Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Mississippi Care Center of Greenville
Docket No. A-12-28
Decision No. 2450
March 30, 2012

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Mississippi Care Center of Greenville (MCC) appeals the September 30, 2011 decision of Administrative Law Judge (ALJ) Richard J. Smith upholding a determination by the Centers for Medicare & Medicaid Services (CMS) to impose remedies for MCC's noncompliance with requirements for long-term care facilities participating in the Medicare program. *MS Care Center of Greenville*, DAB CR2439 (2011) (ALJ Decision). CMS made its determination based on the results of a complaint survey done by the state survey agency, the Mississippi State Department of Health (MSDH), at MCC. Following an in-person hearing, the ALJ concluded that MCC was not in substantial compliance with Medicare participation requirements at 42 C.F.R. §§ 483.13(c) and 483.25(h) from May 9 through June 2, 2010; that CMS's determination that the facility's noncompliance posed immediate jeopardy to resident health and safety from May 9 through June 1, 2010 was not clearly erroneous; and that the civil money penalties (CMPs) imposed by CMS – $3,550 per day for the period of immediate jeopardy and $100 per day for the one day of noncompliance following abatement of the immediate jeopardy (June 2, 2010) – were reasonable. After considering all of MCC's arguments on appeal, we affirm the ALJ Decision.

Applicable Law

Long-term care facilities participating in the Medicare and Medicaid programs are subject to the survey and enforcement procedures set out in 42 C.F.R. Part 488, subparts E and F, to determine if they are in substantial compliance with the program requirements in 42 C.F.R. Part 483, subpart B. "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." 42 C.F.R. § 488.301. "Noncompliance," in turn, is defined as "any deficiency that causes a facility to not be in substantial compliance." *Id.* Surveyors report survey findings in a Statement of Deficiencies (SOD). The SOD identifies each "deficiency" under its regulatory requirement, citing both the regulation at issue and the corresponding "tag" number used by surveyors for organizational purposes. "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.

A long-term care facility found not to be in substantial compliance is subject to various enforcement remedies, including CMPs. 42 C.F.R. §§ 488.402(b), (c), 488.406, 488.408. CMS has the option to impose a CMP whenever a facility is not in substantial compliance. 42 C.F.R. §§ 488.402(b), 488.430. CMS may impose per-instance or, as it did here, per-day CMPs. 42 C.F.R. § 488.408(d)(1)(iii)-(iv), (e)(1)(iii)-(iv). There are two ranges of per-day CMPs, with the applicable range depending on the severity of the noncompliance. 42 C.F.R. § 488.438(a)(1). The range for noncompliance that constitutes immediate jeopardy is $3,050-$10,000 per day. 42 C.F.R. §§ 488.408(e)(1)(iii), 488.438(a)(1)(i). The range for noncompliance that is not immediate jeopardy is $50-$3,000 per day. 42 C.F.R. §§ 488.408(d)(1)(iii), 488.438(a)(1)(ii). When CMS imposes one or more of the alternative remedies in section 488.406 for a facility's noncompliance, those remedies continue until "[t]he facility has achieved substantial compliance, as determined by CMS or the State based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit . . . ." 42 C.F.R. § 488.454(a)(1).

Factual Background[1]

The Survey and ALJ Proceeding

MCC participates in the Medicare program as a skilled nursing facility (SNF). ALJ Decision at 1. MSDH conducted a complaint survey at MCC after MCC self-reported an elopement incident at its facility; the survey ended on June 4, 2009. *Id.* at 2; P. Ex. 1. Based on the survey findings (recorded on the SOD), CMS determined that MCC was not in substantial compliance with two Medicare participation requirements: 42 C.F.R. §§ 483.13(c) and 483.25(h). ALJ Decision at 2; CMS Ex. 2. By letter dated June 18, 2010, CMS notified MCC of its noncompliance determination as well as its determination that the noncompliance with both requirements constituted immediate jeopardy from May 9 through June 1, 2010 and continued at a less-than-immediate jeopardy level from June 2, 2010 until the facility achieved substantial compliance. ALJ Decision at 2; CMS Ex. 4. The CMS letter also informed MCC of remedies imposed, including CMPs of $3,550 per day for the immediate jeopardy period and $100 per day

[1] The information in this section, unless otherwise indicated, is drawn from undisputed findings of fact in the ALJ Decision and undisputed facts in the record before him and is presented to provide a context for the discussion of the issues raised on appeal. Nothing in this section is intended to replace, modify, or supplement the ALJ's findings of fact or conclusions of law.

for the noncompliance that continued after the jeopardy was abated. CMS Ex. 4, at 2. By letter dated August 10, 2010, CMS notified MCC that a revisit survey conducted on July 22, 2010 found the facility in substantial compliance effective June 3, 2010 and that as a result, CMS was rescinding all remedies except the CMPs. CMS Ex. 5.

By letter dated August 16, 2010, MCC timely requested a hearing. ALJ Decision at 2; P. Ex. 2. The ALJ conducted an in-person hearing February 23 through 25, 2010, followed by post-hearing briefing. ALJ Decision at 2.

Summary of ALJ Findings of Facts

Resident (R) 1

The incident that led to the survey at issue stems from the elopement of one MCC resident who, for privacy reasons, is identified as R1. ALJ Decision at 3. R1 was admitted to MCC on April 14, 2010 with diagnoses of post cardiac arrest with anoxic encephalopathy (a degenerative brain disease caused by prolonged insufficient oxygen supply), hypertension, expressive aphasia (defects in ability to communicate through speech), and amputation of one leg above the knee. *Id.* at 4-5, citing Tr. at 329, 333; *see also* CMS Ex. 2, at 3-4. His room was on the second floor of the facility. *Id.* at 3. When first admitted, R1 was heavily sedated; consequently, he was bed-bound and not inclined to wander. *Id.* at 5, citing Tr. at 330. However, as he was weaned from the sedatives, R1 began to get up from bed and use a wheelchair or hop on one leg to move around the halls and wander in and out of other residents' rooms. *Id.*, citing Tr. at 341. Nurses notes for April 24, 2010 state that R1 was at the "elevator, trying to get on" and "keeps pulling w/c [wheelchair] alarm off." *Id.*, citing CMS Ex. 9, at 18. R1 continually got out of his wheelchair, even after the facility used a soft-belt restraint to try to keep him in the wheelchair because he was able to break the restraint. *Id.*, citing CMS Ex. 9, at 19.

On May 3, 2010, due to R1's increased agitation and activity, MCC reassessed R1 as an elopement risk. ALJ Decision at 5, citing P. Ex. 18; P. Ex. 19, at 2; Tr. at 346. MCC also added care plan approaches to address this risk, which included the following, among others: "Place [R1] in an area where constant observation is possible"; "Make sure staff is aware of his wander/elopement risk"; "Place a picture of resident in elopement book"; "Be mindful of his location"; "Observe closely." ALJ Decision at 5-6, citing P. Ex. 19, at 2. R1 also had multiple conditions placing him "at great risk of injury, or worse, if he eloped." *Id.* at 6. R1 had cognitive impairments, poor decision-making skills, and short and long-term memory problems. *Id.*, citing P. Ex. 19, at 1; CMS Ex. 9, at 6, 8, 9. His care plan noted that he had fallen at least four times since his admission and was at risk for more falls due to his amputation, unsteady gait, and constant attempts to get out of his wheelchair. *Id.*, citing CMS Ex. 9, at 8.

The Elopement

On May 9, 2010, R1, in his wheelchair, got into the elevator, rode down to the first floor, went out an allegedly secure exit door to the patio, and rolled through a gate, the facility parking lot, and across a street and into the parking lot of the Krystal Double Quick, a convenience store with a fast-food window. ALJ Decision at 3. There is no dispute that no one saw R1 exit the building. *Id.*, citing CMS Ex. 1; *see also* CMS Ex. 2, at 3. By coincidence, a certified nurse aide (CNA) "noticed [R1] across the street in the Krystal Double Quick parking lot when she went to move her car."[2] ALJ Decision at 3, citing P. Ex. 30, at 1, 4. A little while later, another CNA who was unable to find R1 in the building went outside and "saw R1 in the parking lot of the adjacent convenience store with the other CNA." *Id.,* citing P. Ex. 30, at 3. These two CNAs and another CNA took R1 back to the facility, but not more than one-half hour later, R1 again got on the elevator and left the building behind a visitor, ending up in the facility's parking lot. *Id.* at 3-4. This time, R1 was within reach of a CNA who brought him back to the second floor. *Id.*

The Facility's Security System

MCC utilized exit door locks that were opened by using a coded keypad and security cameras directed at the elevators as elopement prevention devices. ALJ Decision at 7. The ALJ found, however, that MCC had no written policies or procedures for preventing residents at risk of elopement from obtaining the exit door codes or following visitors out the doors. *Id.* He also found the facility had not established policies or procedures for staff monitoring of the security cameras. *Id.* at 8. These deficiencies, the ALJ found, constituted failure to provide adequate supervision and assistive devices to prevent accidents as well as failure to develop written policies and procedures prohibiting neglect. *Id.* at 8-9.

Standard of Review

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

[2] MCC alleges that the ALJ ignored evidence that it says shows that R1 was in MCC's parking lot when first seen. We discuss later why we reject this allegation.

Discussion

A. *The ALJ's conclusion that MCC was not in substantial compliance with 42 C.F.R. § 483.25(h) because it failed to provide supervision and assistance devices adequate to address the risk of resident elopements is supported by substantial evidence and free of legal error.*

Section 483.25(h) requires facilities like MCC to "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." This provision is part of the quality of care regulation at section 483.25 requiring 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." While cited under section 483.25(h) generally, the noncompliance here involves inadequate supervision and assistive devices to prevent accidents, which is addressed in section 483.25(h)(2). 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 17-30 (2000), *aff'd, Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 (6th Cir. 2003) (all upholding findings of noncompliance with section 483.25(h)(2) that included failure to provide adequate supervision to residents at risk of elopement).

The cited cases establish that while section 483.25(h)(2) does not make a facility strictly liable for accidents that occur, it does require the facility to 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. *Golden Age,* DAB No. 2026, at 11 (2006), citing *Woodstock Care Ctr. v. Thompson*, 363 F.3d at 589-90 (sustaining the Board's and the ALJ's holding that a SNF must take "all reasonable precautions against residents' accidents"). A facility is permitted the flexibility to choose the methods of supervision it uses to prevent accidents, but the chosen methods must be adequate under the circumstances, and whether supervision is "adequate" depends on the resident's ability to protect himself or herself from harm under the circumstance. *Golden Living Center – Riverchase*, DAB No. 2314, at 8 (2010), citing *Golden Age* and *Woodstock Care Ctr. v. Thompson.* As discussed below, we conclude that substantial evidence supports the ALJ's conclusion that MCC was not in substantial compliance with section 483.25(h)(2) because it failed to give R1 supervision and assistance devices adequate to address his known elopement risk. We further find no legal error in the ALJ's conclusion.

The ALJ found that R1 eloped twice the evening of May 9, 2010, at 7:00 p.m. and again "not more than a half hour later" by going down the elevator in his wheelchair and out a supposedly locked exit door that leads to the patio and parking lot. ALJ Decision at 3. MCC does not dispute that R1 exited the building the first time and implicitly concedes that the first exit was an elopement. Request for Review (RR) at 19 (stating that MCC "does not dispute . . . that R1 exited the building unsupervised . . . ."); RR at 10 (stating with respect to the first exit that R1 "was located . . . within 8 minutes or less of his elopement").[3] MCC does dispute where R1 was found after he left the facility. RR at 10. MCC claims that R1 was located in the facility parking lot, not in the Krystal Double Quick parking lot across the street. RR at 10. MCC also suggests, citing testimony by Quality Assurance Nurse Cingolani, that the parking lot was part of the facility's premises. RR at 19, n.9.[4] Even assuming, for purposes of argument, that R1 was still in MCC's parking lot when found and that the parking lot is part of MCC's premises, that does not undercut the ALJ's finding of noncompliance because MCC "has not disputed . . . that R1 exited the facility unsupervised" and does not assert that the parking lot was a safe location. *Id.*; *see also* State Operations Manual (SOM), CMS Pub. 100-7, Appendix PP (F323 guidelines), available at http://www.cms.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf ("Elopement occurs when a resident leaves the premises or a safe area without authorization . . . and/or any necessary supervision to do so."). As the SOM indicates, being struck by a motor vehicle is one of the risks a resident may encounter when leaving a safe area. *Id.*

Moreover, MCC's Request for Review cites no evidence for its assertion that R1 was located in the facility's parking lot, and substantial evidence relied upon by the ALJ indicates that R1 was either in or approaching the Krystal Double Quick parking lot when first spotted. *See* ALJ Decision at 3 (citing P. Ex. 30, at 4 – written statement of CNA Edwards, the first staff member to see R1 after he left the facility, that she "noticed [R1] crossing the street in his wheel chair"; P. Ex. 30, at 1 – MCC incident report stating that R1 "was seen in w/c leaving facility parking lot by CNA . . . Edwards; resident trying to

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[3] MCC cites no evidence for the assertion that R1 was located within 8 minutes, and none of the contemporaneous accounts documents the precise length of time R1 was outside the facility before staff found him.

[4] Based on its theory that the parking lot is part of MCC's premises, MCC disputes the ALJ's rejection of Nurse Cingolani's testimony that R1 was still on the premises because MCC's property line "even goes out into that street," referring to the street separating MCC's parking lot from the parking lot of the Krystal Double Quick. RR at 19, citing ALJ Decision at 3 n.3 (citing Tr. at 189). The ALJ found this testimony "disingenuous" with "no basis in fact or reality," noting that the witness neither saw the resident outside the facility nor interviewed the CNA who reported finding the resident in the parking lot of the fast food restaurant. *Id.* The Board defers to ALJ credibility determinations absent compelling reasons for rejecting them. *See, e.g., Cedar Lake Nursing Home*, DAB No. 2390, at 9 (2011). We find no reason to reject this ALJ credibility determination.

enter parking lot of next door Krystal/Double Quick";[5] P. Ex. 30, at 3 – written statement of CNA Porter that when she went out to look for R1 she "noticed [him] in the parking lot of Krystal's").

MCC also disputes the ALJ's finding that R1 eloped, or even exited the building, a second time on May 9, 2010. RR at 7. MCC asserts that after R1 rolled himself onto the elevator the second time, registered nurse (RN) Sudduth called the laundry, and a laundry employee stopped R1 on the first floor. *Id.* at 8. We conclude that substantial evidence supports the ALJ's finding that R1, in fact, left the facility a second time on May 9, 2010. The ALJ relied on RN Sudduth's nurse's note, which states:

> 7:30 pm = [R1] brought back to floor again – the laundry person stated she saw visitor leaving the building & this pt was right behind them & out in the parking lot – a CNA was in reach & returned him to the floor[.]

CMS Ex. 9, at 24, cited in ALJ Decision at 7.[6] MCC faults the ALJ's reliance on this note, arguing that the note was not contemporaneous but, instead, was "entered the day after the incident." RR at 7. Although RN Sudduth's note is labeled a late entry ("LE"), the date on the note is "5-9-10," the same day as the elopements, not the next day as MCC asserts. P. Ex. 20, at 2. Her note also is consistent with the incident description in MCC's report to its liability insurer (which RN Sudduth also wrote) and which states that the laundry employee "saw [R1] go out the exit door – as a visitor left the building . . . ."[7] P. Ex. 29, at 2. MCC has not explained why it would tell its liability insurer that the resident had left the facility unless it were true.[8]

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[5] The statement that R1 was seen "trying to enter parking lot of next door Krystal Double Quick" is the second part of a sentence in the incident report filed by the facility that begins by saying CNA Edwards saw R1 "leaving facility parking lot." P. Ex. 30, at 1. MCC argues that the first part "denotes the resident was still in the parking lot when he was first noticed." RR at 20. However, the second part, which MCC ignores, tends to undercut that argument.

[6] The ALJ cited page 23 of CMS Exhibit 9 for this nurse's note, but it is clear from the portion he quotes that he was referring to the nurse's note that appears on page 24 of CMS Exhibit 9.

[7] A note written by Director of Nursing (DON) Holderman on the same report says that R1 was stopped "before leaving the premises[,]" P. Ex. 29, at 2, but she does not indicate whether "premises" means the facility's parking lot or the building. In this regard, we note that the 24-hour nursing report for May 10, 2010 states, "[R1] outside in Kristal & MCC parking lot yesterday . . . ." P. Ex. 44, at 3. Absent any other explanation, the ALJ could reasonably read "MCC parking lot" as a reference to where R1 was found the second time he left the facility.

[8] We reject MCC's assertion that the ALJ erred by not weighing against this evidence a nurse's note written by LPN Bell and testimony by DON Holderman. RR at 7, 8. Neither the note nor the testimony states that R1 was inside the facility when staff retrieved him.

With respect to whether the second exit was an elopement, the ALJ stated that "[a] CNA was in reach of [R1]" the second time. ALJ Decision at 4. This statement arguably creates a question as to whether R1 was unsupervised when he left the facility the second time. Thus, even under the facts found by the ALJ, it not clear whether the second exit qualifies as an elopement. However, that is immaterial because what is important about the second incident, as discussed by the ALJ, is that the fact that R1 exited the building twice within such a short span of time indicates that there were problems with its security systems that the facility had not yet addressed, specifically residents' ability to exit despite the locked doors and security cameras. ALJ Decision at 7-8. That R1 was able to exit the facility twice within 30 minutes, using the same means of egress, reasonably supports the ALJ's conclusion that MCC staff was not supervising him adequately, or consistent with his care plan. It also supports the ALJ's finding that the assistance devices on which the facility relied in addition to supervision and which R1 managed to circumvent – the exit door lock codes and security cameras – were not effective in preventing elopement, in part because visitors had access to the codes and the cameras were not being monitored. ALJ Decision at 7-8.

Moreover, contrary to what MCC argues, R1's elopement was reasonably foreseeable. Although MCC asserts that R1 "had no prior history whatsoever of elopement or exit-seeking behavior," Reply Br. at 3, the record shows that shortly before the elopement, R1 was wandering to areas within the facility where he could not be observed and exhibiting exit-seeking behavior. A nurse's note written on May 9, 2010, before R1 eloped, states that staff found it impossible to keep R1 under constant observation and that he kept going to another hall and into the rooms of other residents, scaring them in the process. ALJ Decision at 6, citing CMS Ex. 9, at 23. Yet, as the ALJ stated, "nothing was done to remedy this obviously-dangerous situation." *Id.* (citations omitted).

Another nursing note states that just prior to his elopement on May 9, R1 had been sitting at the elevator for long intervals and was moved several times but came back to the elevator soon after. ALJ Decision at 7, citing CMS Ex. 9, at 23. MCC does not explain why its staff should not have considered the likelihood that R1 spent so much time around the elevator because he was trying to use it to get down to the main floor, which would put him in a position to try to exit the facility. Nor does MCC explain why staff should not have regarded R1's repeated returns to the elevator after being removed from that location as likely exit-seeking behavior. Clearly R1's elopement was foreseeable in light of this documented behavior, and his second exit from the facility was even more foreseeable since he had actually eloped not more than 30 minutes earlier. Nonetheless, as the ALJ found, there is no evidence that staff made any effort to increase its supervision of R1 until after the second exit:

> [I]t was only after the second elopement, that Petitioner took any deliberate action to protect R1. Petitioner at that time placed R1 on one-on-one observation until such time as he could be evaluated for and transferred to a psychiatric unit.

ALJ Decision at 7.[9] MCC also should have been able to foresee that giving out exit door lock codes to visitors enhanced the risk that R1 and other residents like him would elope.

For the reasons stated above, we conclude that substantial evidence on the record as a whole amply supports the ALJ's conclusion that MCC was not in substantial compliance with section 483.25(h)(2), and the ALJ's conclusion is also free of legal error.

B. *The ALJ's conclusion that MCC was not in substantial compliance with 42 C.F.R. § 483.13(c) because it failed to develop policies and procedures adequate to protect residents at risk of elopement is supported by substantial evidence and free of legal error.*

Section 483.13(c) requires long-term care facilities like MCC to "develop and implement written policies and procedures that prohibit . . . neglect . . . ." 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. As the quoted language indicates, noncompliance with section 483.13(c) can be based on either failure to develop policies or procedures adequate to prevent neglect or failure to implement such policies. *See also Life Care Center of Gwinnett*, DAB No. 2240, at 7 (2009) (absent contrary showing, evidence reasonably supported conclusion of noncompliance with section 483.13(c) because the facility either did not have an anti-neglect policy and procedures sufficiently clear to prohibit the neglect that occurred or had not implemented its policy in a manner that would effectively prevent such neglect); *Liberty Health & Rehab of Indianola, LLC*, DAB No. 2434 (2011) (finding noncompliance with section 483.13(c) and section 483.25(h)(2) where facility had a policy prohibiting neglect but failed to implement policies intended to protect residents from elopement).

The ALJ found that the evidence at the time of R1's elopement establishes that "Petitioner failed to develop and implement policies and procedures that, among other things protected R1 against neglect . . . ." ALJ Decision at 8-9. MCC failed to develop adequate policies and procedures for preventing elopement, the ALJ found, because the policies and procedures addressing elopement prevention that existed at the time of R1's

[9] Contrary to what MCC suggests (RR at 15), the ALJ's statement does not constitute a finding that one-on-one supervision was required before R1's elopement. The statement merely states the fact that MCC began to use this intervention after the elopements when it finally reassessed the level of supervision he needed.

elopement did not address two elopement prevention systems the facility chose to use and which played a critical role in R1's elopement – door lock keypad codes and security cameras. Since we uphold the ALJ's conclusion that MCC was noncompliant with section 483.13(c) because it did not develop written policies and procedures adequate to protect residents at risk of elopement, we need not decide whether MCC was also noncompliant with that regulation based on failure to implement policies and procedures.

It is undisputed that R1 eloped from MCC on May 9, 2010. The ALJ found that MCC was relying on its exit door lock code and security camera systems to prevent elopement but had no written policies or procedures addressing either the use of the codes or the monitoring of the security cameras. ALJ Decision at 7, 8. The ALJ further found that the failure to ensure these systems were functioning and being implemented properly by staff played a role in R1's exits from the facility. *Id.* The ALJ based his findings on a document entitled "ELOPEMENT POTENTIAL/WANDERING INSTRUCTIONS" and the surveyor's testimony about that document. The document states as follows:

> 1. An Elopement assessment must be completed on the day of admission. If the resident is identified as an elopement risk, the resident will be care planned accordingly.
> 2. Elopement risk must be added to the C.N.A. care plan.
> 3. The supervisor will initiate Visual Checks as necessary.

ALJ Decision at 6, citing CMS Ex. 14; *see also* P. Ex. 5.[10] The surveyor testified that this was the document MCC's Director of Nursing presented to her when she asked for a copy of the facility's elopement policy. Tr. at 81. On their face, the instructions support the ALJ's findings because they do not address the door lock codes for the exit doors or security cameras. The ALJ also cited surveyor testimony that although MCC routinely gave door lock codes to visitors, MCC's policies and procedures did not discuss the codes, who had access to them, how often they should be changed, or how to instruct visitors not to give away the codes or let residents out.[11] Tr. at 95-96, 105-06.

The ALJ relied on this testimony in rejecting MCC's argument that it had adequate facility-wide interventions in place, including those mentioned in MCC's Elopement

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[10] This policy was revised on June 1, 2010, during the survey. CMS Ex. 11, at 2-3; *see also* Tr. at 97-98 (surveyor testimony comparing the initial and revised policies).

[11] The surveyor also testified that the instructions were inadequate because they did not sufficiently instruct staff in how to minimize elopement risk, update care plan interventions, or review their effectiveness, and did not mention the elopement book (identifying at-risk residents) that was supposed to be kept at each nursing station. Tr. at 81-83, 241-42, 250-51.

Prevention/Wandering Instructions. After citing the omissions to which the surveyor testified, and the fact R1 had twice exited the doors, the ALJ concluded that the lack of written policies and procedures addressing the door lock codes meant that the codes did not function as intended (to deter residents from exiting the facility unattended) because "[e]ither [R1] was able to access the code or he followed a visitor out the door without anyone detecting his exit."[12] ALJ Decision at 7.

MCC does not deny that its Elopement Potential/Wandering Instructions did not cover the codes or that facility staff routinely shared codes with visitors, as the surveyor testified. Indeed, MCC's Quality Assurance Nurse/Risk Manager testified that "[m]ost visitors who are common to the facility, who . . . visit the facility often, use the access code, just like we do . . . to get in and out." Tr. at 195. An incident report sent to its liability insurer on the day of the elopement states that R1 "followed unaware family member out of facility." CMS Ex. 9, at 13; Tr. at 368-69.

MCC nonetheless objects to the ALJ's reliance on the surveyor's testimony because, MCC asserts, it "did have in effect a separate Door Code policy which [the surveyor] did not review." RR at 17. MCC cites no such policy in the record, and we find none. Instead, the exhibit MCC cites is the facility's Security Alarm Checks/Daily Checks Log. RR at 17, citing P. Ex. 43. MCC has not explained why the practice of checking the security alarms daily evidenced by this log has any relevance to the findings of noncompliance. The facility was not cited for a problem with security alarms but, rather, failure to have a policy addressing access to its door lock codes, and MCC has not established any operational relationship between these two measures. Even assuming MCC was checking the coded keypads for the door locks daily, as well as the security alarms, we agree with the ALJ that the checks are irrelevant because MCC's noncompliance with section 483.13(c) was based on failure to have a written policy and procedures governing access to the codes for opening the doors, not on any operational failure of the keypads or locking mechanism:

> Obviously, the use of the exit codes was intended to deter residents from exiting the facility unattended, yet this intervention for preventing elopement was ineffective to say the least, especially if nearly everyone had access to the codes as seems to have been the case. The fact that the facility made daily checks to the door locks is irrelevant once it had routinely provided the access code for these locks to visitors to the facility. The door locks served as a method of augmenting its supervision of its residents by securing the facility's exit doors from residents seeking to elope from the

[12] Since the ALJ made no finding in his Decision that R1's second exit was undetected, we assume the ALJ used the term "undetected" here only in regard to the first exit.

> facility. The fact that R1 exited the facility twice in the same day unequivocally establishes that this measure failed. Yet, Petitioner does not address this other than to [discuss what measures it took after the elopement].

ALJ Decision at 7-8.

MCC also objects to the ALJ's reliance on its lack of policies and procedures for the door lock codes because, MCC contends, it did not have notice that "[t]he key code policy [was] an issue in this matter." RR at 16. We find no merit to this argument. The SOD, contrary to MCC's assertion, does mention the door lock codes when recounting – under both the section 483.13(c) and the section 483.25(h) findings – the surveyor's interview with a maintenance employee of MCC. CMS Ex. 2, at 7, 21. While the SOD findings do not specifically state that the facility's written policies and procedures did not cover use of these codes, MCC has not explained why the SOD discussion would not be sufficient to alert it to the need to be prepared to address any issues regarding the codes during the hearing. Moreover, the Board has held that an ALJ does not err in permitting issues to be raised during the hearing that were not clearly raised on the SOD provided the party has notice and a meaningful opportunity to be heard on those issues. *Livingston Care Center,* DAB No. 1871 (2003), *aff'd, Livingston Care Ctr. v. U.S. Dep't of Health and Human Servs.*, 388 F.3d 168 (6th Cir. 2004). CMS's discussion of the inadequacy of MCC's elopement prevention policies and procedures in its prehearing brief referred to problems involving door lock code security. *See* Prehearing Brief of [CMS] at 9, 10 (dated Jan. 31, 2011). Moreover, as indicated above, the surveyor specifically testified about the absence of the door code policies and procedures at the hearing. Tr. at 105-06. MCC had an opportunity to respond to this testimony through its witnesses who followed the surveyor on the witness stand, including a post-hearing witness allowed to testify by deposition. MCC has not explained why these opportunities were not meaningful.

The ALJ also found MCC's elopement prevention policy did not address whether and how staff were to monitor the security cameras trained on the second floor elevator, the elevator used by R1, who was in a wheelchair, to ride down to the first floor where he exited the facility. ALJ Decision at 8. MCC does not dispute that finding but suggests the ALJ should not have relied on this omission, arguing that "there is no one policy which is required to prevent elopements." RR at 18. This argument is beside the point. While a facility does have flexibility with respect to development of specific written policies and procedures for prevention of neglect, where a facility relies in part on system-wide interventions to protect residents from neglect, it must have written policies and procedures instructing staff on the measures the facility has chosen to use. The ALJ aptly stated:

> If a facility relies on devices such as key-coded door locks and security cameras with monitors to assist in preventing elopements, then the facility must make sure that it has established policies and procedures for these interventions, and those policies and procedures must address how the devices will be used and who will be assigned to monitor the devices and interventions.

ALJ Decision at 8.

MCC argues that it was unnecessary to instruct staff to monitor the cameras directed at the elevators because the elevators were in front of the second floor nurse's station.[13] RR at 18. This argument is meritless as evidenced by the fact that R1 was able to get on the elevator unobserved – in his wheelchair – despite the proximity of the nurse's station. MCC's argument is also undercut by the very fact that the facility chose to direct the cameras at the elevators. MCC's choice to direct the cameras at the elevators reflects a judgment on the facility's part that the mere proximity of the elevators to the nurse's station would not be an adequate intervention to prevent residents from getting on the elevators unseen by staff. As the ALJ stated, "[s]ecurity cameras are of little utility in preventing an elopement if no one is watching the monitors, and that is exactly what happened here." ALJ Decision at 8.

We conclude for the reasons stated above that substantial evidence supports the ALJ's findings that MCC failed to develop written policies and procedures addressing the door lock codes and security cameras. R1 was able to elope precisely because he was able to get on the elevator unseen, despite the presence of the security cameras, and exit the facility by following a visitor out an exit door, despite the fact that the door was equipped with a lock that could only be opened by using a door lock code. These circumstances illustrate the critical role that the door lock codes and security cameras played in MCC's elopement prevention system and the need for MCC to develop written policies and procedures that addressed these interventions. MCC's failure to do so, without more, is sufficient to uphold the ALJ's conclusion that MCC was not in substantial compliance with section 483.13(c).

In reaching this conclusion, we have considered but find no merit to MCC's argument that the ALJ erred because the only written policy he specifically discussed was the Elopement Potential/Wandering Instructions in Petitioner's Exhibit 5, the policy given to the surveyor during the survey. MCC cites other policies in evidence and argues that

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[13] The ALJ also cited testimony by a MCC witness that, although not entirely clear, seemed to indicate cameras were also used to monitor exit doors. ALJ Decision at 8 n.9, citing Tr. at 196.

these policies, together with the Elopement Potential/Wandering Instructions, comprise a "composite elopement policy for MCC." RR at 15 n.7 (citing P. Exs. 3-12); *see also* RR at 9 (stating that the ALJ ignored the Missing Resident (Elopement) policy in Petitioner's Exhibit 7). The Board has held that while an ALJ does not have to address every fact in the record, he or she must address evidence that conflicts with the evidence supporting the ALJ's findings of fact. *Texan Nursing & Rehabilitation of Amarillo, LLC*, DAB No. 2323, at 15 (2010), citing *Estes Nursing Facility Civic Center*, DAB No. 2000 (2005). The ALJ here, however, was not required to address the policies and procedures cited by MCC because they do not address the door lock codes or monitoring of the security cameras and, thus, do not conflict with the findings of fact on which the ALJ relied for his noncompliance determination.

Moreover, MCC has not established, with one possible exception, that the other policies it cites are even relevant to the issue of what MCC was doing to prevent elopement before R1 eloped. The elopement policies and procedures in Petitioner's Exhibits 8 and 9 were "reviewed & revised 6/2010," after R1's elopement (May 9, 2010). Petitioner's Exhibits 4 and 6 on their face instruct staff on reporting and investigating abuse and neglect, not how to prevent elopement. *See also* Tr. at 277 (surveyor testimony that Petitioner's Exhibit 4 does not address prevention). Petitioner's Exhibit 7, "Missing Residents (Elopement)," instructs staff on how to locate residents after a resident is missing but, as the surveyor testified, "[t]hat still would leave the prevention of elopement policy, the potential, lacking." Tr. at 248. Petitioner's Exhibit 12, "24 Hour Report Policy," requires staff to place 24-hour report forms at the nurse's station and to report resident status changes on those forms but does not instruct staff to treat elopements as "status changes." When interviewed, nursing staff gave the surveyor conflicting statements as to whether elopements or attempted elopements would necessarily be reported on those forms. Tr. at 266-67; CMS Ex. 2, at 6, 8.[14]

The visual checks policy in Petitioner's Exhibit 10 provides detail absent from the bare statement in the Elopement Prevention/Wandering Instructions to "conduct visual checks as necessary" but is undated. The last "policy" cited by MCC is the Missing Resident Drill in Petitioner's Exhibit 11A. At the hearing, MCC counsel stated his "understand[ing]" that this document "is not a policy" when asking the surveyor if she recalled seeing the document. Tr. at 249. (The surveyor recalled seeing the document but did not recall if she thoroughly reviewed it. *Id.*) Assuming, nonetheless, that Petitioner's Exhibit 11A is a "policy," it arguably has some relevance when considered

[14] MCC points to the fact that the May 9, 10 and 11, 2010 24-hour reports mention R1's elopement (although MCC calls it an "attempted elopement"). RR at 12, citing P. Ex. 44. However, the issue is not whether staff put this elopement on the report but whether the facility's written policies required staff to do so.

together with the elopement drill checklist in Petitioner's Exhibit 46, because Exhibit 11A requires such drills quarterly, and the surveyor testified that such drills "would help in prevention as well as afterwards." Tr. at 261-62, 280-81. However, nothing in this policy addresses the door lock codes or security cameras.

For the reasons stated above we conclude that substantial evidence supports the ALJ's finding that MCC was not in substantial compliance with section 483.13(c).

C. *The ALJ did not err in concluding that MCC did not show CMS's immediate jeopardy determination to be clearly erroneous.*

Immediate jeopardy exists when 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. CMS' s determination that a deficiency constitutes immediate jeopardy must be upheld unless the facility is able to prove that the determination is clearly erroneous. 42 C.F.R. § 498.60(c)(2); *Woodstock Care Center*. The "clearly erroneous" standard means that CMS's immediate jeopardy determination is presumed to be correct, and the burden of proving the determination clearly erroneous is a heavy one. *See, e.g., Maysville Nursing & Rehabilitation Facility*, DAB No. 2317, at 11 (2010); *Liberty Commons Nursing and Rehab Center – Johnston*, DAB No. 2031, at 18 (2006), *aff'd, Liberty Commons Nursing and Rehab Ctr. – Johnston v. Leavitt*, 241 F. App'x 76 (4th Cir. 2007). When CMS issued the nursing facility survey, certification, and enforcement regulations, it acknowledged that "distinctions between different levels of noncompliance . . . do not represent mathematical judgments for which there are clear or objectively measured boundaries." 59 Fed. Reg. 56,116, 56,179 (Nov. 10, 1994). "This inherent imprecision is precisely why CMS's immediate jeopardy determination, a matter of professional judgment and expertise, is entitled to deference." *Daughters of Miriam Center*, DAB No. 2067, at 15 (2007).

We agree with the ALJ that MCC did not carry its heavy burden to show that CMS's immediate jeopardy determination was clearly erroneous. Although there is no evidence that R1 was harmed during his elopement, immediate jeopardy, as the ALJ noted (ALJ Decision at 9), does not require actual harm but, as the regulatory definition indicates, only a likelihood of serious harm. *Dumas Nursing and Rehabilitation, L.P.*, DAB No. 2347 at 19 (2010), citing *Life Care Center of Tullahoma*, DAB No. 2304, at 58 (2010), *aff'd, Life Care Center of Tullahoma v. Sebelius,* No. 10-3465 (6th Cir., Dec. 16, 1011) (available at http://www.ca6.uscourts.gov/opinions.pdf/11a0852n-06.pdf). MCC argues that immediate jeopardy can only be cited in a "crisis situation." RR at 18-19, citing SOM § 3010A. We reject this argument here, as the Board has rejected similar arguments in other cases, because, while ALJs and the Board may find the SOM instructive, they are bound by the regulatory definition in 42 C.F.R. § 488.301, not by the

SOM. In *Foxwood Springs Living Center*, DAB No. 2294, at 9 (2009), the Board explained that "[w]hile the SOM may reflect CMS's interpretations of the applicable statutes and regulations, the SOM provisions are not substantive rules themselves." In *Agape Rehabilitation of Rock Hill*, DAB No. 2411, at 19 (2011), the Board rejected the facility's argument that the SOM reference to "harm or potential harm [that is] likely to occur in the very near future" defines the phrase "likely to cause, serious injury, harm, impairment, or death to a resident" in section 488.301 (emphasis added). The Board noted that section 488.301 "neither defines the term 'likelihood' nor sets any parameters as to the timing of potential harm." DAB No. 2411, at 19. Similarly, section 488.301 does not define immediate jeopardy as a "crisis situation," and, thus, did not require the ALJ here to find a "crisis situation" in order to uphold CMS's determination that MCC's noncompliance was "likely to cause, serious injury, harm, impairment, or death to a resident."

Even if the regulations did define immediate jeopardy as a "crisis situation," we would have no trouble finding a crisis situation here in light of the facts surrounding R1's elopement and MCC's incomplete and inadequately implemented elopement prevention policies and procedures, which affected all residents assessed as elopement risks. MCC does not explain why R1's being outside the facility in his wheelchair without supervision (or even staff knowledge of his whereabouts until a staff member went down to move her car and saw him) did not present a crisis situation. MCC merely reiterates its argument that R1 was still in the facility's parking lot when first spotted. RR at 19-20. Regardless of where R1 was located when first spotted, it is undisputed that by the time staff was able to retrieve him, he had crossed the street in his wheelchair and was in the parking lot of the Krystal Double Quick, which was a restaurant, convenience store, and gasoline station. Tr. at 91. Under these circumstances, and given his mental and physical impairments, including the loss of a leg and his tendency to get out of his wheelchair without assistance, there was a clear likelihood of serious harm to R1 while he was outside the facility. As the ALJ concluded:

> Clearly, the likelihood of serious harm or death to R1 was great due to his cognitive impairment, his history of falls, and his lack of safety awareness. Once he eloped from the facility, he was a risk for falling or being struck by a motor vehicle.

ALJ Decision at 9.

Contrary to what MCC suggests (RR at 19), the ALJ's conclusion is not based on application of a strict liability standard or a finding that a mere exit from a facility is a basis for finding immediate jeopardy. The ALJ's conclusion is based on the inadequacies of MCC's system-wide interventions as well as MCC's own assessment of R1 as being

unsafe if he eloped. P. Ex. 19, at 1-2. It is also based on the records documenting R1's serious physical and mental limitations as well as his behavior – leading up to and during the elopement – that put him at risk. Regardless of whether he was found in the facility parking lot, the street, or the Krystal Double Quick parking lot, R1 was still exposed to dangers that presented a likelihood of serious harm, including the possibility of being struck by a car. *See Kenton Healthcare, LLC,* DAB No. 2186 at 23-24 (2008) (upholding determination of immediate jeopardy to impaired residents who eloped and were found in facility's parking lot). In this regard, we note the surveyor's testimony that there were numerous cars in the facility's parking lot. Tr. at 88. It is also a mere fortuity that R1's absence was discovered at all. Had he not been spotted and retrieved he likely would have been exposed to the very serious and immediate dangers of traffic in other streets surrounding the facility. The surveyor testified that although she observed only two or three cars in the side street that R1 crossed in his wheelchair the day she examined that area, the street in front of MCC is "a real busy street" with two-way traffic and no sidewalks. Tr. at 88-90; *see also Owensboro Place Care and Rehabilitation Center*, DAB No. 2397, at 12-15 (2011) (upholding immediate jeopardy finding where facility was located near traffic areas and main roads). The surveyor also testified that R1 was not capable of judging what was safe and unsafe without supervision outside the facility and would have been in danger of his chair tipping over. Tr. at 99-100.

Contrary to what MCC asserts, the fact that MSDH did not send a surveyor to the facility until May 20, 2010, in response to the facility's May 12, 2010 phone report and May 17, 2010 written report of R1's elopement, is not evidence that serious harm to R1 was not likely. *See* RR at 20-21 (citing the SOM as instructing the state survey agency to initiate a survey within two working days of receiving a report that an immediate jeopardy may be present and ongoing).[15] MCC seems to be asking us to infer that MSDH's alleged failure to begin the survey within the period specified in the SOM means it did not consider R1 to be facing likely serious harm when it received the reports. Even if there were a basis for such an inference, it would be irrelevant because the surveyors and CMS must assess the likelihood of serious harm based on circumstances at the facility at the time of the incident reported, which, in this case, were the circumstances surrounding R1's elopement on May 9, 2010. Moreover, the evidence cited by MCC does not support the proposed inference because the reports show that by the time MCC reported the elopement, it had transferred R1 to a psychiatric facility – on May 12, 2010. P. Ex. 30. Accordingly, MSDH would have known that a present and ongoing likelihood of serious harm to R1 no longer existed.

[15] The surveyor who went to the facility on May 20, 2010 testified that she had been asked to open the survey because the surveyor who was to conduct the survey (and did so on June 1-2, 2010) was ill. Tr. at 48. The first surveyor was at the facility for approximately one and one-half hours, primarily to "validate that the client was no longer in the facility" and to verify the staff-to-resident ratio, which she did. Tr. at 58, 48-50.

To the extent MCC is suggesting that the alleged delay by the State agency was an irregularity that should eliminate the findings of noncompliance or immediate jeopardy determination, that suggestion, as CMS notes, has no basis in law. See 42 C.F.R. § 488.318(b); *Beechwood Sanitarium,* DAB No. 1824 (2002) (inadequacies or irregularities in the survey process do not invalidate adequately documented deficiencies or relieve a facility of its obligations to meet all requirements for participation in Medicare and Medicaid).

For the stated reasons, we uphold the ALJ's conclusion that CMS's immediate jeopardy determination was not clearly erroneous.

D. *The ALJ correctly found no clear error in CMS's determination that immediate jeopardy began May 9, 2010 and continued through June 1, 2010 and that noncompliance continued for one day thereafter, June 2, 2010.*

CMS determined that the immediate jeopardy continued from May 9, 2010, the day of R1's elopement, through June 1, 2010, the jeopardy having been abated on June 2, 2010, and imposed a CMP of $3,550 per day for that noncompliance. CMS Ex. 4, at 2. CMS also determined that the facility remained out of substantial compliance at a scope and severity level less than immediate jeopardy on June 2, 2010 and imposed a CMP of $100 per day for that day. *Id.* The ALJ upheld both determinations. ALJ Decision at 9-10.

MCC argues that the ALJ erred in upholding the period of noncompliance without discussing the evidence which MCC asserts shows an earlier date of compliance. RR at 22. MCC's argument addresses specifically the ALJ's finding that the immediate jeopardy was not abated until June 2, 2010, not the ALJ's finding regarding the one day of noncompliance at a lower level. MCC argues that the "the substantial weight of the evidence and testimony presented at the Hearing clearly showed that MCC abated any alleged IJ on May 9" (RR at 23) and that the ALJ committed clear error in not discussing this evidence (RR at 25-26).

While the ALJ found that the immediate jeopardy continued from May 9 through June 1, 2010, and that noncompliance at a lower level continued on June 2, 2010, he did not discuss in the context of that finding his reasons for upholding CMS's determination as to the duration of the immediate jeopardy. However, the ALJ did discuss under his other findings corrective actions that did not occur until June 1, 2010, for example, posting signs at doors warning visitors not to allow residents to follow them out and posting a sign at the gate to remind people to close it. ALJ Decision at 8. Thus, we disagree with MCC's statement that "the ALJ's decision totally ignores any discussion of the reasonableness of the duration of the IJ finding" and that this was clear error. RR at 22.

Even if the ALJ had committed clear error in this regard, it would be harmless. MCC has the burden of establishing a compliance date earlier than that found by CMS; CMS is not required to establish a lack of substantial compliance for each day a remedy remains in effect. *See, e.g., Kenton Healthcare, LLC* at 24-25; *Lake Mary Health Care*, DAB No. 2081 at 30 (2007); *see also* 42 C.F.R. §§ 488.454(a) and 488.440(a)-(b). Similarly, the facility's burden of demonstrating clear error in CMS's immediate jeopardy determination "extends to overcoming CMS's determination as to how long the noncompliance remained at the immediate jeopardy level." *Azalea Court*, DAB No. 2352, at 17 (2010), citing *Brian Center Health and Rehabilitation/Goldsboro*, DAB No. 2336, at 7 (2010). As the Board held in *Brian Center*, "[a] determination by CMS that a [facility's] ongoing [noncompliance] remains at the level of immediate jeopardy during a given period constitutes a determination about the 'level of noncompliance' and, therefore, is subject to the clearly erroneous standard of review under section 498.60(c)(2)." DAB No. 2336, at 7-8. Thus, it is not incumbent on CMS to justify the June 2, 2010 date for the abatement of the immediate jeopardy at MCC, but, rather, on MCC to show an earlier date of abatement and return to substantial compliance.

MCC has not carried this burden. The surveyor acknowledged that MCC had taken some corrective action – such as some in-service training – before the survey. Tr. at 128. However, she observed "close to a hundred employees" still being trained on June 1-2, 2010. Tr. at 271-72. She also testified that the cameras directed at the elevator were not always being monitored when she was at MCC doing the survey and that information – one resident's room number and another resident's name – was missing from the elopement book. Tr. at 128-29. The surveyor further testified that MCC's written policies and procedures "weren't comprehensive enough to lead staff to know how to prevent . . . residents from elop[ing]." Tr. at 129. The record shows that the facility revised those policies on June 1, 2010 during the survey. P. Ex. 48, at 3; CMS Ex. 2, at 11-12; Tr. at 96. It also shows that the information from the elopement book was added on that date. P. Ex. 48, at 3.

In addition, after claiming that it "abated any alleged IJ on May 9," MCC then contradicts that claim by discussing measures it took after that date and characterizes as "sufficient . . . to effectively eliminate any perceived jeopardy . . . ." RR at 23-25 (discussing, e.g., in-service training and elopement drills conducted May 9-11 and elopement book review and care plan updates on May 10). MCC has not carried its burden of showing that it abated the immediate jeopardy before June 2, 2010. It also has not shown that it was in substantial compliance on June 2.

E. *The ALJ did not err in concluding that the CMP amounts were reasonable.*

When appealing a finding of noncompliance, a facility may contend that the amount of the CMP imposed for that noncompliance is unreasonable. *See, e.g., Lutheran Home at Trinity Oaks*, DAB No. 2111, at 21 (2007); *Capitol Hill Community Rehabilitation and Specialty Care Center*, DAB No. 1629, at 5 (1997). The ALJ found reasonable the CMPs imposed by CMS: $3,550 per day for the period of MCC's immediate jeopardy-level noncompliance (May 9 through June 1, 2010), and $100 per-day CMP for one day of noncompliance at a level less than immediate jeopardy (June 2, 2010). Although the heading in its Request for Review purports to challenge the ALJ's findings with respect to both CMPs, MCC addresses only the immediate jeopardy-level CMP. Accordingly, we affirm the $100 per-day CMP for June 2, 2010 without discussion. For the reasons that follow, we also uphold the ALJ's determination as to the $3,550 per-day CMP.

An ALJ (or the Board) determines de novo whether a CMP is reasonable based on facts and evidence in the appeal record concerning the factors specified in section 488.438. *See* 42 C.F.R. § 488.438(e), (f); *Senior Rehabilitation and Skilled Nursing Center*, DAB No. 2300, at 19-20 (2010); *Lakeridge Villa Healthcare Center*, DAB No. 2396, at 14 (2011). Those factors are: (1) the SNF's history of noncompliance; (2) the SNF's financial condition – that is, its ability to pay a CMP; (3) the severity and scope of the noncompliance, and "the relationship of the one deficiency to other deficiencies resulting in noncompliance"; and (4) the SNF's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. 42 C.F.R. §§ 488.438(f), 488.404(b), (c)(1). With respect to the culpability factor, however, "[t]he absence of culpability is not a mitigating circumstance in reducing the amount of the penalty." *Id.* § 488.438(f)(4). Once an ALJ has determined that CMS had a valid legal basis (namely, the existence of noncompliance) to impose a CMP, the ALJ (or the Board on appeal) may not reduce that CMP to zero or below the regulatory minimum amount. *Id.* § 488.438(e)(1); *Somerset Nursing & Rehabilitation Facility*, DAB No. 2353, at 26-27 (2010).

In determining that the $3,550 per-day CMP was reasonable, the ALJ considered all the factors on which evidence had been presented but based his determination largely on the facility's culpability:

> The facility here is culpable for the deficiency because it did not properly supervise its staff to determine whether its own policies and procedures intended to prevent elopements were being implemented as required. This measure of culpability, taken into consideration together with the finding of immediate jeopardy, is sufficient to sustain the CMP at $3,550 per day for the period of May 9, 2010 through June 1, 2010.

ALJ Decision at 10. He noted that CMS did not cite facility history and MCC did not argue that its financial condition precluded paying a CMP of $3,550 per day. *Id.* He also noted the amount was at the low end of the range for CMPs applicable to immediate jeopardy, $3,050-$10,000. *Id.*; *see also* 42 C.F.R. § 488.438(a)(1)(i) (setting the range).

MCC acknowledges that the regulatory definition of "culpability . . . includes but is not limited to, neglect, indifference, or disregard for resident care, comfort or safety." RR at 27, citing 42 C.F.R. § 488.438(f)(4). However, MCC asserts that the "evidence clearly and unequivocally shows that this was not a case where the Facility exhibited neglect, indifference, or disregard for resident care." *Id.* MCC's argument ignores the fact that MCC's noncompliance with section 483.13(c) involves MCC's failure to develop written policies and procedures prohibiting neglect as required by the regulation. MCC also has not effectively challenged the ALJ's finding of culpability, which reflects his more specific findings regarding the security systems the facility had chosen to use. *See* ALJ Decision at 7-8. MCC merely reiterates measures it took, such as assessing R1 and developing a care plan for him and doing regular checks of its keypad system. RR at 27. The Board has already concluded that these limited interventions do not undercut the ALJ's conclusions that MCC had not developed adequate policies and procedures to prevent neglect and had not provided R1 with adequate supervision or assistive devices to prevent accidents.

MCC also cites measures it took only after R1 eloped, such as investigating R1's elopement, putting R1 on one-on-one monitoring until he could be transferred and drilling staff on elopement. RR at 27-28. MCC argues that these measures "are not the actions of an indifferent or neglectful facility." *Id.* at 28. There are two problems with this argument. First, MCC's culpability must be measured by what it did prior to R1's elopement, not after. Second, the issue is not whether MCC is an indifferent or neglectful facility generally but, rather, whether the particular circumstances surrounding the findings of noncompliance at issue here (and the determination of immediate jeopardy) evidence indifferent or neglectful conduct.

We conclude that the ALJ did not err in determining that the $3,550 per-day CMP and the $100 per-day CMP were reasonable for the time periods imposed.

Conclusion

For the reasons stated above, we affirm the ALJ Decision in its entirety.

/s/
Judith A. Ballard

/s/
Constance B. Tobias

/s/
Sheila Ann Hegy
Presiding Board Member