that allocating the burden of persuasion to the [facility] does not violate APA procedural requirements." *Azalea Court*, DAB No. 2352, at 16 (2010), quoting *Carrington Place of Muscatine*, DAB No. 2321, at 24 (2010). The Board in those cases relied on *Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004), *aff'd*, *Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 F. App'x 181

(6th Cir. 2005), in which it concluded that, under the statutes and regulations governing nursing home participation in the Medicare program, a facility is the proponent of an order finding it in substantial compliance. *See also Texan Nursing & Rehab of Amarillo, LLC*, DAB No. 2323, at 18 (2010) ("the burden of proof applied by the ALJ is consistent with the Board's decisions on the burden of proof in long-term care facility cases, none of which has been reversed on appeal on that issue.").

Owensboro also argues that placing on it the burden of ultimate persuasion on the compliance issue is invalid because it is a substantive rule that was not promulgated pursuant to the notice and comment procedures in the APA. RR at 23. The Board has stated, however, that the burden of proof it applies is not a "rule" under the APA but is, instead, "in the nature of an order setting forth a rationale, based on the statute and regulations, that establishes precedent for ALJ hearings in these cases." *See, e.g., Liberty Commons Nursing and Rehab – Alamance* at 10 and *Lakeridge Villa Health Care Center*, DAB No. 1988, at 6 (2005), *aff'd Lakeridge Villa Health Care Ctr. v. Leavitt*, 202 F. App'x 903 (6th Cir. 2006), both citing *Batavia Nursing and Convalescent Center*.[5]

In any event, the ultimate burden of persuasion is relevant only if the evidence is in equipoise, which it is not here, where Owensboro disputes none of the material facts about R. 1's elopement on December 25, 2008. *Azalea Court* at 16; *see also Fairfax Nursing Home v. Dep't of Health & Human Servs.*, 300 F.3d 835, at 840 n.4 (7th Cir. 2002), *cert. denied*, 537 U.S. 1111 (2003) (declining to address Board's rejection of the same APA arguments where evidence not in equipoise).

We thus sustain the ALJ's determination that Owensboro was not in substantial compliance with 42 C.F.R. § 483.25(h).

2. The ALJ did not err in concluding that CMS's determination of immediate jeopardy was not clearly erroneous.

Section 498.60(c) requires the ALJ and the Board to uphold CMS's determination that the noncompliance with section 483.25 posed immediate jeopardy "unless it is clearly erroneous." Under that standard, CMS's determination of immediate jeopardy is presumed to be correct, and Owensboro faces a "heavy burden" to demonstrate clear

[5] Owensboro also cites *Grace Healthcare of Benton v. Dept. of Health and Human Svcs.*, 589 F.3d 926 (8th Cir. 2009), for the proposition that the APA applies to these proceedings. The Board has rejected the argument made in other cases, though not here, that the court in *Grace Healthcare* held that the longstanding assignment of the burden of persuasion to petitioners in these cases is inconsistent with the APA. *See*, e.g., *Greenbrier Nursing and Rehabilitation Center*, DAB No. 2335, at 17 (2010) ("nothing in the Eighth Circuit decision in *Grace Healthcare* . . . requires us to revisit that issue"); *Texan Nursing & Rehab of Amarillo* at 18 n.9 (2010) ("the burden of proof issue was not even raised, much less decided" in *Grace Healthcare*).

error. *Azalea Court* at 16-17, and cases cited therein. While Owensboro argues that this standard "is blatantly at odds with requirements of the federal APA" and "does not excuse CMS from having the burden of putting on a prima facie case" of immediate jeopardy, Owensboro recognizes that the Board has rejected this argument. RR at 5-6. Indeed, the Board "has held that once CMS establishes noncompliance, it does not need to make a prima facie case with respect to the level of noncompliance." *Highland Pines Nursing Home, Ltd.*, DAB No. 2361, at 5 (2011), citing *Daughters of Miriam Center*, DAB No. 2067, at 7-8 (2007), and *Liberty Commons Nursing and Rehab Center – Johnston*, DAB No. 2031 at 18-19 (2006), *aff'd*, *Liberty Commons Nursing & Rehab Ctr. – Johnston v. Leavitt*, 241 F. App'x 76 (4th Cir. 2007). In *Liberty Commons – Johnston*, the Board found that extending CMS's obligation to make a prima facie case of noncompliance to the level of noncompliance or allocating the burden of proof on that issue to CMS would be inconsistent with the regulatory limitation on the scope of review in section 498.60(c). *Liberty Commons – Johnston*, at 18. In affirming *Liberty Commons – Johnston*, the Fourth Circuit also rejected Liberty Commons's argument that the Board violated the APA, or due process, when it "placed the burden on . . . the petitioner . . . to show that CMS's determination that the noncompliance was at the 'immediate jeopardy' level was clearly erroneous, rather than requiring the Secretary to again establish this during the appeals procedure." 241 F. App'x 76, at **3. Liberty Commons's argument, the court stated, "ignores the relevant regulation [section 498.60(c)] which explicitly sets forth the burden of proof with respect to the level of noncompliance . . . ." *Id*. at **4.

Owensboro has provided no reason to revisit or decline to apply this precedent here. Nor has Owensboro met its burden of showing that CMS's assessment that the noncompliance posed immediate jeopardy was clearly erroneous. In decisions the ALJ cited, the Board has addressed the obvious perils faced by mentally compromised residents who elope from nursing facilities. ALJ Decision at 9, citing *Century Care of Crystal Coast* at 24 (2007) and *Kenton Healthcare, LLC*, DAB No. 2186, at 23-26 (2008). The resident in question in the case before us, who suffered from dementia and Alzheimer's and was assessed as being "oblivious to needs or safety," faced additional peril from the elements, as she left the facility wearing nothing on her feet but stockings, and no coat or jacket (only a sweatshirt) on a day when the temperature stood at freezing. Her discovery before leaving the grounds of the facility was a fortuitous circumstance, not a result of the facility's application of its anti-elopement policy. *See Kenton Healthcare, LLC* at 23-24 (immediate jeopardy to impaired residents who eloped and were found in facility's parking lot); Tr. at 63 (Owensboro's facility located near "a lot of traffic areas" with "a couple of main roads there very close by"). Such fortuitous circumstances do not diminish the plain threat to R. 1, or to any of the "at least 15 residents . . . at risk for elopement" (ALJ Decision at 9) posed by the failure by many facility staff to follow the facility's anti-elopement policy.

Owensboro also cites the fact that on the SOD for the initial survey ending February 3, 2009, the State agency assessed the scope and severity of Owensboro's noncompliance with section 483.25(h) at less than the immediate jeopardy level.[6] CMS Ex. 16, at 5. The State agency subsequently revised that determination and concluded that the noncompliance *did* pose immediate jeopardy, and CMS agreed. P. Ex. 1 (State agency notice, Apr. 15, 2009); CMS Ex. 1 (CMS notice May 15, 2009). CMS's later determination, which was based on further review by the State agency and an additional visit by a survey team that included the surveyor from the earlier survey (Tr. at 25), is the relevant determination that the ALJ and the Board are bound to sustain absent a showing that it was clearly erroneous. For the reasons explained above, Owensboro did not make that showing. In any event, CMS's later determination would have prevailed even if the State agency had not revised its earlier finding that the noncompliance did not pose immediate jeopardy. Act §§ 1819(h)(2) (State agency makes recommended findings regarding noncompliance and recommends actions to remedy the noncompliance, but the Secretary makes findings of noncompliance and decides what remedial actions to take); 1919(g)(3)(A) (Secretary's determination as to a facility's noncompliance with Medicaid requirements is binding and supersedes that of the State survey); s*ee Britthaven of Chapel Hill*, DAB No. 2284, at 6-7 (2009) (State agency merely recommends findings of compliance (or noncompliance); CMS ultimately determines whether the facility is in substantial compliance and whether immediate jeopardy exists); *Lake Mary Health Care*, DAB No. 2081, at 5-7 (2007) (ultimate responsibility for the interpretation and enforcement of federal participation requirements lies with CMS, not with the state surveyors, and CMS's finding of noncompliance and imposition of remedies for a determination of immediate jeopardy take precedence over the state's position).

Owensboro's complaint that it was not informed until the April 3 survey that "there was an alleged immediate jeopardy situation which existed more than three months previously" (RR at 9-10) has no merit. Nothing in the regulations precludes a state or CMS from re-evaluating its findings of noncompliance and concluding that they constitute immediate jeopardy. Moreover, CMS may impose a CMP for past noncompliance, including the number of days of immediate jeopardy. 42 C.F.R. § 488.430. Thus, a facility cannot expect to always have advance notice that a penalty will be assessed in the higher, immediate jeopardy range. Finally, Owensboro was required to take corrective action, regardless of the level of noncompliance.

[6] The State agency rated the deficiency at the "D" level of scope and severity, meaning noncompliance that poses the potential for more than minimal harm, thus constituting a deficiency at less than the immediate jeopardy level. SOM § 7400.5.1 (Sept. 10, 2010, previously at § 7400E).

3. The ALJ did not err in determining that the noncompliance at the immediate jeopardy level continued from December 25, 2008 through February 12, 2009.

CMS and the State agency determined that Owensboro abated the immediate jeopardy and attained substantial compliance by February 12, 2009. Owensboro asserts that it abated any immediate jeopardy and achieved substantial compliance on December 25, 2008. RR at 4, 10, 19-20. We address the duration of the noncompliance and the immediate jeopardy issues together, as did the ALJ. *See* ALJ Decision at 9-11 (discussing the ALJ's finding and conclusion that "CMS's determinations as to the duration of the periods of noncompliance and immediate jeopardy are consistent with statutory and regulatory requirements").

Owensboro argues principally that "any immediate jeopardy situation which might have existed on December 25, 2008 was immediately corrected" by measures Owensboro implemented that day, and that "[t]here is no evidence that the Petitioner was out of substantial compliance with the regulation after December 25, 2008." RR at 10-11. Owensboro also argues that CMS failed to support its determination that the facility abated the immediate jeopardy and attained substantial compliance by February 12, 2008. Owensboro asserts that "CMS simply fails to explain why the date of February 12, 2009 is significant to it and why it determined the immediate jeopardy was abated as of that date" and that "[t]o state the facility returned to compliance on February 12, 2009 because that is the date required by the plan of correction is to mischaracterize the requirements of the regulations." P. Reply at 3, 5. Owensboro claims "CMS failed to even present a prima facie case that any immediate jeopardy situation existed after the in-services following up on the December 25, 2008 elopement were immediately conducted." RR at 17-18.

Owensboro misapprehends the allocation of the burden of persuasion regarding the duration of noncompliance and immediate jeopardy. The burden of persuasion is on the facility. The Board has made it clear that the facility bears the burden of showing that it returned to substantial compliance on a date earlier than that determined by CMS and has rejected the idea that CMS must establish a lack of substantial compliance during each day in which a remedy remains in effect. *Kenton Healthcare, LLC* at 24-25; *Lake Mary HealthCare* at 30. Similarly, the facility's burden of demonstrating clear error in CMS's immediate jeopardy determination "extends to overcoming CMS's determination as to how long the noncompliance remained at the immediate jeopardy level." *Azalea Court* at 17, citing *Brian Center Health and Rehabilitation/Goldsboro,* DAB No. 2336, at 7 (2010). As the Board held in *Brian Center*, "[a] determination by CMS that a [facility's] ongoing [noncompliance] remains at the level of immediate jeopardy during a given period constitutes a determination about the 'level of noncompliance' and, therefore, is subject to the clearly erroneous standard of review under section 498.60(c)(2)." *Brian*

Center at 7-8. The Board has also held that "[t]he burden is on the facility to show that it timely completed the implementation of [its] plan [of correction] and in fact abated the jeopardy (to reduce the applicable CMP range) or achieved substantial compliance (to end the application of remedies)." *Lake Mary* at 29, citing, e.g., *Spring Meadows Health Care Center*, DAB No. 1966 (2005); *see also Brian Center* at 9, and *Azalea Court* at 21 (both citing *Lake Mary*). Thus, it is not incumbent on CMS to justify the February 12 date, but, rather, on Owensboro to show an earlier date of abatement and return to substantial compliance.

Owensboro has not done so here. Owensboro's claim that it abated immediate jeopardy and attained substantial compliance on December 25, 2008 is contradicted by its previous affirmation in its POC that it did not take some of the listed corrective actions until after December 25, 2008. *See* 42 C.F.R. §§ 488.401 (POC is "a plan developed by the facility and approved by CMS or the survey agency that describes the actions the facility will take to correct deficiencies and specifies the date by which those deficiencies will be corrected"); 488.402(d) (facility with deficiencies must submit a POC for approval by CMS or the State survey agency), 488.454(a)(1) (facility's attainment of substantial compliance must be established by a resurvey or after an examination of credible written evidence produced by the facility). For example, Owensboro stated in the POC it submitted March 3, 2009, in response to the February 3 survey, that it had completed four of the measures to attain compliance. P. Ex. 2, at 10-11. Two measures (e.g., "reviewed all residents identified at risk for elopement to ensure all care plans are implemented" and "reeducated staff . . . on all shifts . . . on . . . procedure for door alarm response") were not completed, according to Owensboro, until February 3 and 6, 2009, respectively. *Id*. at 10.

Evidence in addition to the POC also undercuts Owensboro's claim of immediate correction and abatement. The SOD for the April 3, 2009 survey lists actions Owensboro took after R. 1 eloped on December 25, 2008. CMS Ex. 18, at 11-13. The SOD shows that corrective measures were taken in February and March 2009, such as an audit of current residents identified as elopement risks by the DON and the Unit Managers, door alarm drills, and Quality Assurance Committee meetings. *Id*. It also shows that in-service training on door alarms was conducted on February 12 and again on March 5, 2009. *Id*. at 12. Records of in-service training show that "elopement review" was conducted on March 5, 2009, and documentation of door alarm drills shows that drills were conducted beginning on February 11, 2009. P. Exs. 8, 16. Owensboro concedes that not all staff attended the December 25 training. RR at 13. And, notwithstanding Owensboro's claim to have completed its in-service training on December 25, 2008, the surveyor's notes from the survey ending February 3, 2009 show that a dietary employee who was present in the facility on December 25 told the surveyor that he had received no in-service training about alarms. CMS Ex. 7, at 16.

Given Owensboro's burden to demonstrate the abatement of the immediate jeopardy and a return to substantial compliance, and that the POC was Owensboro's own representation of how and when it had implemented the measures it deemed necessary to attain those goals, CMS did not commit a clear error when it relied on the date Owensboro completed the in-service training provided on February 12, 2009, as verified by the State agency during the April 3 survey.

In arguing for an earlier date of abatement, Owensboro also relies on the surveyor's agreement that on December 25, "the facility took immediate measures to ensure that this would not happen again[.]" Tr. at 68, cited at RR at 11; *see also* RR at 3 (citing what Owensboro calls the surveyor's "admission that in-services conducted on December 25, 2008 were effective in resolving" the immediate jeopardy). The surveyor, however, subsequently gave a more specific, qualified answer indicating her agreement only that the facility had conducted in-service training on December 25, not, as Owensboro contends, that the in-service training alone was effective in resolving the immediate jeopardy. Tr. at 76 ("Q: And as the problem in your opinion on the 25th was that staff did not respond to the alarm, that matter was quickly and immediately addressed by the facility with its in-service of staff on that very day, would you agree? A: Yes, they did in-service.").

Owensboro also cites the investigation it conducted of the December 25, 2008 elopement as among the actions it took to remedy noncompliance. RR at 14. It reports that staff working that day were asked to write statements, that several were asked to clarify their statements, and that the DON reviewed the statements and developed a time line of events. *Id*. The ALJ was critical of the investigative efforts, however, noting that the written statements "are vague, incomplete, and inconsistent" and that the facility in its investigation made "no apparent effort . . . to reconcile those inconsistencies." ALJ Decision at 5. The ALJ also noted that the "timeline" the DON reported preparing was not in the record. *Id*. at n.5, citing Tr. at 129. While Owensboro responds that "a thorough investigation was completed," it does not address the substance of the ALJ's criticism. RR at 14. It instead protests that it was not cited for conducting an inadequate investigation, and that investigations are required by a different regulation not at issue here. RR at 16-17; P. Reply at 6-7. The Board has confirmed, however, that the duty of "adequate supervision . . . to prevent accidents" required by section 483.25(h) "encompasses a duty to adequately investigate why an accident occurred in order to prevent future accidents." *Hotel Reed Nursing Center*, DAB No. 2154, at 16 (2008), *aff'd, Hotel Reed Nursing Ctr. V. DHHS*, 333 F. App'x 829 (5th Cir. 2009). This conclusion is consistent with the duty imposed by the regulation "to mitigate foreseeable risks of harm or threats of harm." *Id*. citing *Woodstock Care Center*. The failure to adequately investigate an accident can thus be evidence of noncompliance with the

requirement to ensure adequate supervision and assistance devices to prevent accidents. *Lake Park Nursing and Rehabilitation Center*, DAB No. 2035, at 10-11 (2006). Here, the problems with the witness statements the ALJ noted bolster her conclusion that the facility did not abate the immediate jeopardy on December 25, 2008.

We thus sustain the ALJ's conclusion that CMS's determination of the duration of the periods of noncompliance and immediate jeopardy was consistent with statutory and regulatory requirements.

4. The ALJ did not err in concluding that the amount of the CMP is reasonable.

We also sustain the ALJ's determination that the amount of the CMP is reasonable. The amount of the CMP that CMS imposed for the period of noncompliance at the immediate-jeopardy level, $3,050 per day, is the minimum per-day amount permitted by regulation. 42 C.F.R. §§ 488.438(a)(1)(i), 488.408(e)(1)(iii). Where the per-day CMP amount is at the minimum of the applicable range, the total amount is not subject to review on appeal. *Magnolia Estates Skilled Care*, DAB No. 2228, at 28-29 (2009). The ALJ, thus, did not err in concluding that the CMP is reasonable as a matter of law. ALJ Decision at 11. Indeed, Owensboro makes no argument on appeal regarding the reasonableness of the amount (as opposed to the duration) of the immediate jeopardy CMP.

Conclusion

For the reasons explained above, we sustain the ALJ Decision.

_____/s/_____
Judith A. Ballard

_____/s/_____
Stephen M. Godek

_____/s/_____
Sheila Ann Hegy
Presiding Board Member