Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

The Hilltop on Main,
(CCN 67-5518),

Petitioner,

v.

Centers for Medicare & Medicaid Services

Docket No. C-15-2111

Decision No. CR4801

Date: March 2, 2017

DECISION

The Centers for Medicare & Medicaid Services (CMS) moves for summary judgment on its allegations that The Hilltop on Main (Petitioner or facility) was not in substantial compliance with Medicare participation requirements at 42 C.F.R. §§ 483.13(c), 483.25(h), and 483.75; that CMS's determination that Petitioner's noncompliance posed immediate jeopardy to resident health and safety is not clearly erroneous; and that the civil money penalties (CMPs) proposed by CMS as a consequence of Petitioner's noncompliance are reasonable in amount and duration. Petitioner contests all of these allegations and argues that summary judgment is not appropriate.

I conclude that summary judgment is appropriate in this case because the undisputed facts viewed in a light most favorable to Petitioner establish that: (1) Petitioner did not substantially comply with the Medicare participation requirements found at 42 C.F.R. §§ 483.13(c) and 483.25(h); (2) CMS did not clearly err in determining that Petitioner's noncompliance with §§ 483.13(c) and 483.25(h) posed immediate jeopardy to resident health and safety; and (3) the proposed CMPs are reasonable in amount and duration. I decline to rule on CMS's allegation that Petitioner was not in substantial compliance with 42 C.F.R. § 483.75 because it is not material to the outcome of this case. I therefore grant CMS's motion for summary judgment.

I. Background and Procedural History

Petitioner is a skilled nursing facility (SNF) located in Meridian, Texas. Surveyors from the Texas Department of Aging and Disability Services (state agency) conducted a survey of Petitioner's facility that ended on January 8, 2015. The state agency found that the facility was not in substantial compliance and the conditions constituted immediate jeopardy. CMS Exhibit (CMS Ex.) 3 at 17. Based on the survey findings, CMS determined that the facility was not in substantial compliance with the following participation requirements: 42 C.F.R. §§ 483.13(c) (Tags F224 & F226), 483.25(h) (Tag F323), and 483.75 (Tag F490). CMS Ex. 2 at 10.

On April 3, 2015, Petitioner requested a hearing. On May 11, 2015, Administrative Law Judge Scott Anderson issued an acknowledgment and pre-hearing order establishing a briefing schedule. This case was reassigned to me on October 14, 2016. In accordance with the schedule Judge Anderson set forth, CMS and Petitioner filed prehearing exchanges, including prehearing briefs (CMS Br. and P. Br., respectively), exhibit and witness lists, and proposed exhibits. Within its prehearing brief, CMS moved for summary judgment, which Petitioner opposed in its own prehearing brief. CMS submitted nine exhibits (CMS Exs. 1-9), and Petitioner submitted six exhibits (P. Exs. 1-6). As neither party has objected to any of the proposed exhibits, I admit all of them into the record.

II. Issues

The issues in this case are:

1. Whether summary judgment is appropriate;

2. Whether Petitioner failed to comply substantially with Medicare participation requirements;

3. If Petitioner did not comply substantially with Medicare participation requirements, then whether CMS's immediate jeopardy determination was clearly erroneous; and

4. Whether the remedy proposed is reasonable.

III. Jurisdiction

I have jurisdiction to hear and decide this case. 42 U.S.C. §§ 1320a-7a(c)(2), 1395i-3(h)(2)(B)(ii); 42 C.F.R. §§ 488.408(g), 488.434(a)(2)(viii), 498.3(b)(13).

IV. Discussion

A. Statutory and Regulatory Framework

The Social Security Act (Act) sets requirements for skilled nursing facility (SNF) participation in the Medicare program. The Act authorizes the Secretary of the U.S. Department of Health & Human Services (Secretary) to promulgate regulations implementing those statutory provisions. Act § 1819 (42 U.S.C. § 1395i-3). The Secretary's regulations are found at 42 C.F.R. part 483.

A facility must maintain substantial compliance with program requirements in order to participate in the program. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state agencies to conduct periodic surveys to determine whether SNFs are in substantial compliance with the participation requirements. Act § 1864(a) (42 U.S.C. § 1395aa(a)); 42 C.F.R. §§ 488.10, 488.20. The Act and regulations require that facilities be surveyed on average every twelve months, and more often if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A) (42 U.S.C. § 1395i-3(g)(2)(A)); 42 C.F.R. §§ 488.20(a), 488.308.

B. Findings of Fact, Conclusions of Law and Analysis

1. Summary judgment is appropriate.

Summary judgment is appropriate if there is "no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law." *Mission Hosp. Reg'l Med. Ctr.*, DAB No. 2459 at 5 (2012) (citations omitted). In order to prevail on a motion for summary judgment, the moving party must show that there is no genuine dispute of material fact requiring an evidentiary hearing and that it is entitled to judgment as a matter of law. *Id.* If the moving party meets this initial burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial . . . .'" *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986). "To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact — a fact that, if proven, would affect the outcome of the case under governing law." *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 3 (2010).

In evaluating a motion for summary judgment, an administrative law judge does not address credibility or evaluate the weight of conflicting evidence. *Holy Cross Village at Notre Dame, Inc.*, DAB No. 2291 at 5 (2009). Rather, in examining the evidence to

determine the appropriateness of summary judgment, an administrative law judge must draw all reasonable inferences in the light most favorable to the non-moving party. *See Brightview Care Ctr.*, DAB No. 2132 at 10 (2007) (upholding summary judgment where inferences and views of non-moving party are not reasonable). "[A]t the summary judgment stage the judge's function is not . . . to weigh the evidence and determine the truth of the matter but to determine whether there is a genuine issue for trial." *Anderson v. Liberty Lobby, Inc*., 477 U.S. 242, 255 (1986). However, drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions. *Cedar Lake Nursing Home*, DAB No. 2344 at 7 (2010).

Here, there is no genuine dispute of material fact. The documents in the record, particularly Resident 6's medical records, which Petitioner created and maintained, establish the following undisputed facts:

Resident 6: At the time of the incidents at issue in this case, Resident 6 was a 67-year-old male who was admitted to the facility on December 19, 2014. CMS Ex. 6 at 115, 203. Upon admission, Resident 6 was diagnosed with, *inter alia*, non-Alzheimer's dementia and anxiety disorder. CMS Ex. 6 at 67-68, 94, 97. His medical records indicate that he had impaired cognitive function or impaired thought processes as well as impaired decision making, and his wandering placed him "at significant risk of getting to a potentially dangerous place." CMS Ex. 6 at 43, 202. His initial psychosocial assessment and social history assessed Resident 6 as an elopement risk. CMS Ex. 6 at 205.

In the less than three weeks he resided at the facility, Resident 6 eloped on six separate occasions. The first incident occurred on the morning of December 20, 2014, the day after his admission. On that day, facility staff saw Resident 6 on site at 7:30 a.m., but at 8:10 a.m., Meridian police notified the facility that they had found Resident 6 and would return him to the facility. CMS Ex. 6 at 4-5. The next day, December 21, 2014, Resident 6 climbed out of his window unobserved, shortly after a nurse walked him to his room and left; local police returned Resident 6 to the facility about 20 minutes after he eloped. CMS Ex. 6 at 6. A day later, on December 22, 2014, Resident 6 again eloped through his window unobserved; facility staff contacted the local sheriff's office but was able to locate Resident 6 in a field by a nearby high school. CMS Ex. 6 at 7, 210. Three days after that, on December 25, 2014, Resident 6 attempted to elope by kicking out his window screen and jumping out of the window and later by breaking out through a back door to the facility. CMS Ex. 6 at 1, 35, 41. In both instances, Petitioner's staff was aware of his elopement attempt and quickly intercepted him, although facility staff called EMS to treat injuries Resident 6 suffered from a fall that occurred after he broke through the door. CMS Ex. 6 at 1, 35, 41. Six days thereafter, on December 31, 2014, Resident 6 once again eloped unobserved through his bedroom window at about 1:00 a.m. CMS Ex. 6 at 211. When facility staff discovered him missing, they called 911 and went looking

for him in the neighborhood; local police found him and returned him to the facility at approximately 1:45 a.m. CMS Ex. 6 at 211-12. Upon return, Resident 6 bore abrasions on both his arms. CMS Ex. 6 at 212. Resident 6's final elopement attempt occurred on January 7, 2015. CMS Ex. 6 at 3. In the presence of facility staff, Resident 6 opened a window and jumped out headfirst in spite of staff efforts to prevent his escape. CMS Ex. 6 at 3, 37. He ran outside without a coat and with only one shoe on, even though it was only 32° F outside. CMS Ex. 3 at 1, 10-11. He ran to a nearby house with staff members chasing him, entered it, and told the occupant that the staff members were trying to kill him. CMS Ex. 6 at 37. He eventually calmed down and returned to the facility voluntarily. CMS Ex. 6 at 37.

In response to Resident 6's elopements, Petitioner took various steps to try to prevent him from eloping again. After the first incident (12/20), Petitioner's staff checked all doors, locked them, and removed the door keys to the nursing station; placed Resident 6 in close observation in the secure unit; reoriented him several times per shift with re-direct; and instituted one-on-one monitoring. CMS Ex. 6 at 4. After the second incident (12/21), Petitioner's staff again checked all doors, closed Resident 6's window, explained the dangers of wandering outside the facility to him, and completed a Wander Data Collection Tool. CMS Ex. 6 at 6, 43. After the third incident (12/22), Petitioner's staff continued one-on-one monitoring and began looking for an alternate placement for Resident 6, contacting his state Adult Protective Services (APS) social worker. CMS Ex. 6 at 35, 92. As a result of its one-on-one monitoring of Resident 6, the resident did not attempt to elope on December 23, 2014, and staff was able to cut short his elopement on December 25, 2014. CMS Ex. 6 at 1, 35, 41, 210. In response to the latter incident (12/25), the unit nurse or a nurse's aide stayed with Resident 6 and the nurse kept the keys to his door on her person; later, the facility obtained physician orders for Ativan to manage the resident's agitation and psychosis and a physician assistant assessed Resident 6 on December 26, 2014. CMS Ex. 6 at 1, 28, 35, 41, 49. After the fifth incident (12/31), Petitioner's staff did a head-to-toe assessment of Resident 6, encouraged him to comply with his medication regime, and attempted to distract and re-direct him. CMS Ex. 3 at 7; CMS Ex. 6 at 202. Later that same day, Petitioner attempted to discharge Resident 6 to another facility that had agreed to accept him as a patient; however, he escaped when Petitioner tried to deliver him to the new facility, and the new facility refused to admit him after he was recaptured. CMS Ex. 6 at 36, 92; P. Ex. 2 at 2. After the sixth and final incident (1/7), Petitioner's staff added interventions such as distracting Resident 6 with pleasant diversions, food, conversation, television, and books and providing him with structured activities including toileting and walking both inside and outside. Petitioner's staff also implemented reorientation strategies including signs,

pictures, and memory boxes.[1] CMS Ex. 6 at 202. At no point in this process did Petitioner install an alarm on Resident 6's bedroom window that would alert its staff if he tried to elope unobserved through the window.

Petitioner's Anti-Neglect Policies: Petitioner had a general policy prohibiting abuse, neglect, and exploitation of its residents. CMS Ex. 7 at 11; P. Ex. 5 at 2-3. Petitioner sought to advance that general policy through implementation of a series of more specific anti-abuse and anti-neglect policies. CMS Ex. 7 at 11-17. Such policies included reporting of incidents and accidents; screening of potential employees; training of facility staff to detect and mitigate, or even prevent, potential instances of abuse or neglect; administrative identification and investigation (where necessary) of potential instances of abuse or neglect; and protection of residents during investigations of alleged abuse or neglect. CMS Ex. 7 at 11-17. Petitioner did not provide the surveyor, nor did it submit into the record, any specific anti-elopement policy. CMS Ex. 3 at 13.

Petitioner's Response to the Survey: In response to the surveyor's declaration of immediate jeopardy, Petitioner took a series of steps in mitigation.[2] CMS Ex. 3 at 14-15. On January 7, 2015, Petitioner discharged Resident 6 to a local hospital and refused to re-admit him. CMS Ex. 3 at 14. Petitioner also performed an in-service training about its elopement policy and procedure on January 7-8, 2015. CMS Ex. 3 at 14. Further, by January 10, 2015, Petitioner installed alarms on all the windows in the secure unit where Resident 6 had been living. CMS Ex. 3 at 15. The surveyor monitored these actions and lifted the immediate jeopardy on January 8, 2015.[3] CMS Ex. 3 at 16. The surveyor further found that Petitioner returned to substantial compliance with Medicare participation requirements on January 13, 2015. CMS Ex. 9 at 1.

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[1] The record does not describe precisely what these strategies entailed.

[2] I do not consider these mitigating steps in any way as evidence supporting the existence of deficiencies on the part of Petitioner.

[3] As my analysis below explores, Petitioner's failure to take the reasonable step of installing window alarms is key to my decision to grant CMS summary judgment. This stands in some tension with the surveyor's decision, ratified by CMS, to lift the immediate jeopardy prior to Petitioner installing window alarms in the secure unit where Resident 6 lived prior to discharge. Whether or not this decision was correct in light of my analysis of the significance of installing window alarms, I take CMS's allegation that Petitioner abated immediate jeopardy before installing window alarms as a concession for purposes of this case that Petitioner's noncompliance no longer posed immediate jeopardy to resident health and safety as of January 9, 2015.

The parties' dispute centers not on the existence of the above-described facts, but rather on the legal significance of those facts.[4] Insofar as Petitioner attempts to raise factual disputes in its brief opposing summary judgment, my analysis in sections IV.B.2-IV.B.4, *infra*, shows that those disputes are not material to the issues I must decide. Consequently, I conclude that summary judgment is appropriate in this case.

2. Petitioner was not in substantial compliance with Medicare participation requirements.

a. Petitioner was not in substantial compliance with 42 C.F.R. § 483.13(c) (F224/F226) because it either failed to develop policies and procedures adequate to prevent neglect of Resident 6 or failed to implement its anti-neglect policy with respect to Resident 6.

A facility must develop and implement written policies and procedures prohibiting mistreatment, neglect, and abuse of residents and the misappropriation of residents' property. 42 C.F.R. § 483.13(c). The regulations define "neglect" as "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 42 C.F.R. § 488.301. Noncompliance with section 483.13(c) can be based on failure to develop policies or procedures adequate to prevent neglect, or it can be based on failure to implement such policies. *See, e.g.*, *Mississippi Care Ctr. of Greenville*, DAB No. 2450 at 14-15 (2012) (finding noncompliance with section 483.13(c) where a facility that relied on its exit door lock code and security camera systems to prevent elopement failed to develop written policies and procedures that were adequate to protect residents at risk of elopement).

CMS argues that Petitioner failed to comply with both aspects of section 483.13(c) through its failure to develop policies or procedures to deal with resident elopements and its failure to implement anti-neglect policies and procedures to protect Resident 6 from neglect. CMS Br. at 6-8. Petitioner responds that its anti-neglect policy was sufficiently comprehensive to satisfy section 483.13(c) and that it implemented adequate escalating interventions for Resident 6 to prevent his elopements in compliance with its anti-neglect policy. P. Br. at 11-14.

[4] In the "Summary of Argument" section of its brief, Petitioner appears to contend that the following questions are factual in nature: (1) whether Petitioner was in substantial compliance with the cited regulations, (2) whether the proposed CMP is reasonable, and (3) whether immediate jeopardy existed. P. Br. at 8-9. Petitioner is mistaken; these questions are legal in nature and are therefore susceptible to summary adjudication. It is the answers to these legal questions that control whether CMS is entitled to judgment as a matter of law.

Even when all inferences are drawn in Petitioner's favor, the undisputed facts do not demonstrate that Petitioner developed policies and procedures adequate to prevent neglect of Resident 6. Although Petitioner took multiple steps in an effort to prevent Resident 6 from eloping unobserved, those steps were not tailored to Resident 6's specific circumstances. For example, Petitioner documented that, at times, it provided Resident 6 with one-on-one supervision—which occasionally aided in preventing Resident 6 from eloping unobserved. Nevertheless, Resident 6 was able to elope unobserved through his bedroom window on multiple occasions. In spite of Resident 6's multiple elopements, Petitioner did nothing additional to decrease the possibility that he would do so again. Petitioner's anti-neglect policies thus appear to have been inadequate to minimize the risk of physical harm to residents, such as Resident 6, who may have attempted to elope unobserved through their bedroom windows. This strongly suggests that Petitioner's anti-neglect policies, such as they were, were inadequate to prevent neglect of facility residents.

Even assuming, however, that Petitioner's policies were generally adequate to prevent neglect of facility residents, Petitioner failed to implement those policies specifically with respect to Resident 6. As I have explained, the steps Petitioner took to protect Resident 6 were inadequate to protect him from the risk of physical harm posed by his continued unobserved elopements through his bedroom window. The most obvious step Petitioner could have taken to protect Resident 6 from that risk of harm would have been to place an alarm on his window that would alert staff if he again tried to escape through his window unobserved. Yet, Petitioner did not install window alarms until after the surveyor declared immediate jeopardy and after it discharged Resident 6. Thus, even if Petitioner had adequate anti-neglect policies and procedures, it failed to implement those policies and failed to provide the goods and services necessary to avoid physical harm to Resident 6. Moreover, as I explore more fully in section IV.B.3, *infra*, Petitioner's failure to develop or implement its anti-neglect policies posed immediate jeopardy to resident health and safety. Petitioner was therefore not in substantial compliance with section 483.13(c).

b. Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h) (F323) because it did not take all reasonable steps to mitigate the foreseeable risks of harm posed by Resident 6's unobserved elopements.

Subsection 483.25(h) is part of the quality of care regulation at 42 C.F.R. § 483.25, which states 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." Subsection 483.25(h) imposes specific obligations upon a facility related to accident hazards and accidents, as follows:

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

Appellate panels of the Departmental Appeals Board (DAB) have held that subsection 483.25(h)(2) requires that a facility take "all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents." *Briarwood Nursing Ctr.*, DAB No. 2115 at 11 (2007) (citing *Woodstock Care Ctr. v. Thompson*, 363 F.3d 583, 589 (6th Cir. 2003) (facility must take "all reasonable precautions against residents' accidents"), *aff'g, Woodstock Care Ctr.*, DAB No. 1726 (2000)). Facilities are given "the flexibility to choose the methods" they use to provide supervision or assistive devices to prevent accidents, so long as the chosen methods "constitute an 'adequate' level of supervision under all the circumstances." *Windsor Health Care Ctr.*, DAB No 1902 at 5 (2003), *aff'd, Windsor Health Care Ctr. v. Leavitt*, 127 F. App'x 843 (6th Cir. 2005) (unpublished).

Petitioner did not take all reasonable steps to ensure Resident 6, who suffered from non-Alzheimer's dementia and impaired decision-making, received adequate supervision and assistance devices to mitigate the foreseeable risks of harm he faced when eloping unobserved.[5] The undisputed facts viewed in Petitioner's favor show that Resident 6 continued eloping from the facility despite the steps Petitioner took to prevent further elopements. Furthermore, of the six elopement incidents involving Resident 6, at least three (12/21, 12/22, 12/31) involved Resident 6 eloping through his bedroom window unobserved and another involved him kicking out the screen of his bedroom window (12/25). Despite Resident 6's propensity to elope through his window unobserved, Petitioner took no specific steps to either prevent him from eloping through his window or, at a minimum, to alert facility staff when he was attempting to elope through the window. It was not until the state agency conducted its survey and declared immediate jeopardy—and after Resident 6 no longer lived in the facility—that Petitioner finally placed an alarm on Resident 6's window that would sound if anyone attempted to elope through the window again. Installing such an alarm was a reasonable step that Petitioner

[5] I discuss in more detail the risks of harm posed by Resident 6's unobserved elopements in my analysis of immediate jeopardy. See section IV.B.3, *infra*.

could have taken while Resident 6 lived at the facility to minimize the risk that he would elope from the facility unobserved, which would have had the added benefit of mitigating the risks of harm posed by such elopements.[6]

Petitioner makes two main arguments regarding why it substantially complied with 42 C.F.R. § 483.25(h). First, Petitioner contends that the measures it took to prevent Resident 6 from eloping were adequate. P. Br. at 14-15. Contrary to Petitioner's contention, the undisputed evidence demonstrates that Petitioner's measures were not adequate, as even the occasional one-on-one monitoring instituted after Resident 6's first elopement was insufficient to prevent him from eloping unobserved three additional times (on 12/21, 12/22, and 12/31). The fact that Petitioner's measures prevented or cut short other elopements by Resident 6 does not negate their fundamental inadequacy in preventing him from eloping unobserved.

Second, Petitioner contends that using a window alarm in addition to the measures it already took would not have prevented Resident 6 from eloping. P. Br. at 15-16. While this may be true, it is beside the point. The foreseeable risks of harm Petitioner was required to mitigate were the risks of harm attendant to Resident 6 eloping *unobserved*, not eloping in and of itself. Resident 6 was determined to elope from the facility and had the ability to do so even in the presence of facility staff, but so long as facility staff were aware of his attempts, they could take further steps to mitigate the risks of harm his

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[6] This is not to suggest that installing a window alarm was the *only* reasonable step Petitioner could have taken to mitigate the risks of harm to Resident 6. There may be other steps that might have been reasonable under the circumstances of this case, like installing new windows or devices in current windows that prevent residents from opening the windows more than a crack. *See, e.g., Briarwood Nursing Ctr.*, DAB CR1551 at 6 (2007) (discussing installation of "windows . . . that open no more than six to eight inches" as a measure to reduce the risk of elopement); *Sonogee Rehab. & Living Ctr.*, DAB CR754 (2001) (approving, among other anti-elopement measures, installation of chains on windows that "prevented them from opening to a greater distance than four to six inches"). This is also not to suggest that installing a window alarm in Resident 6's room, without more, would have been sufficient to comply with 42 C.F.R. § 483.25(h). *See Liberty Health & Rehab. of Indianola*, DAB CR2409 at 3 (2011) (observing that alarm "serves as a method for augmenting supervision" and does not relieve facility of "obligation to supervise elopement-prone residents"); *Cedar Lake Nursing Home*, DAB CR1967 at 8 (2009) (noting that "although an alarm system may be a useful tool, no system is fail-safe; alarms are no substitute for adequate staff supervision," especially where the alarms are proven to be faulty). Rather, I merely cite installation of window alarms as an example of a reasonable anti-elopement measure that Petitioner could have taken, but did not take, to protect Resident 6 after it became clear that the already-existing anti-elopement interventions were insufficient.

elopements posed. Resident 6 eloping unobserved prevented facility staff from taking those protective steps. Installing a window alarm was a reasonable step Petitioner could have taken to minimize the possibility that Resident 6 would elope unobserved through his window (as he was wont to do) and maximize the possibility that facility staff would become aware of and take protective steps to mitigate the risks of harm posed by Resident 6's attempted or actual elopements. Petitioner's failure to install a window alarm in spite of these facts rendered the measures it did take inadequate as a matter of law.[7]

Petitioner also argues in passing that CMS is taking a strict liability approach to compliance with § 483.25(h). P. Br. at 14. Petitioner seems to argue implicitly that, were I to conclude it was not in substantial compliance with § 483.25(h), I would be impermissibly holding it strictly liable for Resident 6's elopements. I am aware that appellate decisions of the DAB reject imposing strict liability on a facility merely because it fails to prevent an accident. *See, e.g.*, *Glenoaks Nursing Ctr.*, DAB No. 2522 at 8 (2013) ("Section 483.25(h) does not make a facility strictly liable for accidents that occur . . . ."). As my analysis shows, however, I am not concluding that Petitioner is strictly liable for Resident 6's elopements. Rather, I conclude that Petitioner did not comply substantially with section 483.25(h) because it failed to implement additional reasonable measures to mitigate the risks of harm Resident 6 faced when he eloped unobserved, which failure posed immediate jeopardy to Resident 6's health and safety, see section IV.B.3, *infra*. Had Petitioner taken adequate measures to mitigate those risks (e.g., by installing a working window alarm in Resident 6's bedroom window), the fact that Resident 6 successfully eloped in spite of those measures would not render Petitioner out of substantial compliance with § 483.25(h).

At bottom, I do not disagree with Petitioner's depiction of Resident 6 as a determined exit-seeker who was unusually well equipped (for a SNF resident) to elope. Petitioner was in a difficult position, especially considering the fact that the facility to which Petitioner initially attempted to transfer Resident 6 refused to admit him. Nevertheless, so long as Resident 6 resided at Petitioner's facility, Petitioner had a duty to take all reasonable steps to protect him from accidents. Accordingly, Petitioner was required to do more than it did to ensure that Resident 6 would not elope unobserved. It was fortuitous in this case that Resident 6 was never gone from the facility for more than an hour before being discovered and returned. And yet, that good fortune does not excuse Petitioner's failure to adequately supervise Resident 6 to mitigate the foreseeable risks of harm he faced from eloping unbeknownst to facility staff.

[7] Indeed, although Resident 6 resided in the facility's "secure unit," it is difficult to envision how the unit could be regarded as "secure" if a resident was able to open a ground floor window and exit the building.

c. I need not address CMS's contention that Petitioner was not in substantial compliance with 42 C.F.R. § 483.75 (F490) because it is not material to the outcome of this case.

Section 483.75 provides that "[a] facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." CMS argues that Petitioner's failure to substantially comply with §§ 483.13(c) and 483.25(h) demonstrates conclusively that Petitioner was not administered in a manner consistent with § 483.75 and thus that Petitioner was not in substantial compliance with § 483.75 as a matter of law. It is not clear to me that Petitioner's other deficiencies conclusively establish its noncompliance with § 483.75, but in any event I need not address this alleged deficiency. I am permitted, "in the interests of judicial economy, [to] review only those deficiencies that have a material impact on the outcome of the dispute." *Claiborne-Hughes Health Center v. Sebelius*, 609 F.3d 839, 847 (6th Cir. 2010). As my analysis in sections IV.B.3 and IV.B.4, *infra*, shows, Petitioner's noncompliance with §§ 483.13(c) and 483.25(h) suffices to establish the existence of immediate jeopardy and the reasonableness of the CMPs proposed by CMS. Petitioner's compliance (or not) with § 483.75 is therefore not material to the outcome of this case, and I thus decline to review it.

3. CMS's immediate jeopardy determination was not clearly erroneous.

CMS asserts that Petitioner's deficiency constituted a pattern of immediate jeopardy to resident health and safety (i.e., the "K" scope and severity level) from January 7 through January 8, 2015. CMS Br. at 2, 9-10; CMS Ex. 3 at 1, 16, 32. Petitioner argues that even if I were to find noncompliance, there is insufficient factual and legal justification for a finding of immediate jeopardy. P. Br. 18-21.

Immediate jeopardy exists if a facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. 42 C.F.R. § 488.301. The regulation does not require that a resident *actually* be harmed. *Lakeport Skilled Nursing Ctr.*, DAB No. 2435 at 8 (2012). I must uphold CMS's determination as to the level of a facility's substantial noncompliance (which includes an immediate jeopardy finding) unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The "clearly erroneous" standard imposes on facilities a heavy burden to overcome a finding of immediate jeopardy. Appellate panels of the DAB have sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *See, e.g.*, *Barbourville Nursing Home*, DAB No. 1962 at 11 (2005) (citing *Florence Park Care Ctr.*, DAB No. 1931 at 27-28 (2004)), *aff'd, Barbourville Nursing Home v. U.S. Dep't of Health & Human Servs.*, 174 F. App'x 932 (6th Cir. 2006).

In this case, CMS's finding of immediate jeopardy is not clearly erroneous. Resident 6 faced serious risks of harm when he eloped unobserved through his bedroom window. The facility itself recognized this harm when it determined his wandering placed him "at significant risk of getting to a potentially dangerous place." CMS Ex. 6 at 43. The record shows that despite freezing cold temperatures, Resident 6 eloped without a coat or proper footwear. Although facility staff observed his elopement without proper cold weather clothing and quickly returned him to the facility, he could easily have eloped unobserved while similarly attired, facing the possibility of hypothermia, frostbite, and even death. In addition, given his cognitive deficits and dementia, Resident 6 faced a host of other risks of harm from eloping unobserved (e.g., injuries from various causes, anxiety from unfamiliar surroundings, etc.), and he had diminished capacity to help himself if he were physically injured while away from the facility. He might also have unwittingly committed a crime (such as when he broke into a nearby house during his last elopement) and consequently faced legal repercussions, not to mention potential injury during a possible arrest. Any one of these risks standing alone may not have been "likely" to occur, notwithstanding the facility's documentation that the risk was "significant," but in the aggregate, the totality of risks that Resident 6 faced made it likely that he would suffer some form of serious injury, harm, impairment, or even death. This likelihood of harm directly stemmed from Petitioner's failure to substantially comply with 42 C.F.R. §§ 483.13(c) and 483.25(h). Consequently, I uphold CMS's immediate jeopardy determination.

Petitioner primarily argues that in declaring immediate jeopardy, CMS failed to account for all the steps Petitioner took to mitigate the risks of harm to Resident 6 (and the other residents of the secure unit) from elopement. P. Br. at 18-20. Petitioner adds that CMS did not sufficiently consider the "uniquely difficult elopement" problem posed by Resident 6 in assessing the proper scope and severity of Petitioner's deficiencies related to his elopements. P. Br. 20-21. I am not unsympathetic to the difficulties Petitioner faced in dealing with Resident 6, a spry and capable eloper who was determined to escape the facility to return home. Nonetheless, as I have already explained, Petitioner did not take all reasonable steps to mitigate the risks of harm to Resident 6 from his unobserved elopements, and as a result, Resident 6 faced serious and likely risks to his health and safety.

Petitioner also notes in passing that the surveyor initially gave the impression that she would not declare immediate jeopardy and only did so after talking to her supervisor. P. Br. at 21. Petitioner further notes that Resident 6's elopement from the facility to which it attempted to transfer him on December 31, 2014, was not cited at an immediate jeopardy level. *Id.* I accept these allegations as true for purposes of summary judgment. However, Petitioner has not explained how these facts support its position. My inquiry is confined to whether the undisputed facts in this case establish that CMS's determination of immediate jeopardy is not clearly erroneous. How (or whether) another facility was cited for Resident 6's elopement has no bearing on this inquiry. Moreover, the manner in

which the surveyor cited immediate jeopardy has no bearing on Petitioner's obligation to meet Medicare participation requirements, nor does it invalidate adequately documented deficiencies. 42 C.F.R. § 488.318(b).

4. The remedy proposed is reasonable in amount and duration.

Regarding the amount of the CMP, I examine whether a CMP is reasonable by applying the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of noncompliance; 2) the facility's financial condition; 3) the factors specified in 42 C.F.R. § 488.404; and 4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort, or safety. The absence of culpability is not a mitigating factor. The factors listed in § 488.404 include: 1) the scope and severity of the deficiency; 2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and 3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies. Unless a facility contends that a particular regulatory factor does not support the CMP amount that CMS proposed, the administrative law judge must sustain it. *Coquina Ctr.*, DAB No. 1860 at 32 (2002).

The regulations specify that a CMP that is imposed against a facility on a per-day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408; 488.438. The upper range of a CMP, $3,050 per day to $10,000 per day, is reserved for deficiencies that pose immediate jeopardy to a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. § 488.438(a)(1)(i), (d)(2). The lower range of a CMP, $50 to $3,000 per day, is reserved for deficiencies that do not pose immediate jeopardy, but either cause actual harm to residents, or cause no actual harm but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). In assessing the reasonableness of a CMP amount, an ALJ looks at the per-day amount, rather than the total accrued CMP. *See Kenton Healthcare, LLC*, DAB No. 2186 at 28 (2008). The regulations leave the decision regarding the choice of remedy to CMS, and the amount of the remedy to CMS and the ALJ, requiring only that the regulatory factors at §§ 488.438(f) and 488.404 be considered when determining the amount of a CMP within a particular range. 42 C.F.R. §§ 488.408; 488.408(g)(2); 498.3(d)(11); *see also* 42 C.F.R. § 488.438(e)(2) and (3); *Alexandria Place*, DAB No. 2245 at 27 (2009); *Kenton Healthcare, LLC*, DAB No. 2186 at 28-29.

CMS decided to propose per-day CMPs in this case, and I have found that the immediate jeopardy level of noncompliance was not clearly erroneous. For the period of Petitioner's immediate jeopardy level noncompliance, CMS proposed a CMP of $8,300 per day, which is in the middle-to-high range for immediate jeopardy level noncompliance. For the period of Petitioner's below immediate jeopardy level noncompliance, CMS proposed a CMP of $150 per day, which is in the low range for below immediate jeopardy level noncompliance.

CMS argues generally that the per-day CMPs proposed are reasonable because of the severity of Petitioner's noncompliance and the potential for immediate jeopardy caused thereby. CMS Br. 10. Petitioner contends that CMS's conclusory argument fails to establish the CMPs are reasonable as a matter of law. P. Br. 16-17. Petitioner also points out that there is no evidence in the record showing that CMS attempted to contact Adult Protective Services (APS) or the state long term care ombudsman as required by 42 C.F.R. § 488.431(a)(3). P. Br. 17-18. Petitioner contends that this failure to contact APS or the ombudsman[8] as a matter of law precludes me from concluding that the proposed CMPs are reasonable. P. Br. 18.

Petitioner does not specifically argue that any particular regulatory factor supports a reduction of the CMP amounts proposed by CMS. For that reason alone, I could conclude the CMPs are reasonable in amount and duration. *See Coquina Ctr.*, DAB No. 1860 at 32. However, Petitioner does point to the efforts it took to discharge Resident 6 prior to the immediate jeopardy determination, which would have mitigated the risks of harm arising from his elopements from the facility. P. Br. 17. Although Petitioner does not explicitly tie its efforts to any regulatory factor, implicit in the detailing of its efforts to discharge Resident 6 is the argument that those efforts reduce its culpability for its noncompliance, per the factor found at § 488.438(f)(4), and therefore render the proposed CMP amount unreasonable.

Amount. As my analysis in sections IV.B.2 and IV.B.3, *supra*, show, Petitioner's immediate jeopardy noncompliance was very serious. Despite the steps Petitioner took to mitigate the risks of harm to Resident 6 from his elopements, Resident 6 was able to elope from the facility unobserved in the middle of winter, and it was only by chance that he was not seriously injured or killed as a result of one of those unobserved elopements. Furthermore, Petitioner's noncompliance could have affected other residents who were elopement risks, leading to similar risks of harm to those residents had they been as determined to elope as was Resident 6. Consequently, I agree with CMS that the severity of Petitioner's immediate jeopardy noncompliance justifies a CMP in the middle-to-high range for immediate jeopardy noncompliance.

I accept for purposes of summary judgment not only that Petitioner took steps to discharge Resident 6 but also that Petitioner's efforts to discharge Resident 6 reduced to some degree its culpability for its noncompliance. Nonetheless, I still conclude as a matter of law that the CMP proposed for Petitioner's immediate jeopardy noncompliance was reasonable. Prior to discharging Resident 6, Petitioner had a responsibility to protect him—and all its residents who were at risk for elopement—from the significant risks attendant to unobserved elopements. Petitioner recognized these risks and still failed to take all reasonable steps to mitigate them. If anything, the reduction of Petitioner's

[8] Presumably, Petitioner wishes me to infer, for summary judgment purposes, that CMS failed to satisfy its regulatory obligation to contact APS or the ombudsman.

culpability for its very serious noncompliance is the only reason a CMP in the middle-to-high range, rather than a CMP in the high range, is an appropriate remedy for Petitioner's immediate jeopardy noncompliance. I therefore reject as a matter of law Petitioner's implicit contention that its reduced culpability precludes me from concluding that the CMP proposed by CMS for Petitioner's immediate jeopardy level noncompliance is reasonable.

Petitioner's other general arguments as to why I should not find the CMPs reasonable are similarly unavailing. First, although CMS does not go into great detail in arguing why the regulatory factors support the proposed CMPs, it does make a more-than-conclusory argument about why one of those factors (factor three, at 42 C.F.R. § 488.438(f)(3)) supports the proposed CMPs. Additionally, Petitioner provides no authority for the proposition that CMS's alleged failure to contact APS or the ombudsman as required under § 488.431(a)(3) undermines the reasonableness of the proposed CMPs.

Finally, aside from its general attacks on the reasonableness of the CMPs, Petitioner makes no specific argument as to why the per-day CMP proposed for its below immediate jeopardy level noncompliance ($150) is not reasonable in amount. Given that Petitioner had alleviated the immediate jeopardy situation by January 9, 2015, but had not fully returned to substantial compliance with §§ 483.13(c) and 483.25(h), a CMP in the low range of non-immediate jeopardy noncompliance is reasonable for Petitioner's continued noncompliance.

Duration. The parties' arguments about the reasonableness of the CMPs focus on the amount of the CMPs; they make no specific arguments about the reasonableness of the proposed duration of the CMPs. The duration for each per-day CMP is short: two days for the immediate jeopardy level CMP and four days for the below immediate jeopardy level CMP. The undisputed evidence supports the short duration of the CMPs. Once Petitioner became aware of its immediate jeopardy deficiencies, it took steps to correct them, including discharging Resident 6 from the facility and later installing alarms on the windows in the secure unit where Resident 6 had been living. Petitioner also provided contemporaneous in-service training to its staff regarding elopements. The record thus supports the reasonableness of the duration of the immediate jeopardy level CMP. As for the below immediate jeopardy level CMP, CMS submitted evidence that Petitioner returned to substantial compliance with Medicare participation requirements on January 13, 2015. CMS Ex. 9 at 1. Petitioner in turn failed to present evidence that it returned to substantial compliance prior to January 13, 2015. Petitioner has thus not raised a dispute of material fact as to the reasonableness of the duration of the proposed CMPs. I therefore conclude as a matter of law that the duration of the proposed CMPs is reasonable.

V. Conclusion

For the reasons set forth above, I sustain most of CMS's determinations. I conclude that Petitioner was not in substantial compliance with the participation requirements at 42 C.F.R. §§ 483.13(c) and 483.25(h). I further conclude that CMS did not clearly err in determining that Petitioner's noncompliance posed immediate jeopardy to resident health and safety. I finally conclude that the proposed CMPs, an $8,300.00 per day CMP effective January 7 through 8, 2015, and a $150.00 per day CMP effective January 9 through 12, 2015, a total CMP of $17,200, are reasonable. I do not, however, address CMS's determination that Petitioner was not in substantial compliance with the participation requirement at 42 C.F.R. § 483.75 because that determination is not material to the outcome of this case. In light of the foregoing, I grant CMS's motion for summary judgment.

/s/
Leslie A. Weyn
Administrative Law Judge