Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Liberty Health & Rehab of Indianola, LLC
Docket No. A-12-4
Decision No. 2434
December 30, 2011

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Liberty Health & Rehab of Indianola, LLC (Liberty) appealed the August 5, 2011 decision of Administrative Law Judge (ALJ) Steven T. Kessel. *Liberty Health & Rehab of Indianola, LLC*, DAB CR2409 (2010) (ALJ Decision). The ALJ concluded that Liberty was not in substantial compliance with Medicare program participation requirements from April 18, 2010 through May 4, 2010, due to violations of 42 C.F.R. §§ 483.25(h) (supervision/assistance devices), 483.13(c) (neglect), and 483.75 (administration). The ALJ also concluded that CMS's determination that Liberty's violation of these requirements posed immediate jeopardy from April 18, 2010 through May 4, 2010 was not clearly erroneous. He found reasonable CMS's imposition of a $5,000 per-day civil money penalty (CMP) during this period.

Liberty requested review of the ALJ Decision, contending that it contains both factual and legal errors.

For reasons explained below, we affirm the ALJ Decision in part and reverse it in part.

Applicable Law

The Social Security Act (Act) and federal regulations provide for state agencies to conduct surveys of each Medicare skilled nursing facility and Medicaid nursing facility to evaluate compliance with the Medicare and Medicaid participation requirements. Sections 1819 and 1919 of the Act; 42 C.F.R. Parts 483, 488, and 498.[1] The participation requirements are set forth at 42 C.F.R. Part 483, subpart B. A facility's failure to meet a participation requirement is called a "deficiency." 42 C.F.R. § 488.301. "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.*

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

"Noncompliance" is defined as "any deficiency that causes a facility to not be in substantial compliance." *Id.*

Surveyor findings are reported in a statement of deficiencies (SOD), which identifies each deficiency under its regulatory requirement.

A long-term care facility that is not in substantial compliance is subject to enforcement remedies, including CMPs. 42 C.F.R. §§ 488.402(c), 488.406, 488.408. CMS may impose either a per-instance or per-day CMP when a facility is not in substantial compliance. 42 C.F.R. § 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 immediate jeopardy to facility residents, CMS may impose a per-day CMP in an amount ranging from $3,050-$10,000 per day. 42 C.F.R. § 488.408(e)(1)(iii). The regulations set out several factors that CMS considers to determine the CMP amount. 42 C.F.R. §§ 488.438(f), 488.404.

Relevant Background

The following facts are drawn from both the record and the ALJ Decision and, except as noted, are undisputed.

Liberty is a skilled nursing facility located in Indianola, Mississippi that is authorized to participate in Medicare. The Mississippi state agency conducted a complaint survey at the facility ending on May 5, 2010.

Liberty is located on a busy four-lane state highway. CMS Ex. 21, at ¶¶ 16-19. To prevent elopement-prone residents from leaving the facility unsupervised, it relied in part on alarm devices known as Wanderguards, which were worn as bracelets by residents or attached to their wheelchairs. P. Ex. 1. "If a resident wearing a functioning Wanderguard approaches an exit door, the door locks . . . . The device also causes an alarm to sound if the resident approaches an opened facility door . . . ." ALJ Decision at 3, citing CMS Ex. 8, at 32. Facility policy required nurses to test the Wanderguards each shift. P. Ex. 1.

On April 18, 2010 staff found that three residents' Wanderguards were not functioning. CMS Ex. 13, at 1. Liberty was unable to provide replacement Wanderguards for two of these residents (R2 and R3) until four days later, April 22. *Id.* at 9. The ALJ found that on April 19, staff also determined that R1's Wanderguard had stopped working. ALJ Decision at 5. (As discussed below, Liberty disputes the ALJ's date finding.) On April 21, 2010, nurses on the 7 a.m. to 3 p.m. shift recorded on R1's Medication Administration Record (MAR) and the facility's "Change in Status-24 Hour Report" (24-Hour Report) that R1's Wanderguard was not working. CMS Ex. 4, at 40; CMS Ex. 13, at 7. It is undisputed that Liberty had no replacement Wanderguard for R1 on either

April 19 or April 21. One of these nurses testified that the staff then monitored R1's location in the facility every 15 minutes during the remainder of the shift. P. Ex. 15, at ¶ 6. At 3:55 p.m., after the shift change, R1 was reported by a visitor to be in her wheelchair on the highway in front of the facility. CMS Ex. 20, at 1. She was retrieved and found to be unharmed. *Id.*

Liberty reported R1's elopement to the state agency, which then conducted a survey on May 3 through May 5, 2010. *Id.* As a result of the survey, CMS ultimately determined that Liberty was not in substantial compliance with 42 C.F.R. §§ 483.13(c), 483.25(h), and 483.75 and that these violations posed immediate jeopardy to facility residents from April 21, 2010 through May 4, 2010. CMS Ex. 2. CMS imposed a $5,000 per-day CMP for those dates. *Id.* In its initial brief, CMS asserted that the first day of immediate jeopardy began April 18 rather than April 21 and requested the ALJ to uphold the imposition of a $5,000 per-day penalty for the period April 18 through May 4.[2] CMS Pre-Hearing Br. at 2.

Standard of Review

When the Board reviews an ALJ decision it may either issue a decision or remand the case. 42 C.F.R. § 498.88(a). Our standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. *Guidelines - Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs (Guidelines)*, http://www.hhs.gov/dab/divisions/appellate/guidelines/index.html. Our standard of review on a disputed finding of fact is whether the ALJ decision is supported by substantial evidence on the record as a whole. *Id.*

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).

[2] Initially, CMS imposed a $5,000 CMP for each day from April 21 through May 4, 2010 and a $100 CMP for each day thereafter through May 17, 2010 -- the day before CMS determined Liberty achieved substantial compliance. CMS Ex. 2, at 2; CMS Ex. 3. Subsequently, CMS stated that it was rescinding the $100 CMP because "CMS now believes that [Liberty] removed the immediate jeopardy and achieved substantial compliance on May 5, 2010." CMS Final Br. at 2-3, n.1.

Analysis

I. The ALJ's determination that Liberty failed to comply substantially with 42 C.F.R. §§ 483.13(c) (neglect), 483.25(h) (supervision/assistance devices), and 483.75 (administration) is free of legal error and supported by substantial evidence in the record as a whole.

A. Section 483.25(h)(2) - supervision/assistance devices

Section 483.25(h)(2) of 42 C.F.R. 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."[3] This provision is part of the quality of care regulation at section 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 addressed the requirements of section 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).

On the basis of the following undisputed facts and factual findings by the ALJ, we conclude that the ALJ correctly determined that Liberty failed to provide adequate supervision and assistance devices to residents who were at risk of elopement on April 18 and that this failure posed a risk of more than minimal harm to these residents.

- Liberty was located on a busy state highway. CMS Ex. 1, at 3. The surveyor determined the highway was approximately 79 steps from the facility's front door. *Id.* As of April 2010, Liberty cared for some 18 residents whom it evaluated as at

[3] 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.

risk for elopement. CMS Ex. 11. Liberty had six unlocked, unmonitored exit doors.[4] CMS Ex. 8, at 25; ALJ Decision at 6.

- Liberty relied in large measure on Wanderguards to safeguard these residents. Nurses were required to test the Wanderguards each shift. P. Ex. 1. If a Wanderguard was found to be not working and was not replaced immediately, Liberty asserted and the ALJ accepted, that Liberty's Elopement Risk Reduction Plan (ERRP) required staff to complete visual checks of the resident every 30 minutes and document those checks until a functioning Wanderguard was supplied. P. Br. in Lieu of Hearing, at 9; ALJ Decision at 7; P. Ex. 1; Request for Review (RR) at 10.[5]

- On April 18, 2010, three residents' (R2, R3, and J.P.) Wanderguards stopped working; on April 19, R1's Wanderguard stopped working. ALJ Decision at 5, 8. Liberty was unable to immediately locate functioning replacement Wanderguards for any of these residents. Eventually, it replaced J.P.'s Wanderguard sometime prior to April 21, replaced R1's Wanderguard on April 21, and replaced R2's and R3's Wanderguards on April 22.[6] CMS. Ex. 13, at 9; P. Ex. 15, at ¶ 5; CMS Ex. 12, at 1, 3.

- As to R2 and R3, Liberty does not dispute that it did not conduct documented visual checks of their locations until April 21, three days after the failure of their Wanderguards. While Liberty asserts that its staff monitored R2's and R3's whereabouts on April 19 and 20, it provided no testimonial or other evidence to support that assertion, and the ALJ correctly found it to be unsupported. ALJ Decision at 7.

- R1 was identified by Liberty's staff as a wanderer; she voiced a desire to go home; she wandered "nearly constantly and was oblivious to risks to her personal safety"; on April 4 she had been found in Liberty's parking lot; on April 12 she had been

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[4] The ALJ suggested there may have been eight exit doors, as does CMS. ALJ Decision at 6, n.4, citing CMS Ex. 8, P. Ex. 11; CMS Br. at 8. Liberty explained that there were only six exit doors with the Wanderguard system. P. Reply at 3, n.1, citing CMS Ex. 8, at 25. As to two other exit doors that appear in the door monitoring Logbook, one only opened if the fire alarm was activated and other, the therapy exit, had a manual keypad. *Id.* All were checked regularly for proper function and appear on the Logbook. *Id.,* citing P. Ex. 11.

[5] The ERRP set forth other measures intended to reduce the risk of elopement. These included regularly assessing residents and care planning for those at risk of elopement, photographing at risk residents, requiring staff to familiarize themselves with at-risk residents, and conducting 30-minute visual checks of residents who "have changes in behavior related to exit seeking" and documenting those checks. P. Ex. 1.

[6] Since the surveyor did not collect further information about J.P. and the facts related to R1, R2, and R3 provide an ample basis for upholding the ALJ's decision, we do not discuss J.P. further. CMS Ex. 12, at 1.

hospitalized with an apparent episode of syncope (sudden loss of consciousness) in which she stopped breathing. ALJ Decision at 4, citing CMS Ex. 4 at 17-19; 46. R1's orders provided for replacing any "missing" Wanderguard "immediately" and for "monitor[ing every] 15 minute until [Wanderguard] is in place." CMS Ex. 4, at 34. Liberty does not dispute that it did not institute any monitoring of R1 until April 21, which the ALJ found was two days after the failure of her Wanderguard. ALJ Decision at 5.

- Licensed Practical Nurse (LPN) Worship testified that at approximately 10 a.m. on April 21 she determined that R1's Wanderguard was not working. P. Ex. 15, at ¶ 5. The staff on the 7 a.m. to 3 p.m. shift thereafter documented that they were monitoring R1 at 30-minute intervals. CMS Ex. 8, at 68. LPN Worship also testified that she kept R1 with her for the remainder of the shift. CMS Ex. 4, at 68; P. Ex. 15, at ¶ 6. A registered nurse on duty that shift also wrote on the 24-Hour Report for April 21 that R1's Wanderguard was "not working." CMS Ex. 13, at 7; CMS Ex. 8, at 5.

- There are conflicting statements by staff about what information was transmitted orally to the oncoming 3 to 11 p.m. shift about monitoring R1. The outgoing LPN, LPN Wisdom, says she told the incoming LPN that R1 did not have a Wanderguard and needed monitoring; the incoming LPN denies this. CMS Ex. 8, at 5, 7, 14, 30, 33; CMS Ex. 4, at 51. However, irrespective of what was said to whom, there is no evidence to show the staff on the following shift continued the recently instituted monitoring of R1. Thus, while three staff members on the 3 to 11 shift stated that they remembered seeing R1 at 3:20 or 3:30 p.m., not one of them stated that she understood herself to be responsible for visually monitoring R1 to prevent her elopement. CMS Ex. 8, p. 17; CMS Ex. 10, at 3-5. Indeed, the Certified Nursing Assistant (CNA) who was doing rounds on the West or "A" Wing of the facility (R1 lived on the East of "B" Wing (CMS Ex. 11, at 1)) reported seeing R1 there at 3:30, merely telling R1 to "go around on the other side" (CMS Ex. 8, at 17) and last seeing R1 "rolling her chair toward B Wing" (CMS Ex. 10, at 5).

- At 3:55 p.m., a facility visitor reported seeing R1 outside in her wheelchair. CMS Ex. 20, at 1. Staff immediately retrieved R1 from "the turning lane of Hwy 82 nearest to the facility approximately 3 feet from the curb that ends facility property." *Id.* She was unharmed. *Id.*

These facts establish that Liberty failed to provide, in the first instance, assistance devices that it had determined the residents needed, and, in the absence of assistance devices, adequate supervision in accordance with the ERRP to mitigate the foreseeable risk of elopement by these residents, particularly R1.

On appeal, Liberty argues that specific ALJ factual findings are not supported by substantial evidence in the record as a whole and that these unsupported findings were material to the ALJ's conclusion that it was not in substantial compliance with section 483.25(h)(2) and other program requirements. Below we discuss Liberty's exceptions to the ALJ's findings and why they do not alter our conclusion that the ALJ correctly determined that Liberty was not in substantial compliance with section 425.83(h)(2).

First, Liberty contends that the ALJ erred in finding that R1's Wanderguard was not functioning properly on April 19 and 20 and that, therefore, monitoring was required for R1 on those days. RR at 13-14. We disagree with Liberty's contention. As discussed below, the ALJ's finding was based staff's entries on R1's MAR, the surveyor's testimony about the significance of those entries, and the absence of other evidence about the significance of the entries.

Liberty's policy required nurses to test each resident's Wanderguard once a shift. P. Ex. 1. The nurses documented that they had conducted this testing by writing their initials on the resident's MAR. CMS Ex. 4, at 39. On R1's MAR for the 3 to 11 shift on April 19th and 20th and the 7 to 3 shift on the 20th, the nurse testing the Wanderguard wrote and then circled her initials. *Id.* The ALJ found that the circled initials showed that the nurses were noting that the Wanderguard was not working. In making this finding, the ALJ relied on the surveyor's testimony stating that circled initials on a MAR indicate that "the resident did not receive the medication or device that had been prescribed to him or her." ALJ Decision at 8, citing CMS Ex. 13, at ¶ 13. The ALJ noted that Liberty did not produce the testimony of the nurse who circled her initials or other staff to testify that the "circled initials mean anything other than that which [the surveyor] infers that they mean." *Id.* In the absence of any contrary evidence, the ALJ rejected Liberty's assertion that the surveyor's testimony was "nothing more than supposition" and reasonably concluded that the surveyor was qualified "to testify about common nursing practice." *Id.*, citing P. Final Br. at 13.

The following additional considerations support the ALJ's reliance on the surveyor's testimony. When LPN Worship tested R1's Wanderguard on April 21 and found it was not working, she circled her initials on the MAR when reporting her finding. CMS Ex. 4, at 39. Second, the "instructions" on Liberty's form titled "Nurse's Notes/Medication Information" indicate that nurses are to circle their initials where the medication or service was not received as ordered. CMS Ex. 4, at 38, 40. Third, the surveyor's notes stated that a registered nurse who worked on Monday April 19 told the surveyor that she knew as of April 19 that R1's, R2's and R3's Wanderguards were not working, which is consistent with the circled initials on R1's MAR for that day. CMS 8, at 13.

Nor do we find persuasive the evidence that Liberty cites in support of its position. That evidence is the lack of any reference to a Wanderguard problem in R1's nurses' notes for April 19 (CMS Ex. 4, p. 48) and April 20 (CMS Ex. 4, p. 50); the lack of any report of a

Wanderguard problem for R1 on the 24-Hour Report (CMS Ex. 13, pp. 2, 5); and a statement by an LPN to the surveyor that she tested R1's Wanderguard on the 11 p.m. to 7 a.m. shift on April 19 and 20 and it was working (CMS Ex. 8, at 27). RR at 14.

The cited evidence does not show that R1's Wanderguard was working on these dates. First, the absence of information on the 24-Hour Report (or nurses' notes) about its not working is consistent with the fact that, on these days, the staff also did not record on the report that R2's and R3's Wanderguards were not working. CMS Ex. 13, at 3-6. Moreover, the best evidence as to what the other LPNs meant by circling their initials on the MAR would have been their testimony -- testimony Liberty presumably could have submitted but did not. Finally, the content of the LPN's statement casts doubt on her credibility. She states that on April 19 and 20 she tested and found R1's, R2's and R3's Wanderguards to be working. CMS Ex. 8, at 27. However, it is undisputed that R2's and R3's Wanderguards were **not** working on these days. This fact raises a question as to whether this LPN actually failed to test her residents' Wanderguards on April 19 and 20 but then did not want to admit this failure to the surveyor. Given these considerations, the ALJ could reasonably rely on other evidence here and disregard this LPN's unsworn statement in finding that R1's Wanderguard was not working properly as of April 19.

Therefore, we conclude that the ALJ's finding that staff determined that R1's Wanderguard was not working as of April 19 is supported by substantial evidence in the record as a whole.

Second, while Liberty concedes that R2's and R3's Wanderguards were not working as of April 18, it argues that the ALJ erred in rejecting its assertion that staff instituted 15-minute monitoring for these residents on April 18 that "continued until the Wanderguard bracelets for each resident could be replaced [on April 22]." RR at 9.

As to the staff's care of R2 and R3 on April 18 through 21, Liberty relies on the testimony of LPN Worship, who was on duty on the 7 to 3 shift on April 18 and 21 (but not the 19th and 20th) and, who, on the 18th, found that R2's and R3's Wanderguards were not working. P. Ex. 15, at ¶ 4. LPN Worship stated that she took the following actions in response to her findings.

> At that time, I notified the weekend RN Supervisor . . . [Stevenson] that the bracelets weren't working. I also notified the CNAs working with me on the 7-3 shift to monitor these residents every 15 minutes and keep an eye on them throughout the shift, and asked the CNAs about these residents repeatedly throughout the shift. That morning I also documented on the 24-hour report that their Wanderguards were not working, to monitor them every 15 minutes, and that the staff was aware. None of these three residents made any attempt to exit the

> facility during the 7-3 shift that day. Upon shift change, I informed the oncoming 3-11 shift LPN that these 3 Wanderguards were not working.

Id.

Liberty also relies on a 24-Hour Report dated April 18, 2010. RR at 9, citing CMS Ex. 13, at 1. This document corroborates LPN Worship's testimony that she reported the Wanderguard failures on the April 18 24-Hour Report and stated on the report that these residents should be monitored at 15-minute intervals and that "staff [are] aware." *Id.* Finally, Liberty relies on the CMS surveyor's notes that indicate that nurses documented on R2's and R3's MARs for April 18-22 that their Wanderguards were not working. RR at 9, citing CMS Ex. 8, at 19.

Liberty argues that this evidence shows that it conducted 15-minute surveillance for R2 and R3 as of April 18 and through April 22. RR at 22-23.

For the following reasons, we disagree and conclude that the ALJ correctly found that Liberty failed to prove that its staff monitored R2 and R3 over this entire time.[7]

- Liberty staff did not **document** that they were checking R2 and R3 at regular intervals on April 18, 19, 20, or 21 prior to R1's elopement. As the ALJ pointed out, the ERRP provided that the staff was "to complete a visual check of [these residents] at 30-minute intervals and to sign off on the resident's ADL (activities of daily living) Flow Sheet (or Observation Monitoring Form) at the end of each shift."[8] *Id.* ALJ Decision at 7, citing P. Ex. 1. Liberty provided no ADL Flow Sheets or Observation Monitoring Forms (Monitoring Forms) of its alleged visual

[7] Because we conclude the ALJ correctly found Liberty failed to monitor R1 on April 19 and 20 and R2 and R3 on April 19, 20, and 21, we do not address the ALJ's additional finding that Liberty failed to monitor R1 at 15-minute intervals between 10 a.m. and 3 p.m. on April 21. ALJ Decision at 5-6. Similarly, because we find Liberty did not provide the care called for in the ERRP and R1's orders, we do not review the ALJ's statements about additional measures (such as placing monitors on all doors) that Liberty could have adopted. ALJ Decision at 6-7.

[8] Liberty complains that the ALJ improperly construed its policy to require contemporaneous documentation of each observation on a Monitoring Form. RR at 13; P. Reply at 4. It contends that the policy did not "require[] documentation of this monitoring any more frequently than once per shift (P. Reply at 4) and that testimonial evidence of monitoring has been found to be sufficient in other cases where there was not contemporaneous documentation (RR at 13). We need not address these arguments. As discussed above, for April 19 and 20 and part of April 21, Liberty did not provide even once-a-shift documentation or testimonial evidence of monitoring for R1, R2 and R3. We note also that the form Liberty ultimately used when it did institute monitoring, which is titled "Observation Monitoring for [name]," calls for signed entries by the CNAs at 30-minute intervals describing the "Location of Resident" and "Status of Resident" and an "Every Shift Nurse Sig." *See, e.g.,* CMS Ex. 4, at 64. Liberty's assertion that its policy required only that a nurse sign at the end of a shift would not satisfy the expectations established by the form itself. Moreover, the Director of Nursing told the surveyor that the staff "should have observation sheet [every] 30 [minutes] until new [Wanderguard] put on" and that the "observation monitoring form is [with] the elopement risk reduction plan." CMS Ex. 8, at 19, 21.

checks (30-minute or otherwise) of R2 and R3 for April 18, 19, and 20, and the morning of April 21. Liberty provided Monitoring Forms for R2 and R3 for April 21 and 22, forms that were started after R1 eloped the afternoon of April 21. *Id.* citing P. Ex. 12; P. Ex. 13. Finally, even if staff noted the absence of Wanderguards on R2's and R3's MARs, that does not show that staff were monitoring the residents.

- Liberty presented no **testimony** from staff to support its assertion that they were making visual checks of R2 and R3 every 30 minutes on April 19, 20, and prior to R1's elopement on April 21. Liberty asserts that the ALJ "wrongly dismissed" the testimony of LPN Worship about her actions on April 18 after discovering that R2 and R3's Wanderguards did not work. RR at 11. To the extent the ALJ did not address LPN Worship's testimony, this failure would constitute harmless error because her testimony concerns only whether R2 and R3 were monitored during her shift on April 18; it does not show that staff monitored these residents on April 19 and 20, days LPN Worship did not work. Certainly we reject Liberty's assertion on appeal that LPN Worship's "notification of the next shift" on the April 18 24-Hour Report that R2 and R3 should be monitored every 15 minutes "clearly shows a **continuation** of the intervention beyond that initial 7a-3p shift." RR at 12 (emphasis added). Rather, we conclude that the ALJ could reasonably conclude that, in the absence of documentation or testimony that Liberty was monitoring R2 and R3 after the 18th and before the 3 to 11 shift on April 21, Liberty had failed to show that staff was monitoring R2 and R3 on April 19, 20, and part of April 21.

- Liberty cites a statement from an LPN who worked on the 11 to 7 shift on April 18 and 21. RR at 11, 24, citing CMS Ex. 8, at 28. According to the surveyor's notes, the LPN stated, "We were checking these residents [every] 15 min. We don't document unless they make an attempt to get out." CMS Ex. 8, at 28. Even assuming the LPN was talking about staff actions on the 18th and not the 21st (which the notes do not make clear), this LPN was also not on duty the 19th and 20th. Her statement provides no basis for concluding that she had knowledge about what happened on those days.

- When LPN Worship returned to the facility on April 21, she did institute a Monitoring Form for R1 (CMS Ex. 4, at 68), but neither she nor any other staff instituted a Monitoring Form for R2 and R3 until after R1's elopement during the 3 to 11 shift. The absence of documentation of monitoring for R2 and R3 during the 7 to 3 shift on April 21 tends to show that staff was not monitoring the residents' locations at regular intervals prior to R1's elopement on that day or the prior days.

- Liberty also cites the fact that staff wrote on R2's and R3's MARs on April 19 through 21 that the residents were without functioning Wanderguards. RR at 9. This fact does not show that staff were also making regular visual checks of these residents, particularly in the absence of any other evidence that they were.

Therefore, the ALJ reasonably concluded that Liberty failed to prove that the staff monitored R2 and R3 for elopement on April 19 and 20 or on April 21 prior to R1's elopement.

For the preceding reasons, we conclude that Liberty's arguments that these findings are not supported by substantial evidence in the record as a whole are without merit.

B. 42 C.F.R. § 483.13(c) – neglect

Section 483.13(c) states that a facility "must develop **and implement** written policies and procedures that prohibit mistreatment, neglect and abuse of residents," with "neglect" defined to mean the "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 42 C.F.R. §§ 483.13(c); 488.301 (emphasis added).

The ALJ concluded that Liberty "had developed policies to protect its residents against the risks of elopement [i.e., the ERRP]." ALJ Decision at 3. However, the ALJ also concluded, Liberty failed to implement significant parts of that policy for multiple residents over multiple days. *Id.*

The ERRP required Liberty to identify residents at risk for elopement and to provide needed "systems," which could include Wanderguards. P. Ex. 1. Here Liberty's system for protecting R1, R2, and R3 did include Wanderguards. However, when these Wanderguards failed, Liberty was not only unable to replace them for days, but then failed to implement ERRP monitoring requirements for protecting residents who needed but did not have a Wanderguard by conducting regular documented visual checks over most of time prior to R1's elopement. As discussed above, Liberty's arguments to the contrary rest on allegations about its staff's actions that are not supported by evidence in the record.

As the ALJ concluded, the evidence here establishes that there was a "systemic problem at Petitioner's facility consisting of a failure to implement policies and procedures intended to protect these residents from harm." ALJ Decision at 10. Liberty's failure to follow the ERRP involved at least three residents and multiple staff members over four days and gives rise to an inference that Liberty did not implement key parts of its policy. As the Board has repeatedly held, "'multiple or sufficient examples of neglect may support a reasonable inference that a facility has failed to develop or implement policies and procedures that prohibit neglect.'" *Oceanside Nursing and Rehabilitation Center,*

DAB No. 2382, at 11 (2011); *Columbus Nursing and Rehabilitation Center,* DAB No. 2398 (2011). Here, as in *Oceanside,* the "facts found by the ALJ surrounding such instance(s) demonstrate an underlying breakdown in the facility's implementation of the provisions of an anti-neglect policy." *Oceanside* at 11.

C. 42 C.F.R. § 483.75 – Administration

Section 483.75 provides in pertinent part:

> 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.

We agree with the ALJ that the circumstances here establish that Liberty was not administered in a manner that enabled it to use its resources effectively and efficiently. Although Liberty objects that the ALJ relied on the same analysis to support his conclusion on noncompliance with all three cited requirements, the Board has held that, in appropriate circumstances, a finding of noncompliance with section 483.75 may be derived from findings of noncompliance with other participation requirements. *Stone County Nursing and Rehabilitation Center*, DAB No. 2276, at 15-16 (2009) (citing decisions). Moreover, evidence in addition to that specifically cited by the ALJ supports a finding of noncompliance with section 483.75 here.

As the ALJ noted, Liberty, which was located on a dangerous highway, instituted an elopement prevention system based in large measure on Wanderguards. Liberty relied on 90-day Wanderguards (CSM Ex. 8, at 25), guaranteeing that the devices would become unreliable at fairly short regular intervals and need to be replaced. In spite of these considerations, Liberty's management failed to ensure that the facility maintained an adequate supply of this critical assistance device. Indeed, the surveyor's notes state that the Director of Nursing (DON) reported that, prior to this event, there was no system for monitoring whether the Wanderguard supply was adequate and when more needed to be purchased. *Id.* at 22. Thus, when three Wanderguards failed on April 18 and one failed on April 19, Liberty had no timely replacements. This failure represented a failure to use resources effectively and efficiently since it deprived the staff of a resource that it needed to care for residents.

In addition, the lack of the Wanderguards not only threatened the staff's ability to maintain residents' safety, it also diverted staff resources from routine resident care. The ERRP required the staff to implement and document a system of regular visual checks, duties that would necessarily reduce its ability to provide routine care to other residents. Additionally, in this case nurses drove to other facilities in neighboring towns on April 21 in an ultimately futile search for Wanderguards that were compatible with the Liberty system, another waste of staff resources. CMS Ex. 8, at 11. The staff did this without

consulting with the Administrator or the DON, who were away attending a conference but who said they could have been reached by cell phone. CMS Ex. 8, at 17, 26.

Finally, Liberty presented no evidence to show that anyone in management sought to timely check whether the staff was implementing the ERRP monitoring requirements despite the multiple Wanderguard failures and lack of replacements.

II. We affirm the ALJ's conclusion that CMS's determination that Liberty's noncompliance posed immediate jeopardy was not clearly erroneous and affirm in part and reverse in part his conclusion regarding the duration of the immediate jeopardy.

A. The ALJ correctly upheld CMS's determination that immediate jeopardy existed as of April 18.

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 regulations require that "CMS's determination as to the level of noncompliance of [a skilled nursing facility] must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c). Under that standard, CMS's determination of immediate jeopardy (including the duration of the immediate jeopardy) is presumed to be correct, and Liberty has a heavy burden to demonstrate clear error in that determination,. *Brian Center Health and Rehabilitation/Goldsboro*, DAB No. 2336, at 9 (2010), citing *Barbourville Nursing Home*, DAB No. 1962, at 11 (2005), *aff'd*, *Barbourville Nursing Home v. U.S. Dep't of Health & Human Servs.*, 174 F. App'x 932 (6th Cir. 2006).

There are important reasons for applying the "clearly erroneous" standard to CMS's determination of the level of noncompliance. "[D]istinctions between different levels of noncompliance, whether measured in terms of their frequency or seriousness, do not represent mathematical judgments for which there are clear or objectively measured boundaries." *Medicare and Medicaid Programs; Survey, Certification and Enforcement of Skilled Nursing Facilities and Nursing Facilities,* 59 Fed. Reg. 56,116, 56,179 (Nov. 10, 1994). This is why CMS's immediate jeopardy determination, where it is a matter of professional judgment and expertise, is entitled to deference. *Id.* ("Survey team members and their supervisors ought to have some degree of flexibility, and deference, in applying their expertise in working with these less than perfectly precise concepts"). As the Board stated in *Daughters of Miriam Center*, DAB No. 2067, at 10 (2007), the "boundary between 'likelihood' and mere 'possibility' or 'potential' is a matter of degree and may be difficult to discern in the context of a particular dispute."

The ALJ correctly concluded that CMS's determination that immediate jeopardy existed as of April 18, 2010 was not clearly erroneous. The evidence establishes that a resident

eloping from Liberty faced immediate serious danger if he or she ventured to the highway fronting the facility; that Liberty had six unlocked, unmonitored exit doors; that Liberty's elopement prevention strategy depended in large measure on Wanderguards; that Liberty was not prepared to promptly replace malfunctioning Wanderguards for residents it had assessed as needing them; that, when it could not replace these Wanderguards, Liberty repeatedly failed to effectively implement the monitoring required by its ERRP and R1's physician orders; and that R1 eloped while not wearing a Wanderguard and not being monitored as required by Liberty's policy or her orders. Exacerbating these considerations further was the fact that R1 suffered from dementia, syncope (sudden loss of consciousness) and was "oblivious to risks to her personal safety." ALJ Decision at 4. She was also described by staff as "fast" in her wheelchair (CMS Ex. 1, at 11) and as having "a habit of trying to get out" (CMS Ex. 8, at 16). Plainly, it was not clearly erroneous of CMS to conclude that Liberty's noncompliance was likely to cause serious injury, harm, impairment, or death to a resident.

B. The ALJ did not err in rejecting Liberty's argument that immediate jeopardy was removed by April 21.

Liberty argues that the possibility of serious harm from the situation was "that of elopement and resultant exposure to hazards outside the Facility" and that, by April 21, Liberty had taken steps that "went to the heart of the alleged" immediate jeopardy. RR at 32-34. Specifically, Liberty alleges (and CMS does not deny) that Liberty took the following steps on April 21, after retrieving R1 and redirecting her back to the facility at 3:55 p.m.:

- At 4:00 p.m., started a 24-hour 1-on-1 CNA observation of R1, with additional 15-minute checks by licensed nursing staff;
- Immediately notified R1's physician and responsible party;
- Investigated the incident and documented it in R1's record;
- Had R1's MAR reviewed by the LPN Supervisor and RN Staff Development Coordinator for accuracy and completion;
- Obtained a new working Wanderguard, tested it, and placed it on R1 at approximately 7:15 p.m.;

- Put monitoring in place for R2 and R3 until they received new Wanderguards at 11:00 a.m. on April 22;[9]

- Had the ADON, LPN Supervisor, and RN Staff Development Coordinator check all exit door alarms for proper function;

- Had the Social Services Director check the list of residents at risk for elopement in the ADL and MAR books for completeness and accuracy;

- Had the LPN Supervisor and RN Staff Development Coordinator audit the Elopement Risk Book for accuracy;

- Reviewed care plans for all at-risk residents and updated them as necessary;

- Had the ADON and LPN Supervisor check all residents with Wanderguard bracelets for proper placement and function;

- Had the medical records RN perform an audit of all Wanderguards in the facility;

- Had the LPN Supervisor draft a Continuous Quality Improvement Corrective Action Plan;

- Had the RN Staff Development Coordinator hold an in-service training for all on-duty licensed nurses and CNAs regarding Liberty's ERRP policy, including information related to the facility policy and procedure, as well as required checks and documentation to be completed by the staff and an elopement drill to ensure that the staff knew what to do if a resident did elope; and

- Determined that licensed staff would not be allowed to work until they received the in-service training.

RR at 28-29. The SOD lists all these actions as part of the survey findings, which indicates that the surveyor had verified that they had been taken. CMS Ex. 1, at 48.

CMS's determination that these actions on April 21 were not sufficient to remove the immediate jeopardy was not clearly erroneous. These actions do not prove that Liberty had, by April 21, addressed a key systemic problem causing the immediate jeopardy – the reliance on Wanderguards without an adequate supply of Wanderguards and a means to

[9] The record is unclear whether this was 15-minute or 30-minute intervals. P. Exs. 12, 13 (monitoring sheets at 30 minute intervals); P. Ex. 14, at 2.

protect residents if their Wanderguards failed. Thus, it is undisputed that, as of April 21, Liberty still did not have replacement Wanderguards for R2 and R3 or any additional residents whose Wanderguards could malfunction. Liberty points to evidence to the effect that these two residents were not truly at risk of elopement, but the ALJ reasonably disregarded this evidence as inconsistent with Liberty's own evaluation of the residents. ALJ Decision at 9. Moreover, even if R2 and R3 were at low risk for elopement, the evidence shows that Liberty identified up to 18 of its residents as needing Wanderguards as of that date, and the evidence does not establish that only R1 was a high risk for elopement. Additionally, as discussed below, the evidence indicates that, in addition to R2 and R3, one of these 18 residents did not have a Wanderguard until April 28.

While Liberty's policy of putting monitoring in place if a Wanderguard could not be replaced might provide some protection, the risk of having several Wanderguards fail within a short period, as had recently happened, increased the likelihood that monitoring alone might not be enough, particularly since Liberty had six doors through which a resident could exit. Finally, in this particular case, CMS reasonably relies on the likelihood that, once a resident eloped, serious harm could quickly ensue, given the proximity of the dangerous highway and resident characteristics such as dementia and syncope.

Liberty's actions on April 21 were not, as the ALJ implies in his decision, all "designed uniquely to provide special protection to [R1]." ALJ Decision at 10. But, whether immediate jeopardy continued to exist depended on the likelihood of serious harm to any resident, and so the corrective actions had to address more than just the residents involved in the incident or incidents that brought the noncompliance to a surveyor's attention.

C. CMS's determination that immediate jeopardy continued after April 28 is based on clear legal error and is not factually supported.

Below, we first provide some relevant background. We then discuss why we conclude that the analysis by the ALJ and CMS's key arguments are based on an erroneous legal standard. Next, we address the issues regarding the sufficiency of actions Liberty took prior to May 5 to remove the immediate jeopardy, explaining how some of CMS's new assertions before us are premised on factual or legal errors. Based on our analysis applying the correct legal standard, we affirm the ALJ's conclusion regarding duration of the immediate jeopardy in part and reverse it in part, concluding that Liberty met its heavy burden to prove that CMS clearly erred in continuing the immediate jeopardy beyond April 28, but did not meet that burden with respect to any earlier period.

Liberty asserts and the record shows that it took the following additional steps by April 28 (which were verified by the surveyor, and CMS did not dispute below). On April 22, Liberty provided additional in-service training and another elopement drill (CMS Ex. 1, at 20) and did a second audit of Wanderguards (CMS Ex. 12, at 2). The audit document shows that, by then, R2 and R3 had Wanderguards, as did all other 16 residents on the

audit list except a resident with the initials D.K. CMS Ex. 12, at 2. The document noted that the facility had eight replacement Wanderguards at the time, with two Wanderguards on each medication cart. On April 23, Liberty held a quality assurance meeting via telephone with the Administrator, DON, and Medical Director to "discuss the specifics of the incident involving [R1]" and "findings during initial facility investigation." P. Ex. 5. On April 26, Liberty revised all MARs for residents with Wanderguards to give specific instructions on the facility's monitoring procedure in the event a Wanderguard was deemed inoperable. CMS Ex. 20, at 3; CMS Ex. 1, at 49. On April 28, Liberty did another audit of Wanderguards, checking that each of the residents needing them had Wanderguards and noting that the facility had 11 replacements. CMS Ex. 12, at 2.

Liberty points out that it took these steps before the survey and that, on May 3 after the surveyor declared immediate jeopardy, Liberty submitted to the state survey agency a letter alleging compliance based on these steps it had already taken. Liberty notes that this letter described as "additional enhancements" the following: on April 22, Liberty contacted Systronic Systems to schedule installation of manual key pads on all exit doors that did not already have one, and, on April 26, Liberty ordered new one-year Wanderguards to replace all existing 90-day bracelets. CMS Ex. 20; CMS Ex. 8, at 25; CMS Ex. 14, at 3.

The state survey agency recommended that CMS accept the facility's allegation as removing the immediate jeopardy. CMS Ex. 8, at 42. The SOD included findings regarding the above listed corrective actions, as well as the following (also supported by other CMS exhibits, as noted): Systronic Systems installed the front door keypad on April 29 (CMS Ex. 14, at 25) and completed installation of manual key pads on May 3 (CMS Ex. 1, at 21-22); on May 3-5, Liberty provided further in-service training on the manual key pads (CMS Ex. 1, at 22; CMS Ex. 8, at 25); and on May 5, Liberty replaced the residents' 90-day Wanderguards with one-year ones (CMS Ex. 8, at 25). CMS initially found that Liberty had removed the immediate jeopardy on May 5 and that Liberty had not come into substantial compliance until May 17. CMS later determined that Liberty had both removed the immediate jeopardy **and** achieved substantial compliance by May 5, the date the survey was completed. This was, however, after Liberty had submitted a plan of correction, on the SOD, dated June 18, 2010.

Liberty asserts that the ALJ erred because (1) he applied an erroneous legal standard; and (2) treating the June 18 plan of corrections as representing actions Liberty had pledged to take to remove the immediate jeopardy ignores Liberty's May 3 allegation that it had already achieved compliance, while planning further enhancements. RR at 31-37; Reply Br. at 12. The ALJ Decision states:

> To prove abatement of immediate jeopardy prior to the date that CMS determined that abatement occurred, May 4, 2010, [Liberty] must prove that it effectively implemented *all* of the corrective actions that it pledged to undertake.

ALJ Decision at 11 (italics in original).[10] Liberty argues that, contrary to what the ALJ said, a facility "merely has to implement enough measures sufficient to effectively eliminate the immediate likelihood of serious injury, harm, impairment, or death to a resident" in order to eliminate immediate jeopardy and that, by April 21, it had done so. P. Reply Br. at 6 (emphasis in original). In support of its legal argument, Liberty cites to an ALJ decision, as well as to CMS policy in its State Operations Manual, Appendix Q. RR at 31-33.

In response to Liberty's argument, CMS does not claim that the ALJ stated the correct standard or respond to Liberty's argument that CMS's own manual reflects a different standard. Rather, CMS asserts that the ALJ's immediate jeopardy determination was correct because Liberty "did not prove that it had a plan in place, prior to May 5, [2010] that would protect its vulnerable residents in the event of a Wanderguard failure." *Id.* This assertion ignores the undisputed fact that Liberty not only had its ERRP policy in place, but also had noted on each affected resident's MAR that the resident should be monitored if the Wanderguard failed. More important, CMS's discussion of whether Liberty had such a "plan in place" focuses only on the actions Liberty listed in its June 18 plan of correction as ones completed from May 3-5. *Id.* at 22, citing CMS Ex. 1, at 5, 26, 48; *see also* CMS Final Brief at 31-32 (referring to "allegation of compliance dated June 18, 2010" as a document in which Liberty "stated that it would complete all needed actions by May 5" and to installation of manual key pads on the exit doors as "another intervention the facility decided was necessary to keep residents safe . . .").[11] In other words, CMS (like the ALJ) erroneously relies on complete implementation of the June 18 plan of correction as determinative of whether immediate jeopardy was removed (as opposed to whether substantial compliance was achieved).

CMS and the ALJ erred in suggesting that the **only** way a facility may meet its burden to show that it removed the immediate jeopardy is to show that it effectively implemented **all** of the corrective actions that it pledged to undertake. The regulations and CMS's own guidance establish that completion of all steps in a plan of correction is **not** a prerequisite for removing immediate jeopardy. The regulations authorize a finding of noncompliance if there is a **potential** for more than minimal harm, but define immediate jeopardy in terms of actual or **likely** serious harm, injury, impairment, or death. 42 C.F.R. § 488.301.

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[10] The date CMS determined immediate jeopardy was removed is May 5, 2010, not May 4. CMS Ex. 2. In determining duration of a CMP, CMS does not include the day on which immediate jeopardy is removed or substantial compliance is achieved. *See* 42 C.F.R. § 488.440(h)(penalties accrue until the date of correction). The ALJ correctly stated the date of removal as May 5, 2010 elsewhere in the decision. *See, e.g.*, ALJ Decision at 1.

[11] In its final brief to the ALJ, CMS ignores most of the actions Liberty took prior to May 3, focusing on Liberty's assertion that it had ordered new one-year Wanderguards on April 26 and responding that ordered Wanderguards "do residents no good." CMS Final Brief at 31. This is true, but ignores the evidence that Liberty had ordered 25 of the 90-day Wanderguards as early as April 20, and had **received** the Wanderguards by April 28, when it had 11 replacements on hand, after providing one to each resident who needed it. CMS Ex. 14, at 1; CMS Ex. 12, at 2.

CMS's State Operations Manual, Appendix Q, points out that, for immediate jeopardy, no actual harm is required, but that, in the absence of actual harm, the "high potential for these outcomes to occur in the very near future also constitutes Immediate Jeopardy." SOM, App. Q, § III.

Requiring a facility to complete all of the actions in its plan of corrections in order to remove the immediate jeopardy, in effect, ignores the clear difference between a likelihood and a mere potential. *See Daughters of Miriam Center* at 10 ("the term 'likely' — and its synonym 'probable' — suggest a greater degree of probability that a particular event will occur than the terms 'possible' or 'potential.'"). Moreover, the regulations contemplate that a facility may take longer to come into substantial compliance than to remove any immediate jeopardy. 42 C.F.R. §§ 488.410, 488.412; *see also* § 488.38 ("if immediate jeopardy is removed, but the noncompliance continues, CMS . . . will shift the penalty amount imposed per day to the lower range").

Requiring completion of the plan of correction to remove immediate jeopardy is also inconsistent with the State Operations Manual. Appendix Q to that manual gives examples of situations where immediate jeopardy has been removed by or during the initial survey, but a deficient practice still exists for which a facility must submit a plan of correction. The manual also provides that if the state survey agency finds immediate jeopardy, it will require that—

> the facility submit an allegation that the immediate jeopardy has been removed as well as provide sufficient detail to demonstrate how the immediate jeopardy has been addressed so that the State can verify onsite the removal of the immediate jeopardy. A plan of correction should be deferred until the facility has successfully demonstrated removal of immediate jeopardy.

SOM, § 7301.1(7). This clearly indicates that a determination that immediate jeopardy has been removed does not depend even on whether a facility has submitted a plan of correction, much less on whether it has effectively implemented *all* of the corrective actions. Certainly, a facility must take corrective actions, and the actions in a facility's plan of correction may be some evidence of what is necessary in order for the facility to come into substantial compliance. Yet, as the Board recognized in *Azalea Court,* DAB No. 2352, at 19 (2010), the dates posited in a facility's plan of correction for fully correcting its noncompliance "are not necessarily dispositive of when that noncompliance ceased to pose immediate jeopardy." When the noncompliance has been sufficiently corrected that it is no longer likely to cause serious harm, injury, impairment or death, immediate jeopardy has been removed even if a facility has not yet taken all of

the actions it said it would take (or CMS required it to take) to eliminate any potential for more than minimal harm (i.e., to return to substantial compliance).[12]

We therefore conclude that reliance by CMS and the ALJ on the bare fact that not all of the steps identified in the June 18 plan of correction were completed before May 5 as requiring a determination that immediate jeopardy continued through that date was legally erroneous. Having thus concluded that CMS's determination was based on an erroneous legal premise, we must next consider whether the record nevertheless provides an alternative basis to defer to that determination, as CMS argued before us.

As noted above, the burden of showing clear error in an immediate jeopardy determination is indeed a heavy one, but that hurdle has not always proved insurmountable. In several other cases, the Board has overturned an ALJ's conclusion that CMS's determination that noncompliance continued at an immediate jeopardy level to a particular date was not clearly erroneous. *See, e.g., Gooding Rehabilitation & Living Center,* DAB No. 2239, at 17 (2009)*; Azalea Court,* at 19. Further, where CMS's determination about the level of noncompliance is based on facts different from those found on appeal, an ALJ or the Board may modify the determination accordingly without inappropriately substituting our judgment for that of CMS. *Lake City Extended Care Center,* DAB No. 1658 (1998); *Cross Creek Health Care Center*, DAB No. 1665 (1998). Before us, CMS raises some arguments regarding duration of the immediate jeopardy that merit discussion. As discussed below, however, these new arguments are based in part on factual assertions not supported by the record, ignore key facts that are undisputed, or depend on erroneous legal premises.

First, CMS argues that Liberty "does not address the crucial fact that led to the immediate jeopardy determination in the first place – the failure to have an adequate supply of Wanderguards available in the event that a resident needs one to remain safe." CMS Response at 24. As Liberty replies, this allegation is unfounded. RR at 14. The record shows that Liberty took the following steps to ensure an adequate supply of accessible Wanderguards. On the morning of April 20, Liberty ordered 25 additional 90-day Wanderguards. CMS Ex. 14, at 1, 2. On April 26, Liberty ordered five 12-month

[12] What we conclude here is consistent with what the Board has said in cases like *Lake Mary Health Care,* DAB No. 2081 (2007), where a facility relied solely on CMS's mere **acceptance** of a plan of correction to show it had abated immediate jeopardy. In that context, the Board in *Lake Mary* at 29 referred to the facility's burden "to show that it timely completed the implementation of [the plan of correction] and in fact abated the immediate jeopardy (to reduce the applicable CMP range) or achieved substantial compliance (to end the application of the remedies)." (Emphasis added.) The Board went on to make the key point that it "is not enough that some steps have been taken, but rather the facility must prove the goal has been accomplished." *Id. Spring Meadows Health Care Center*, DAB No. 1966 (2005), cited in *Lake Mary*, states only that the facility "had the burden to show that the immediate jeopardy situation did not continue because [the facility] had taken appropriate corrective action to remove the immediate jeopardy."

Wanderguards.[13] *Id.* at 3. As of April 22, 17 of the 18 residents who needed Wanderguards had a functioning Wanderguard, and there were eight extra Wanderguards in the facility, which indicates the order of April 20 had been received. CMS Ex. 12, at 2. **As of April 28, all 18 residents who required Wanderguards had a functioning one, with 11 extra Wanderguards on hand.** *Id.*

Not only does the cited evidence show that Liberty had an adequate supply of Wanderguards by April 22 and additional Wanderguards on order, the record also shows that Liberty took steps to ensure that those Wanderguards were easily accessible to staff and that in the future Wanderguards would be ordered in a timely fashion. By April 22, Liberty had placed replacement Wanderguards on medication carts - thereby providing immediate access to Wanderguards should a staff member need to replace a resident's Wanderguard. CMS Ex. 12, at 2. This step would also make it more likely that staff would notice if replacement Wanderguards were not readily available and prompt reordering. Additionally, the surveyor's notes indicate that the DON told her that responsibility for tracking Wanderguard supply had now been assigned to a specific person in Central Supply. CMS Ex. 8, at 22. Indeed, the evidence shows that, by April 28, Liberty had an ample number of replacements, had made the replacements more available to staff, had ordered replacements with a longer life, and had taken steps to make it more likely staff would be aware if the supply of Wanderguards was low and that replacements would be timely ordered.

In response to Liberty's reliance on the fact that it did audits and checking of all Wanderguards, CMS argues that "the evidence is undisputed that the audit revealed there were other residents who needed Wanderguards but did not have them." CMS Response at 25. CMS asserts that—

> Liberty Health staff determined that Resident A.L., who resided in room B20D was at risk for elopement. CMS Ex. 11, at 11. Yet, the Change in Status sheet, dated April 21, 2010, indicated Resident A.L. had no Wanderguard. CMS Ex. 13 at 8. Liberty Health staff had also determined that Resident D.K. did not have a Wanderguard on [April] 22, 2010. CMS Ex. 12 at 2. The change in status sheet, dated April 28, 2010, indicated that Resident D.K. received a new order for a Wanderguard. CMS Ex. 13 at 24. There is no evidence in the record as to when Resident[] A.L. and Resident D.K. received their Wanderguards. Until they received them **or** until the manual keypads were installed, the exit doors remained an accident hazard for both residents.

Id. (emphasis added).

Liberty replies that it is "patently untrue" that there were two residents who needed Wanderguards but did not receive them before May 5. Reply Br. at 16. With respect to

[13] We note that, on May 4, Liberty ordered 20 more 12-month Wanderguards. CMS Ex. 14, at 4.

Resident A.L., Liberty argues that CMS ignores "vital context" to the notation in the change of status sheet for April 21, specifically, that Resident A.L. was returned to the facility that day from the Senior Care Unit (SCU), with no Wanderguard upon return. *Id.* citing CMS Ex. 13, at 8. According to Liberty, CMS also ignores the entry in the audit performed later that same day, showing that A.L. did by then have a working Wanderguard attached to her wheelchair (since she was unable to ambulate without assistance), and the entries in the subsequent audits showing that A.L. had a properly functioning Wanderguard on both those dates as well. *Id.* citing CMS Ex. 12, at 1-2. With respect to Resident D.K, Liberty argues that "D.K. did not actually have a physician's order in place for a Wanderguard, and therefore was not required to have one, until April 28, 2010." *Id.*, citing CMS Ex. 13, at 24. According to Liberty, the April 28 audit shows that D.K. did in fact have a working Wanderguard on that date. *Id.* at 17, citing CMS Ex. 12, at 2.

CMS did not timely raise any issue below with respect to residents D.K. and A.L. Thus, Liberty had no opportunity to present testimony to support its assertions about the residents, and the ALJ made no findings regarding them. The documents regarding these residents are in the record and are sufficiently clear, however. Based on our review, we agree with Liberty that CMS misread what the records as a whole show with respect to these residents. As Liberty asserts, the cited documents show that A.L. had a working Wanderguard attached to her wheelchair as of April 22 and that D.K. had a Wanderguard as of April 28. While Liberty did not prove that D.K did not need a Wanderguard before April 28, the record clearly shows that he had one as of that date.[14]

Therefore, we conclude that CMS's argument on appeal that the immediate jeopardy continued beyond April 28 because of D.K. and A.L. is based on a factual error. Furthermore, given what the record shows, CMS's assertion that a hazard existed for residents A.L. and D.K. only until they **either** had Wanderguards **or** the key pads were installed on the doors undercuts CMS's determination that the immediate jeopardy was removed only after the key pads been installed, staff had received training on the key pads, **and** Liberty had received the one-year Wanderguards.

CMS nonetheless tries to buttress its position that the immediate jeopardy continued until May 5 by pointing out that Liberty's Administrator explained in his May 3 letter that Liberty "opted to go to the 1 year in place of the 90-day bracelet to extend the longevity and decrease risk of freq[uently] expiring bracelets." CMS Response, *citing* CMS Ex. 8, at 25. CMS asserts, "Clearly, the one year Wanderguards were part of Liberty Health's plan to protect its residents from the risks associated with Wanderguard failure." *Id.* This is true, but does not explain why the other parts of the plan that had previously been implemented by April 28, including obtaining an adequate supply of 90-day

[14] While D.K. may not have had a physician's order for a Wanderguard prior to April 28, Liberty's April 22 audit identifies D.K. as a resident who needed a Wanderguard, but did not have one. CMS Ex. 12, at 2.

Wanderguards and noting on each affected resident's MAR that 15-minute checks should be instituted if a Wanderguard failed and could not be immediately replaced, were not sufficient so that it was no longer likely a resident would elope.

We also note that the facility's records of its April 28 audit of Wanderguards, together with the records of the new orders for Wanderguards, indicate that some residents had had their old Wanderguards replaced because otherwise more than 11 replacements would have been on hand on April 28. Also, in describing to the surveyor what she did in auditing the Wanderguards in use on April 21, Liberty's ADON said she had "looked to see if [the Wanderguards in] use were in date and working properly." CMS Ex. 8, at 32. Thus, she would have been aware which Wanderguards were nearing the end of their expected life and needed to be replaced. Replacing at least a significant number of Wanderguards with new ones reduced the likelihood that residents' 90-day Wanderguards would cease to function, and that this would not be discovered timely, despite the checks of function every shift.

CMS also raises on appeal a question regarding in-service training – albeit a more limited one than the ALJ suggested. The ALJ found that a comparison of the employee badge list and in-service sheets showed that not all staff had received training prior to May 4, 2010. ALJ Decision at 11, citing P. Ex. 6 (sign-in sheets for training on "Elopement Policy [and] Drill") and CMS Ex. 17, at 1-3 (Liberty employee badge list). While the sign-in sheets do not contain all of the names on the staff list, Liberty challenges the ALJ's conclusion on the ground that the staff that required training, i.e., its professional staff, were trained before being allowed to work. According to Liberty, the ALJ mistakenly faulted it for not training people on the staff who were not directly responsible for patient care such as its cook and maintenance person. Liberty also points out that it had always said that no **professional** staff member was allowed to care for residents until they received in-service training on the ERRP policy, and that CMS had never found this to be insufficient or raised an issue about the sufficiency of the training. Indeed, the SOD states: "Licensed Nurses will not be permitted to work until the [ERRP] policy has been reviewed by the employee." CMS Ex. 1, at 21. The SOD verified that the facility had implemented the corrective actions, as stated in the May 3 letter, which included this prohibition. *Id.* at 22; CMS Ex. 20, at 2. According to Liberty, training the professional staff responsible for residents' care before they were allowed to work reduced the likelihood of serious harm. RR at 36.

CMS does not dispute Liberty's assertion that professional staff were not allowed to work until they received the in-service training. CMS argues only that the maintenance person was important to the facility's effort to keep elopement-prone residents safe because he was responsible for checking the exit doors to ensure that the Wanderguard system was working. CMS Response at 24-25. As discussed above, the question is whether Liberty had sufficiently corrected its deficient practices to remove the immediate jeopardy. The record shows that the maintenance person had been checking the doors every week, per facility policy. P. Ex. 11. The survey did not find, and CMS has not alleged, that the

facility's system or implementation of its policy was deficient in this regard. Nor has CMS identified any reason to think the maintenance person would not continue to fulfill his duty. Indeed, CMS determined that Liberty had come into substantial compliance on May 5, even though it had no evidence he had been trained by that date. Nor did CMS raise this as an issue below, even though it had the lists on which the ALJ relied.

In sum, under the particular circumstances of this case, we conclude that CMS's determination that immediate jeopardy continued on April 28 and until May 5 is clearly erroneous because:

- CMS, like the ALJ, mistakenly relies on an erroneous legal standard, treating all of the actions in Liberty's plan of correction to achieve substantial compliance as actions required in order to remove the immediate jeopardy.

- CMS relies on appeal on its mistaken reading of the record as meaning that A.L. and D.K. were not protected until the key pads were installed. Yet, the record shows both residents had Wanderguards by April 28, and CMS conceded that **either** providing residents with Wanderguards **or** having key pads would protect them. As mentioned above, these types of Wanderguards would not only sound an alarm when near a door, but would also automatically lock the door.

- CMS also relies on lack of training of the maintenance person, but the evidence shows that retraining maintenance staff was not even included in the plan of correction and was not relevant to the areas found deficient.

- The undisputed evidence shows that by April 28 Liberty had taken numerous steps (verified during the survey) that substantially reduced the risk of events that might cause serious harm, so the noncompliance was no longer likely to cause such harm.

Thus, we affirm the ALJ's determination in part and reverse it in part, holding that the immediate jeopardy was removed on April 28.

III. The ALJ did not err in determining that $5,000 per day was a reasonable amount for the period of immediate jeopardy; a lesser per-day amount of $100 is reasonable for the period April 28 through May 4.

CMS levied a $5,000 per-day CMP. In determining the reasonableness of the amount of a CMP, the ALJ is to consider the factors set out in 42 C.F.R. § 488.438(f), which are (1) the facility's history of noncompliance, (2) its financial condition, (3) factors specified in section 488.404, and (4) the facility's degree of culpability, defined as including neglect, indifference, or disregard for resident care, comfort or safety. Absence of culpability is not a mitigating factor. 42 C.F.R. § 488.438(f)(4). The factors specified in section

488.404, in turn, include the seriousness (scope and severity) of the deficiencies, their relationship to each other, and the facility's prior history of noncompliance in general and with respect to the particular deficiencies at issue.

The ALJ upheld the $5,000 per-day CMP on the basis of the following considerations. ALJ Decision at 11-12. The amount falls below the mid-point of the immediate jeopardy level penalty range. The noncompliance in this case was "quite serious," as evidenced by the elopement of R1. Liberty was "culpable" for its noncompliance, i.e., Liberty failed to implement the ERRP for several residents over several days for residents who staff knew were at "a heightened risk for elopement and consequent injury or death." *Id.* at 12. Finally, in 2008, Liberty was found noncompliant with section 483.25(h). *Id.*, citing CMS Ex. 19, at 1.

On appeal, Liberty argues that, even if its noncompliance was at the immediate jeopardy level, a per-day CMP of $5,000 is unreasonable. As to the question of culpability, which the regulations describe as "neglect, indifference, or disregard for resident care," Liberty points to all the actions it took before and after R1's elopement. RR at 38.

Liberty's position is without merit. First, much of Liberty's argument assumes that it did things (like monitor R2 and R3) that the contemporaneous record does not show it did. Second, section 488.301 defines "neglect" as a "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." Liberty's failure to implement its ERRP deprived residents of goods and services necessary for avoiding physical harm. The fact that Liberty acted proactively to provide those goods and services after R1 eloped does not change the fact that its conduct immediately prior to that time constituted neglect.

Liberty points to the fact that it self-reported R1's elopement to the state agency. It argues that sanctioning facilities after they self-report diminishes facilities' incentives to file such reports. RR at 39.

We reject this argument as a basis for modifying the CMP amount. Whether a facility self-reported an incident that led to a survey and noncompliance finding is not a relevant consideration for an ALJ or the Board under the regulations in determining a CMP amount. How CMS balances any tension between expecting facilities to self-report and then sanctioning facilities that do self-report is a policy question for CMS, not the Board.

As to the fact that the ALJ cited its prior noncompliance with section 483.25(h), Liberty points out that the prior citation was in 2008, did not involve elopement, and was at a non-immediate jeopardy level. RR at 39, citing *CMS Ex. 19, p. 1.* It also points out that it has had no immediate jeopardy for "at least its last 4 annual surveys." *Id.*
These considerations, in the context of the other factors supporting this CMP, are not grounds for reversing the ALJ's determination that $5,000 is reasonable. Rather, as the ALJ

found, the facts that the penalty was below the mid-point of the immediate jeopardy range; involved a noncompliance that was "quite serious," and involved neglect of residents' safety support the CMP amount whether or not Liberty's prior record included elopement-related deficiencies, especially since the record did include a finding of noncompliance with section 483.25(h) that caused actual harm. CMS Ex. 19, at 1.

Thus, we affirm the ALJ's conclusion that $5,000 per day is a reasonable amount for the period of immediate jeopardy. Since we reverse in part the ALJ's determination regarding the duration of the immediate jeopardy, however, we must consider what amount is reasonable for the period from April 28 (when we conclude the immediate jeopardy was removed) through May 4 (the last full day Liberty was not in substantial compliance).

As noted in footnote 2 above, CMS had initially imposed a CMP of $100 per day for the period after the immediate jeopardy was removed and before the date the state survey agency found substantial compliance was achieved, May 17. This amount is at the very low end of the range ($50 - $3,050) for CMPs for noncompliance not at the immediate jeopardy level. Although Liberty had challenged the finding that the noncompliance continued after May 4, Liberty did not specifically challenge the reasonableness of the $100 amount. Thus, we conclude that, for the period of continuing noncompliance, a CMP in the amount of $100 per day is reasonable.

Conclusion

For the reasons stated above, we affirm the ALJ's conclusion that Liberty was not in substantial compliance with Medicare participation requirements. We also affirm his conclusions that the noncompliance began April 18, 2010, that CMS's determination that the noncompliance was at the immediate jeopardy level was not clearly erroneous, and that $5,000 is a reasonable amount for the immediate jeopardy period. We affirm his conclusion on the duration of the immediate jeopardy in part and reverse it in part. We modify the

decision accordingly and uphold a $5,000 per-day CMP for the period April 18 through April 27, 2010, and a $100 per-day CMP through May 4, 2010.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Judith A. Ballard
Presiding Board Member