Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Azalea Court
(CCN: 10-5558),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-08-551

Decision No. CR2134

Date: May 25, 2010

DECISION

Petitioner, Azalea Court, challenges the decision of the Centers for Medicare and Medicaid Services (CMS) that it was not in substantial compliance with program participation requirements. Petitioner also challenges CMS's imposition of remedies, which includes: a civil money penalty (CMP) totaling $264,200; a denial of payment for new admissions (DPNA) from April 26, 2008 through May 21, 2008; and loss of Petitioner's ability to operate a nurse aide training and competency evaluation program (NATCEP) for two years. For the reasons discussed below, I find that Petitioner was out of substantial compliance with participation requirements during the relevant period and that the remedies imposed are reasonable.

I. Background

On April 11, 2008, the Florida Agency for Health Care Administration (State Agency) completed a recertification survey at Petitioner's facility. As a result, by letter dated April 24, 2008, CMS notified Petitioner that it was out of substantial compliance with participation requirements and that conditions in the facility constituted immediate jeopardy to resident health and safety and substandard quality of care. Accordingly, CMS would impose remedies that included: a CMP of $3,050 per day effective January 27, 2008, which was to continue until immediate jeopardy was removed or Petitioner was

terminated; a DPNA effective April 26, 2008; possible loss of NATCEP; and discretionary termination on May 4, 2008, if the immediate jeopardy was not removed by that date. CMS Exhibit (Ex.) 21; CMS Ex. 1, at 12-16.

Following a revisit survey conducted on April 30, 2008, CMS notified Petitioner by letter dated May 5, 2008 that: the immediate jeopardy citations were abated as of April 19, 2008; Petitioner was out of substantial compliance with participation requirements at the non-immediate jeopardy level; CMS was imposing a CMP of $250 per day effective April 20, 2008, until Petitioner returned to substantial compliance; and the discretionary termination date was changed to a mandatory six-month termination date of October 10, 2008. CMS Ex. 1, at 17-19; CMS Brief (Br.) at 2; P. Br. at 1. The State Agency conducted a second revisit on May 22, 2008 and found Petitioner in substantial compliance effective that date. The DPNA was thus in effect from April 26 through May 21, 2008. The CMP of $3,050 per day was effective for 84 days, and the CMP of $250 per day was in effect for 32 days. It is undisputed that the total CMP imposed is $264,200. CMS Ex. 31; P. Br. at 1; CMS Br. at 2.

Petitioner requested a hearing by letter dated June 19, 2008. On June 26, 2008, I was assigned the case for hearing and decision. The parties requested time to try to settle the case, which I granted, but the effort was unsuccessful. On December 3, 2008, I set a hearing date of March 31-April 3, 2009. The parties submitted a joint motion to reschedule the hearing, and I ultimately held the hearing July 14-16, 2009, in Miami, Florida. A 514-page transcript (Tr.) of the hearing was prepared. Both parties submitted briefs and response briefs (CMS and P. Response). I admitted P. Exs. 1-40[1] and CMS Exs. 1-31. Testifying for CMS were State Agency surveyors Michael De Gruccio and Mary Jane Battaglia, R.N. Testifying for Petitioner were: Lenox Wilson, L.P.N.; Manise Lormilsaint, C.N.A.; Catherine Davis, Petitioner's Risk Manager; Todd Mehaffey, Regional Vice President for Seacrest Healthcare Management, a company which has a consulting contract with Petitioner; Julie Dawkins,[2] who, at the relevant time, was Vice President of Clinical Services for Seacrest Healthcare Management; and Donna Dickerson, who, at the relevant time, was a Regional Clinical Consultant for Seacrest Healthcare Management.

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[1] Although the transcript reflects that I admitted 43 Petitioner exhibits, there are, in fact, only 40 exhibits. P. Ex. 41 was not admitted into evidence. P. Ex. 42 was on Petitioner's witness list, as all CMS's exhibits and copies of CMS exhibits were not offered at hearing as P. Ex. 42. No P. Ex. 43 was ever listed as an exhibit.

[2] I reserved decision as to whether Ms. Dawkins was qualified as an expert in long-term care nursing pending my review of the list of other long-term care nursing home cases for which Ms. Dawkins has been offered as an expert. Tr. at 409. Petitioner provided the list, which the Civil Remedies Division received on August 25, 2009. Ms. Dawkins has testified in five state cases, but in no other federal case. I find that Ms. Dawkins is qualified as an expert in long-term nursing care.

II. Issues

1. Whether Petitioner was out of substantial compliance with participation requirements.

2. If Petitioner was out of substantial compliance with participation requirements, whether the remedies imposed are reasonable.

III. Applicable Law

The statutory and regulatory requirements for participation by a long-term care facility are found at sections 1819 (Skilled Nursing Facilities (SNF)) and 1919 (Nursing Facilities (NF)) of the Social Security Act (Act) and at 42 C.F.R. Part 483. Section 1819(h)(2) of the Act vests the Secretary of Health and Human Services (Secretary) with authority to impose enforcement remedies against a SNF for failure to comply substantially with federal participation requirements established by sections 1819(b), (c), and (d) of the Act (and section 1919(h)(2) of the Act gives similar enforcement authority to the states). Among these remedies are included termination of a noncompliant facility's participation in Medicare, imposition of a DPNA, CMPs, and appointment of temporary management. Act §1819(h)(2)(B). The Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility that is not complying substantially with federal participation requirements. *"Substantial compliance* means a level of compliance with the requirements of participation 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 (emphasis in original). A deficiency is a violation of a participation requirement established by sections 1819(b), (c), and (d) of the Act or the Secretary's regulations at 42 C.F.R. Part 483, Subpart B. Facilities that participate in Medicare may be surveyed on behalf of CMS by state survey agencies to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-488.28, 488.300-335.

The regulations specify the enforcement remedies that CMS may impose if a facility is not in substantial compliance with Medicare requirements. 42 C.F.R. § 488.406. CMS may impose a CMP for each day a facility is not in substantial compliance, or for each instance of noncompliance. The regulations provide that a CMP that is imposed against a facility on a per-day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP, from $3,050 per day to $10,000 per day, is reserved for deficiencies that pose immediate jeopardy to a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i), (d)(2). Pursuant to 42 C.F.R. § 488.301, "*[i]mmediate jeopardy* means 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." (Emphasis in original). The lower range of CMP, from $50 per day to $3,000 per day, is reserved for deficiencies that do not constitute immediate jeopardy but either cause actual harm to

residents, or cause no actual harm but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). CMS is authorized to impose a per-instance CMP (PICMP) from $1,000 to $10,000, whether or not immediate jeopardy is identified. 42 C.F.R. § 488.438(a)(2).

The Act and regulations make a hearing before an administrative law judge (ALJ) available to a long-term care facility against which CMS has determined to impose an enforcement remedy. Act §§ 1128(A)(c)(2), 1866(h); 42 C.F.R. §§ 488.408(g); 498.3(b)(13). The hearing before an ALJ is a de novo proceeding. *Residence at Salem Woods*, DAB No. 2052 (2006); *Cal Turner Extended Care Pavilion*, DAB No. 2030 (2006); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Anesthesiologists Affiliated, et al.*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." *See* 42 C.F.R. § 488.408(g)(1); *see also* 42 C.F.R. §§ 488.330(e), 498.3. However, CMS's choice of remedies or the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance that CMS finds if a successful challenge would affect the range of the CMP that CMS could impose or impact the facility's authority to conduct a NATCEP. 42 C.F.R. §§ 498.3(b)(14), (d)(10)(i). CMS's determination as to the level of noncompliance "must be upheld unless it is clearly erroneous," including the finding of immediate jeopardy. 42 C.F.R. § 498.60(c)(2); *Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (Board) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g., Koester Pavilion*, DAB No. 1750 (2000). ALJ review of a CMP is subject to 42 C.F.R. § 488.438(e).

The standard of proof, or quantum of evidence, required is a preponderance of the evidence. CMS bears the burden of coming forward with evidence and making a prima facie showing of a basis for imposition of an enforcement remedy. Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense. *See Batavia Nursing & Convalescent Inn*, DAB No. 1911 (2004); *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 F. Appendix 181 (6th Cir. 2005); *Emerald Oaks*, DAB No. 1800; *Cross Creek Health Care Ctr.*, DAB No. 1665 (1998); *Hillman Rehab. Ctr.*, DAB No. 1611 (1997), *aff'd*, No. 98-3789, 1999 WL 34813783 (D.N.J. May 13, 1999).

Petitioner disputes this allocation of the burden of proof and asserts that CMS must be

required to prove its case by a preponderance of the evidence. P. Br. at 4, 18-20.[3] The evidence here is not in equipoise, however, and CMS would have prevailed here even if I had allocated the burden of proof to CMS. *Cmty. Skilled Nursing Ctr.*, DAB No. 1987, at 4 (2005).

IV. Analysis

My findings of fact and conclusions of law are set forth in bold and are followed by my analysis.

During the April 11, 2008 survey, Petitioner was found out of substantial compliance with the following participation requirements: 42 C.F.R. § 483.10(a)(1), (2) (F Tag[4] 151, at a scope and severity level (SS) K;[5] 42 C.F.R. § 483.25(h) (F Tag 323, SS K); 42 C.F.R. § 483.13(c) (F Tag 224, SS J); 42 C.F.R. § 483.13(c) (F Tag 226, SS J); 42 C.F.R. § 483.13(b), 483.13(b)(1)(i) (F Tag 223, SS G); 42 C.F.R. § 483.25(c) (F Tag 314, SS G); 42 C.F.R. § 483.15(h)(2) (F Tag 253, SS F); 42 C.F.R. § 483.35(i)(2) (F Tag 371, SS F); 42 C.F.R. § 483.65(c) (F Tag 445, SS F); 42 C.F.R. § 483.15(a) (F Tag 241, SS E); 42 C.F.R. § 483.15(e)(1) (F Tag 246, SS E); 42 C.F.R. § 483.15(f)(1) (F Tag 248, SS E); 42 C.F.R. §§ 483.10(e), 483.75(l)(4) (F Tag 164, SS D); 42 C.F.R. § 483.10(i)(1) (F Tag

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[3] Petitioner also asserts the *Hillman* standard is a substantive rule that was required to be promulgated under the Administrative Procedure Act. P. Br. at 19. That issue has been addressed in the cases cited above and is not at issue here, where I have found CMS proved its case by a preponderance of the evidence. Petitioner's arguments with regard to the burden of proof, however, are included in the record for purposes of appeal. *See* P. Br. at 18-19.

[4] An F Tag designation refers to the part of the State Operations Manual (SOM) that pertains to the specific regulatory provision allegedly violated, as set out in the statement of deficiencies (SOD).

[5] CMS and a state use scope and severity levels when selecting remedies. The scope and severity level is designated by an alpha character, A through L, which CMS or the state agency selects from the scope and severity matrix published in the SOM, section 7400E. S*ee* 42 C.F.R. § 488.408. A scope and severity level of A, B, or C indicates a deficiency that presents no actual harm but has the potential for minimal harm. Facilities with deficiencies of a level no greater than C remain in substantial compliance. A scope and severity level of D, E, or F indicates a deficiency that presents no actual harm but has the potential for more than minimal harm that does not amount to immediate jeopardy. A scope and severity level of G, H, or I indicates a deficiency that involves actual harm that does not amount to immediate jeopardy. Scope and severity levels J, K, and L are deficiencies that constitute immediate jeopardy to resident health or safety. The matrix, which is based on 42 C.F.R. § 488.408, specifies which remedies are required and optional at each level based upon the frequency of the deficiency, i.e., whether a deficiency is isolated, part of a pattern, or widespread. 42 C.F.R. § 488.301.

170, SS D); 42 C.F.R. § 483.15(g)(1) (F Tag 250, SS D); 42 C.F.R. § 483.20, 483.20(b) (F Tag 272, SS D); 42 C.F.R. §§ 483.20(d), 483.20(k)(1) (F Tag 279, SS D); 42 C.F.R. § 483.20(k)(3)(i) (F Tag 281, SS D); 42 C.F.R. § 483.20(k)(3)(ii) (F Tag 282, SS D); 42 C.F.R. §§ 483.20(m), 483.20(e) (F Tag 285, SS D); 42 C.F.R. § 483.25 (F Tag 309, SS D); 42 C.F.R. § 483.25(a)(3) (F Tag 312, SS D); 42 C.F.R. § 483.25(d) (F Tag 315, SS D); 42 C.F.R. § 483.25(k) (F Tag 328, SS D); 42 C.F.R. § 483.25(l) (F Tag 329, SS D); 42 C.F.R. § 483.25(m)(1) (F Tag 332, SS D); 42 C.F.R. § 483.25(n) (F Tag 334, SS D); 42 C.F.R. § 483.35(g) (F Tag 369, SS D); 42 C.F.R. § 483.60(b), (d), (e) (F Tag 431, SS D); 42 C.F.R. § 483.65(a) (F Tag 441, SS D). Petitioner was also cited for the following C level citations, but the C level citations do not support a finding of substantial noncompliance: 42 C.F.R. §§ 483.10(b)(5)-(10), 483.10(b)(1) (F Tag 156, SS C); 42 C.F.R. § 483.10(k) (F Tag 174, SS C); 42 C.F.R. § 483.15(c)(6) (F Tag 244, SS C); 42 C.F.R. § 483.30(e) (F Tag 356, SS C); 42 C.F.R. § 483.35(i)(3) (F Tag 372, SS C); and 42 C.F.R. § 483.70(h)(4) (F Tag 469, SS C). P. Ex. 17.

In this decision, I discuss only the immediate jeopardy Tags at F 323 and F 224. I am not required to make findings of fact and conclusions of law on deficiencies that are not necessary to support the remedies imposed, as is the case here where the CMP imposed is at the minimum for per-day CMP at an immediate jeopardy level. *Batavia Nursing and Convalescent Ctr.*, DAB No. 1904, at 21-22; *Cmty. Skilled Nursing Ctr.*, DAB No. 1987; *Golden Living Ctr. – Frankfort*, DAB No. 2296, at 3 n.2 (2009). Thus, I do not address all the immediate jeopardy deficiencies cited by the surveyors. With regard to the lower level deficiencies that CMS alleged, while Petitioner asserted in its hearing request that it would contest the lower level deficiencies cited in the SOD, Petitioner has not adduced evidence or presented argument to rebut the allegations. The allegations in the SOD in this case are sufficient to establish a prima facie case unless disproved or rebutted. Accordingly, I sustain these lower level deficiencies.[6]

1. Petitioner was out of substantial compliance with the participation requirement at 42 C.F.R. § 483.25(h) (F Tag 323, SS K).

Pursuant to 42 C.F.R. § 483.25(h),

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

[6] Petitioner argues that its resident population is made up of younger residents living in the facility due to physical disabilities coupled with mental health issues, which makes for a challenging environment. P. Br. at 5-6. The make-up of a facility's population does not change a facility's responsibilities under the Act and regulations. And, although Resident 3 (discussed below) is a younger individual, Resident 37 (also discussed below) was, at the relevant time, 79 years old.

The Board has stated with regard to subsection (h)(1),

> The standard in section 483.25(h)(1) itself – that a facility "ensure that the resident environment is as free of accident hazards as possible" in order to meet the quality of care goal in section 483.25 – places a continuum of affirmative duties on a facility. A facility must determine whether any condition exists in the environment that could endanger a resident's safety. If so, the facility must remove that condition if possible, and, when not possible, it must take action to protect residents from the danger posed by that condition.

Laurelwood Care Ctr., DAB No. 2229, at 8 (2009) (quoting *Me. Veterans' Home – Scarborough*, DAB No. 1975, at 5 (2005)). The Board states further that section 483.25(h)(1) clearly informs facilities that they must ensure that the resident environment remains as free of accident hazards as possible. The Board cites 42 C.F.R. § 483.20(b) in noting that other program requirements in the regulations require nursing home facilities to engage in a comprehensive assessment of a resident's needs. The Board states that such an assessment necessarily includes evaluating the benefits and risks of a particular service initiated by a facility. *Laurelwood Care Ctr.*, DAB No. 2229, at 8 (citing *Me. Veterans' Home – Scarborough*, DAB No. 1975).

The Board has recently stated with regard to section 483.25(h)(2) that:

> [S]ection 483.25(h)(2) requires that a facility take "all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents." *Briarwood Nursing Center*, DAB No. 2115, at 11 (2007), citing *Woodstock Care Ctr. v. Thompson*, 363 F. 3d 583, 590 (6th Cir. 2003) (facility must take "all reasonable precautions against residents' accidents"); ALJ Decision at 7. A facility is permitted the flexibility to choose the methods it uses to prevent accidents, but the chosen methods must constitute an "adequate" level of supervision under all the circumstances. *Briarwood* at 5. Furthermore, as the Board noted in *Kenton Healthcare, LLC*, DAB No. 2186 [at 22] (2008):
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> > The Board has confirmed that the measures that a facility adopts to care for its residents are evidence of the facility's evaluation of what must be done to attain or maintain a resident's highest practicable physical, mental and psychosocial well-being, as required by section 483.25. *Woodland Village Nursing Center*, DAB No. 2053, at 8-9 (2006), *aff'd*, *Woodland Village Nursing Ctr. v. U.S. Dep't of Health & Human Servs.*, 239 Fed. App'x 80 (5th Cir. 2007),

> citing *Spring Meadows Health Care Center*, [DAB No. 1966] at 16-18 [(2005)] (addressing facility failures to observe their own policies for resident care). Failure to fully employ those measures as intended may thus be . . . evidence that the facility failed to provide residents with needed care and supervision as required by the regulation.

Cedar Lake Nursing Home, DAB No. 2288, at 6-7 (2009).

The April 11, 2008 statement of deficiencies reflects that Petitioner:

> [F]ailed to provide the supervision necessary to prevent avoidable accidents at a level likely to allow, cause, or result in serious injury, harm, impairment or death as evidenced by: 1 (Resident #3) out of 37 sampled residents found asleep and unsupervised with a lit cigarette smoldering on a towel on the Resident's lap; and 1 (Resident # 37) out of 37 sampled residents [was] found wandering alone on a major 4 lane roadway with a non-functional wanderguard. Furthermore, the facility was found to have purposely disabled the wanderguard alarm system during the survey and to have failed to ensure an environment free from hazards.

P. Ex. 17, at 114.

Resident 37

Resident 37 was 79-years-old at the relevant time. He was originally admitted to Petitioner's facility on November 24, 2003. CMS Ex. 18, at 1. His diagnoses included Alzheimer's disease, delirium, and visual problems. He had difficulty making himself understood and understanding others. He took antipsychotic, antianxiety, antidepressant, and hypnotic drugs, and was on a behavior management program. Based on minimum data set (MDS) responses, resident assessment protocols (RAPs) were triggered for wandering and resisting care. Staff noted in a December 2, 2007 RAP worksheet for behavioral symptoms that "[r]esident has some behavior issues. He is a wanderer and has a wanderguard because he is a risk for elopement. Usualyy (sic) he is easily directed. At times he can be resistive to care. Proceed to Care Plan." *Id.* at 6. Staff noted in a RAP worksheet for falls that the resident has a history "of falls and is at risk r/t his poor safety awareness. No recent falls at this time. He will always need supervision." *Id.* at 7. A January 1, 2008 care plan noted that the resident was "[a]t risk for further elopement R/T hx of trying to get out of facility. Would open exit door and sets the alarm. Poor safety awareness." As to the approaches to deal with this behavior, the staff were told to: approach him calmly; observe his whereabouts at all times; check his wanderguard for placement and function; redirect him when going out of the facility; give him medications as ordered; encourage family visits; walk with him as tolerated; and refer

him to a physician if he becomes unmanageable. CMS Ex. 18, at 8. Petitioner's Risk Manager, Ms. Davis, testified that during the day Resident 1 was in a program in a special area where he ate and where there were activities geared to individuals with dementia. The daily time frame for the program was approximately 10:00 a.m. to 7:00 p.m. During this time, Ms. Davis asserted that Resident 37 should have been "continuously monitored by a staff member." Tr. at 286.

On January 27, 2008, Resident 37 eloped from the facility. An incident report notes:

> At approximately 5:30 PM on Sunday, January 27, a motorist called the facility and asked if one of our residents was outside. We looked immediately for [Resident 37], who is confused and his habits are that he walks frequently and quickly around the facility. He was down the street on Haverhill road (the road which goes South by the facility). Two employees went to get him. The motorist also called 911, so fire rescue arrived soon after our employees arrived. Employees brought resident back to the facility. [Resident 37] had on the facility ID bracelet and his wanderguard.

CMS Ex. 18, at 11. The facility analysis noted:

> Resident, who walks around the facility, walked out of the facility at approximately 5:15 PM and walked down the street. He is a known elopement risk and had on his wanderguard bracelet. The wanderguard door and bracelet had been checked earlier in the day and was functioning. Upon his return his wanderguard was found not to be functioning. All exits, when tested, upon his return, were functioning.

CMS Ex. 18, at 12.

Resident 37's care plan required Petitioner to monitor him by checking his wanderguard bracelet for functionality. CMS concluded that an immediate jeopardy situation existed as a result of Resident 37's elopement due to Petitioner's failure to keep track of when wanderguard bracelets expired. P. Ex. 28, at 5-8; CMS Br. at 9.

Two types of wanderguard systems exist. Some are configured as a selective locking system, which allows all residents, other than those wearing a wanderguard bracelet, to exit a facility freely. When a resident wearing a wanderguard bracelet approaches the door, it automatically locks and prevents the resident from exiting. The lock typically disengages once the wanderguarded resident leaves the door area. Other systems do not engage a locking mechanism. These systems have a sensor that triggers an alarm when a resident wearing a wanderguard comes within a certain radius of the wanderguarded door. The alarm alerts staff members to a potential elopement. The alarm typically

sounds until it is disengaged via a security code keypad or other mechanism. It is undisputed that Petitioner used a wanderguard alarm system, rather than a locking system, to monitor its residents prone to elopement. Tr. at 67, 69-71. As Petitioner notes, its wanderguard system serves solely to act as an audio alarm to alert Petitioner's staff that a monitored resident has attempted to leave the facility. P. Br. at 12; P. Response at 8.[7] Petitioner also asserts, and CMS does not dispute, that Resident 37's wanderguard bracelet was tested earlier in the day on which he eloped, and the bracelet was working. Tr. at 297, 313-15.

CMS asserts that: it is undisputed that Resident 37 eloped; his disappearance was not discovered until a motorist called the facility to report the elopement; the resident was walking along a busy highway a half mile from the facility; and the resident should have been constantly monitored by a staff member. Tr. at 286. CMS further maintains that the wanderguard bracelets that Petitioner used were only effective for 90 days and required replacement at the end of this interval. In addition, CMS notes that, at the time of the elopement, Petitioner failed to: have a system in place to keep track of when the bracelets were put into service; or employ a tickler system to trigger when they needed replacement. CMS Br. at 7.

CMS asserts that Petitioner determined that the most likely cause of Resident 37's elopement was an expired wanderguard bracelet. Mr. Mehaffey testified for Petitioner that it was not foreseeable that Resident 37's wanderguard bracelet would expire between three daily checks. Tr. at 297. CMS countered by arguing that it was unlikely that the facility would discover that a wanderguard bracelet became inoperable "at the precise minute of occurrence considering that only three checks were performed over a course of twenty-four hours." CMS Br. at 8. CMS also asserts that the surveyors found that Petitioner was aware that many of its residents had the code to the wanderguard alarm and could silence it.[8] CMS contends that Petitioner did not try to prevent its alert and oriented residents from ascertaining the code until it changed the code on April 11, 2008, in response to the surveyors' observations. CMS further avers that Petitioner contended that there were no foreseeable problems with its residents knowing the wanderguard code, since there had not been any known or documented incidents of resident elopement.

CMS maintains that Petitioner should have taken additional steps to change the code more frequently. For instance, Petitioner could have safeguarded the code from resident view by: covering up the entry; instructing residents in the immediate area to stand back;

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[7] Petitioner notes that it also has a magnetic lock general security system designed to prevent unauthorized ingress and egress, but still permit emergency exit at all exterior doors. Tr. at 275; P. Br. at 12.

[8] The SOD notes that on April 11, 2008, at 4:50 p.m., the surveyors asked Residents 31 and 24 if they knew the code for disabling the wanderguard alarm at the exit doors. Apparently, they gave the correct combination. P. Ex. 17, at 54.

or researching alternative keypads that would preclude observation of code entry, such as a floating or rotating keypad. CMS Br. at 8 (citing CMS Ex. 19, at 11); Tr. at 316, 439. CMS asserts that Petitioner did not explain why alert and oriented residents needed to know the wanderguard code, because the facility did not employ a locking mechanism. The door only sounded an alarm when a wanderguarded resident approached the door. All other residents could exit the facility at will. Even if the alarm triggered when a non-wanderguarded resident attempted to exit, the alarm would just have alerted staff to investigate the possibility of elopement. CMS asserts that the problem with allowing non-wanderguarded residents to have the code is that they were empowered to allow wanderguarded residents to exit the facility without staff knowledge by turning off the alarm. CMS Br. at 9 (citing P. Ex. 28, at 8-9).

CMS asserts that the only remedial measures that Petitioner took after Resident 37's elopement were to begin keeping track of wanderguard expiration dates and equip the resident with two wanderguard bracelets. The facility did not explain the purpose of the second bracelet, or how it would better address the systemic breakdown of its elopement protocol. Petitioner also treated the fact that many residents possessed the wanderguard code as a "non-issue."

CMS also questions what happened once a wanderguard alarm sounded. CMS notes that once the alarm sounded, Petitioner assumed that a staff member would investigate the reason for the alarm and deactivate it. However, not all wanderguarded doors were visible from the nursing station, and no "designated" staff members were assigned to investigate the alarm. Petitioner's policy did not require the staff member deactivating the alarm to notify other staff. Thus, if the alarm went off and was deactivated, staff could assume another staff member had turned it off, when a resident might have done so instead. Petitioner conceded that it was aware that its residents would sometimes turn the alarm off when triggered (Tr. at 289) and that the practice continued to on or about April 13, 2008. P. Ex. 17; CMS Br. at 10.

CMS states that the surveyors tested the alarm during the survey and notes that facility staff failed to respond to the alarm. Surveyors also noted that the facility disarmed the alarm during the survey. CMS Ex. 19, at 6; Tr. at 72, 73. While CMS notes Petitioner's contention that the alarm was ignored and disarmed to accommodate the survey team, Petitioner did not provide any evidence or testimony to indicate what measures it put into place to ensure the protection of its residents when the alarm was ignored and then disarmed. *See* P. Br. at 10-11.

CMS notes that while Petitioner is permitted the flexibility to choose the methods of supervision it uses to prevent accidents, the methods must be adequate under the circumstances. In addition, a facility must be able to show that there are redundancies of protection or multiple interventions that provide adequate supervision to prevent elopement. CMS Br. at 12 (citing *Libertywood Nursing Ctr.*, DAB CR1945, at 5 (2009)); *Mitchell Village Care Ctr.*, DAB CR1589, at 9 (2007).

Petitioner asserts that it determined that the most reasonable and likely cause for Resident 37's elopement was a faulty wanderguard bracelet. Tr. at 273-74, 297. Its staff checked the bracelet at each shift change prior to his elopement, and each time it functioned properly but did not work when Resident 37 was returned to the facility. Tr. at 297, 313-15. This failure occurred despite the fact that Petitioner's wanderguard bracelet was most recently tested less than eight hours prior to the resident's elopement. P. Response at 6; Tr. at 297, 313-15. Petitioner asserts that no standard requires replacement of the bracelets every 90 days.

Petitioner argues that neither state nor federal agencies investigated the elopement when it was self-reported. In addition, Petitioner notes that when agency concerns exist, those concerns are usually addressed by inspection. Tr. at 277, 296.

Petitioner asserts that not all elopements are per se a failure to comply with the regulations. Not all elopements are preventable. Here, proper measures were in place to prevent Resident 37's elopement. The facility did not fail either deliberately or negligently to protect its residents. *Oakwood Manor Nursing Ctr.*, DAB CR818 (2001) (citing *Beverly Health & Rehab. Ctr.-Williamsburg*, DAB No. 1748 (2000)).

Moreover, Petitioner argues it took "appropriate and abundant" steps to ensure that an elopement would not occur again. It began to chart the expiration of wanderguard bracelets to insure that the bracelets were changed before their expiration date. Also, the Risk Manager verified weekly that they all worked. Tr. at 415; P. Response at 8. This was done within 24 hours of Resident 37's elopement. Tr. at 431, 454. Petitioner also provided in-service training to staff on elopement risks and issues. Tr. at 273.

Petitioner also argues that preventing alert residents from learning the code that silences the audio alarm is completely unrelated to Resident 37's elopement and is the only alleged deficient practice. No regulation or standard of practice requires that alert and aware residents be prevented from knowing a wanderguard code, and it is common knowledge within facilities and virtually impossible to prevent. Thus, attempting to prevent alert and aware residents from knowing the wanderguard code is both unrealistic and unnecessary. Tr. at 417; P. Response at 8. Petitioner argues that it has implemented a system to both properly protect its at-risk residents and allow autonomy and freedom of movement to its alert and aware residents. Rather than a code entry to silence the alarm, Petitioner could have had a system necessitating only the pushing of a button to silence the alarm. However, its use of a numeric code that has to be observed and later recalled constitutes heightened protection.

Rather than unrealistically attempting to guard the code, Petitioner asserts that it changed the code on occasion (and more frequently since the survey). Petitioner notes that it is uncontested that some alert and aware residents have the ability to observe staff enter the code. But, Petitioner asserts CMS did not present evidence that alert and aware residents both knew the code and how and when to enter it. And, there is no evidence that

residents without cognitive impairment would intentionally enter the code to allow an impaired resident to elope. P. Br. at 10. Ms. Dickerson testified that would not be likely. Tr. at 438. Mr. Mehaffey testified that Petitioner has never had an instance where an alert and aware resident silenced the alarm and let a mentally or cognitively impaired resident leave the facility. Tr. at 316.

Petitioner also asserts that there is no evidence staff would not respond to an alarm that unexpectedly sounded and then was silenced. Staff did not respond to an alarm sounded during the surveyors' test. However, knowing that the administrator was working on the doors with the surveyors, it made sense for staff not to respond, and they were aware of the surveyors' presence. Tr. at 94; P. Response at 10-11.

CMS has shown, and Petitioner failed to rebut, that Petitioner failed to take all reasonable steps to ensure that Resident 37 received supervision to meet his assessed needs and to mitigate the foreseeable risks of harm from accidents, which, in this case, was his elopement. Most importantly, Petitioner did not have a sufficient system for responding when a wanderguard alarm went off. This danger was not simply confined to Resident 37 but extended to any facility resident assessed to need wanderguard protection. CMS showed that not all wanderguarded doors were visible from the nursing station (Tr. at 77-78, 150; P. Ex. 22) and that Petitioner did not have designated staff to investigate when an alarm went off. Hence, no accountability existed. A staff member deactivating an alarm was not required to notify other staff regarding the outcome. When the alarm deactivated, staff might presume another staff member had turned off the alarm when a resident might have done so instead. This left open the possibility that a resident might elope. Moreover, Petitioner did not assure that the exit doors were monitored when the system was tested during the survey, and its wanderguarded residents were left potentially able to elope.

Ms. Davis admitted that some residents had the code for the wanderguard, because they were "observant and independent" and "get up and watch and look." She testified that if a resident set off the alarm, one of the residents who had the code "might get up and turn it off before the staff member got there." Tr. at 289. Thus, a resident could elope. No evidence exists that Petitioner addressed this systemic problem in its elopement protocol prior to the survey. Although Petitioner asserted that it was unlikely that a non-wanderguarded resident with the code could allow a wanderguarded resident to exit the facility without staff knowledge, Petitioner did not plan for that possibility, even after Resident 37's elopement.

CMS showed also, and Petitioner did not dispute, that at the time of the elopement the wanderguard bracelets were effective for only 90 days, and Petitioner did not have a system in place to trigger when they needed replacement.

Finally, Petitioner did not explain why the facility did not realize Resident 37 had eloped when, according to Ms. Davis, he should have been continuously monitored by a staff member, and his care plan required that his whereabouts be observed at all times.

Resident 3

Resident 3 was admitted to Petitioner's facility on February 5, 2008, about two months before the survey at issue. At the time of the survey, Resident 3 was a 45-year-old man with diagnoses of gastric anomaly, depressive disorder, constipation, insomnia, decubitus ulcer, cellulitis, paraplegia, and bilateral below the knee amputations. CMS Ex. 9, at 5, 23. Resident 3 was on numerous drugs, including Ambien, Procrit, Remeron, Fentanyl, Percocet, Amitriptyline, Pepcid, Levaquin, and Methadone. The side effects of these medications may impair thinking or include drowsiness, dizziness, or fainting. CMS Br. at 14-15; Tr. at 143-45; CMS Ex. 9, at 48; 72-73; 78-79; 88-89.

Resident 3 was a smoker, and, on February 5, 2008, a smoking safety screen was completed for him. The safety screen showed that he was able to safely: ignite a lighter independently; hold a cigarette/cigar/pipe independently; use an ashtray appropriately; keep ashes from dropping on himself; and extinguish a cigarette/cigar/pipe. Resident 3 was noted to demonstrate and comply with smoking in approved areas and with keeping smoking materials in a safe location designated by the facility. Resident 3 was free from smoking related burns to himself, clothes, or furniture, and he was cognitively intact and demonstrated good decision making. However, the screen also stated "no" to a question that the "Resident/patient does not exhibit side effects from medications including sedation, drowsiness or dizziness." The screen notes that if "yes" was answered to all these questions, the screener could simply select whether the individual could smoke independently or with assistance. Here, the screener stated that the resident was "[a]ble to smoke independently." However, if a "no" was answered to one of the questions, the screener was supposed to select the type of supervision required and explain why. The screener failed to do so here, even though the screener cited that Resident 3 exhibited side effects from medications, including sedation, drowsiness, or dizziness.[9] CMS Ex. 9, at 22. At no point over the next two months is there evidence of record that Petitioner further assessed Resident 3's smoking in light of potential medication effects. And, no evidence exists that Petitioner care planned for Resident 3's smoking behavior in light of it.

[9] At hearing, Mr. Mehaffey suggested the way the question was worded was a double negative and that he thinks the screener's true intent would have been to answer yes to the question regarding side effects from medications. He indicated his belief that the form was incorrectly filled out. Tr. at 326-28. However, if the facility wanted to impeach the credibility of the exhibit, the facility should have elicited testimony from the author of the exhibit.

On April 11, 2008, at 9:30 a.m.,[10] Surveyor Susan Lucas, who did not testify, observed Resident 3. Her surveyor note indicates that:

> [Resident 3] seen out front [with] cigarette on lap. Hole burned in towel. Lighter on lap. Towel smoldering – smoke coming out edges of hole glowing red. [Resident 3] asleep out front. Steve woke resident up. [Resident 3] poured water on it to extinguish.

CMS Ex. 19, at 34. Petitioner does not dispute that the incident occurred. P. Br. at 9-10; *see* P. Ex. 2, at 16. Facility records show that this was not the first time that the resident had been observed asleep in a compromised position. On March 11, 2008, nurse's progress notes indicate that Resident 3 was "always in [wheelchair] falling asleep. Advised/encouraged to get in bed for more comfort . . . but [resident] refused."[11] CMS Ex. 19, at 39. On March 25, 2008, at 12:30 a.m., nurse's progress notes indicate that:

> When this nurse was leaving facility to go home in evening it was noted by this writer that this Resident was sitting outside in front of the facility door sleeping with a lighted cigarette in his mouth. This writer took the cigarette out of his mouth & woke [resident] up. Counseled [resident] on smoking when he is sleepy & the danger that could happen with a lighted cigarette. [Resident] refused to go in facility to go to bed.

CMS Ex. 9, at 40; P. Ex. 2, at 13. No incident report was prepared, no new assessment or investigation was done, no new interventions were put in place for the resident's smoking, and no smoking care plan was prepared. On April 9, 2008, nurse's progress notes report that at 1:00 a.m.:

> Resident sitting in chair resting [with] eyes closed. . . . Resident has an iron plugged on his table. Iron removed and stored away from resident room. Resident woke up and asked about this iron. . . . [E]xplained [to Resident 3] why iron was taken away.

CMS Ex. 9, at 41; P. Ex. 2, at 14. No incident report was prepared and no assessment was done.

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[10] Petitioner asserts that the incident occurred at 9:30 p.m. P. Response at 13. However, the record reflects that the surveyor observation was actually made at 9:30 a.m. CMS Ex. 19, at 34; P. Ex. 2, at 16.

[11] Petitioner asserts that this notation was made at 5:30 a.m. and that it is unfounded to contend, as CMS does, that this was a result of his medication, because that time of the morning is a reasonable time to be asleep. P. Response at 12. At the least, however, it shows that Resident 3 had a propensity to fall asleep in his wheelchair.

Petitioner notes that Resident 3 kept a late schedule and smoked outside until past midnight on many occasions. P. Br. at 9; P. Response at 12. Petitioner acknowledges that Resident 3 was on a number of medications, which have a sedative effect. *Id.* But, it notes Ms. Dawkins' testimony that after long-term use of these medications the sedative effect diminishes. Tr. at 362-68. Petitioner asserts that nursing judgment and observation are to be used to evaluate a patient's ability to smoke independently, and such judgment and observation, in accordance with Petitioner's policies, led staff to assess Resident 3 as an independent smoker. Tr. at 372-74; P. Br. at 9.

Whether or not the sedative effect of medications may diminish in an individual resident, there is no documentation or testimony to prove that Petitioner ever assessed Resident 3 to find out if the sedative effects of these medications had been blunted. And, the one smoking screen done noted that Resident 3 was so impacted by his medications. In fact Ms. Davis, Petitioner's Risk Manager, testified at hearing that Resident 3 should not have been designated to smoke independently, because he had been found violating the smoking policy on March 25, 2008, when he was found asleep with a lit cigarette in his mouth.[12] Tr. at 285. Although Ms. Davis stated that this incident and the fact that Resident 3 was violating Petitioner's smoking policy was found during chart review, as noted, no incident report was prepared, no new smoking assessment was done, and no new interventions were care planned.

While Petitioner contends that Resident 3 had insomnia and woke frequently during the night (P. Response at 13, citing CMS Ex. 9, at 1, 46), this assertion does not negate the fact that Petitioner did not assess Resident 3 after he fell asleep twice with a lit cigarette in his mouth and once with an iron plugged in.

Petitioner asserts that no standard exists that independent smokers be constantly supervised or may not smoke outside the building. However, Petitioner also understands that it is the facility's "responsibility to ensure that all necessary precautions are taken and specific and intentional assessments are performed to determine a resident's ability to make these decisions for himself. . . ." P. Response at 14. Resident 3 should have been reassessed and care planned for his smoking behaviors the first time he was found asleep with a lit cigarette in his mouth. CMS Ex. 19, at 9; P. Ex. 27, at 10.

CMS also asserts that the facility failed to provide necessary safety devices (fire extinguishers and smoking aprons) within easy reach of its residents smoking in non-designated areas. It also failed to enforce its prohibition against smoking in non-designated areas. Specifically, the facility failed to provide a designated smoking area with the appropriate safety equipment when Resident 3 was smoking in a non-designated smoking area, although the facility was aware that residents smoked there. There were no smoking aprons or blankets available nearby. Furthermore, there were no smoking

[12] Although the facility's smoking policy in effect at the relevant time was referenced (Tr. at 361), neither party referred me to where that policy was located.

aprons available even in the designated smoking areas. One of the CNAs indicated that she had not seen a smoking apron in about six months. CMS Ex. 19, at 9.

Petitioner does not dispute that it did not have smoking aprons or that safety devices were within reach of its residents smoking in non-designated areas at the relevant times. Instead it asserts that it obtained smoking aprons from a "sister facility" during the survey. P. Br. at 17. Petitioner's failure to recognize prior to the survey that it should have had safety devices in an area where it knew its residents congregated to smoke is a deficiency as well.

2. Petitioner was out of compliance with the participation requirement at 42 C.F.R. § 483.13(c) (F Tag 224, SS J).

Pursuant to 42 C.F.R. § 483.13(c),

> (c) *Staff treatment of residents.* The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

The SOD alleged that Petitioner:

> [N]eglected to assess and supervise 1 (Resident #3) out of 37 residents for safe smoking and 1 (Resident #37) out of 37 residents for elopement resulting in the likelihood of serious injury, harm, impairment or death. Resident #37 was found wandering alone on a major 4 lane roadway with a non-functional wanderguard alarm bracelet. Furthermore, the facility failed to provide necessary care and services to obtain a wound care consult as ordered for Resident #3, resulting in the development of new pressure sores. P. Ex. 17, at 45.

CMS asserts that F Tag 224 is cited when there are deficiencies concerning neglect. CMS Br. at 20 (citing the SOD, Appendix PP, Guidance to Surveyors for Long Term Care Facilities). CMS notes that the regulations define "neglect" as the "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." *Id.*

With regard to Resident 37's elopement, discussed above, CMS asserts that Petitioner neglected the resident when it failed to address the issue of allowing some of its residents to possess the wanderguard code (when it could have simply covered the keypad to obscure entries, or directed residents to stand back when the alarm triggered until after it was deactivated). Additionally, staff could not see all the wanderguarded doors from the

nursing station and did not take steps to further train its staff regarding the wanderguard system and the facility's elopement protocol. CMS asserts that regardless of how Resident 37 eloped, the facility was required to address all likely and probable avenues of elopement. There were no "checks and balances" in Petitioner's anti-elopement system. When the alarm went off, there was no way to determine who deactivated the alarm or that what had triggered the alarm had been resolved. CMS Br. at 20-21.

Petitioner asserts that the fact that Resident 37 eloped does not mean that Petitioner failed in its obligation to take all reasonable steps to prevent the occurrence. Petitioner argues that the question is not just whether an unwanted result occurs, but whether the facility failed, either deliberately or negligently, to protect its residents. Here, immediately after the elopement, Petitioner took measures to prevent a recurrence. It began to chart the expiration of wanderguard bracelets, wanderguard bracelets were changed, and, weekly, the Risk Manager verified all bracelets worked. P. Br. at 11.

I find that Petitioner negligently failed to protect its residents. Petitioner failed to train its staff to ensure that staff knew who should deactivate an alarm. And, Petitioner had no process to let staff know when an incident triggering an alarm was resolved. Petitioner also failed to ensure that its residents did not know the code to the wanderguard alarm.

With regard to Resident 3, CMS asserts that he was on numerous medications with sedative side effects. Even after having been discovered sleeping with a lit cigarette, Petitioner neglected to conduct another smoking screen for the resident to determine what types of interventions and supervision were required for him to smoke safely. *See* P. Br. at 21. While Petitioner asserts that its smoking policy was more than adequate and that Resident 3 had a right to make decisions about his own life, it recognizes that "it is the facility's responsibility to ensure that all necessary precautions are taken and specific intentional assessments are performed to determine a resident's ability to make these decisions for himself . . . ." P. Br. at 14. I find Petitioner failed to do so.

CMS also asserts that Petitioner neglected Resident 3 by failing to obtain two wound care consultations as ordered, which resulted in the development of a new pressure sore. CMS Ex. 9, at 70, 83; CMS Br. at 21-22. CMS asserts that Ms. Lucas observed that Resident 3 had three wounds not previously documented.[13] CMS Ex. 9, at 69; CMS Ex. 19, at 46, 47; *see* CMS Ex. 19, at 15, 16; P. Ex. 27, at 14. CMS notes that Ms. Lucas observed that the wounds were old enough that Petitioner should have documented them. She explained that the wounds were open areas of skin, rather than a closed sore symptomatic of a new wound. She observed that the wounds should have been apparent to those

[13] As noted above, Ms. Lucas did not testify at the hearing. Petitioner offered, and I accepted as an exhibit, P. Ex. 27, which is Ms. Lucas' deposition testimony taken for a State hearing regarding the survey at issue in this case. Petitioner did not request that Ms. Lucas be called as a witness at the hearing before me. Thus, I am reviewing Ms. Lucas' deposition testimony and rely on it where it is consistent with other exhibits of record, which include surveyor notes.

providing hygiene care for Resident 3. CMS Ex. 19, at 45-48; *see* CMS Ex. 19, at 15; P. Ex. 27, at 15-18.

Resident 3 also confirmed to Ms. Lucas that he had not received the two wound care consultations his physician ordered. He had asked to see the wound care specialist but had not been provided with an answer. He also told Ms. Lucas that he was worried his wounds were not healing. A CNA explained to Ms. Lucas that Petitioner had attempted to provide the wound care consultations but that the resident's insurance declined to provide them. CMS Ex. 19, at 15, 45-48; P. Ex. 27, at 18. Ms. Lucas stated that Resident 3's wound care nurse indicated that wound care was outside of his scope of practice and training. P. Ex. 27, at 19.

CMS also asserts that Ms. Lucas observed Resident 3's wound care on April 9, 2008 and found the wound care nurse failed to wash his hands and properly apply accuzyme, the resident's wound medication. CMS Ex. 19, at 40, 43, 45-47. Ms. Lucas stated that accuzyme has an enzyme type action that is made to eat away at dead tissue to promote healing. The wound care nurse "slabbed" the accuzyme over the entire area so that instead of just being applied to the wound bed, it was applied to healthy tissue. P. Ex. 27, at 21-22.

CMS also notes that the facility failed to provide a wheelchair cushion for Resident 3, despite the resident having an order for one. CMS Ex. 19, at 40; P. Ex. 27, at 22. Furthermore, the resident's care plan lacked a description of his pressure sore treatment. CMS Ex. 19, at 40; P. Ex. 27, at 23.

Petitioner attempts to rebut CMS's case by asserting that Resident 3 received proper wound care from the facility through its wound care nurse and other staff. Petitioner also asserts that the resident was under the care of a physician. Petitioner maintains that the clinical record shows that there were no new wounds at the time of the survey, because the resident's scar tissue, being pink, appeared to be a wound to the surveyor who was not familiar with the resident. P. Br. at 13; P. Response at 18-19 (citing Tr. at 450-53; P. Ex. 2). Even if I accept all that Petitioner says to be true, Petitioner still neglected to obtain wound care consultations for the resident, failed to provide an ordered wheel chair cushion, and failed to specifically rebut Ms. Lucas' observations of Resident 3's wound care treatment on April 9, 2008. This constitutes a deficiency under the applicable regulation.

3. Petitioner's noncompliance constituted immediate jeopardy to its residents.

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. Immediate jeopardy thus exists in either of two circumstances. The first is when the provider's

noncompliance has caused either death or "serious" harm to one or more residents. The second is when the provider's noncompliance is "likely to cause" death or serious harm. The regulations at 42 C.F.R. § 498.60(c)(2) also provide that a CMS determination concerning the level of noncompliance must be upheld unless it is "clearly erroneous." *Daughters of Miriam Ctr.,* DAB No. 2067 (2007). Citing the decision in *Daughters of Miriam Ctr.,* Petitioner asserts that it is not enough to show that a potential for serious harm or death exists but that such outcome is likely, i.e. more probable that a serious injury will occur than not.[14] P. Br. at 18.

CMS's determinations under these F Tags were not clearly erroneous. The facility's noncompliance was likely to cause death or serious harm to Petitioner's residents. Until the facility examined its protocol for reacting to wanderguard alarms, trained its staff in how to respond, and ensured that its residents did not know the wanderguard code, residents could still elope. When a resident eloped, the resident was exposed to dangers in the environment. Surveyors De Gruccio and Battaglia testified that the facility was in a residential area, but faces a highway. There is a fence around the front, but there is an opening for people to walk from the sidewalk into the parking lot. Moreover, the gates are left open. Tr. at 66, 148. The dangers to a demented resident, such as Resident 37, from cars and other environmental dangers (such as weather) are self-evident. And there was actual danger to Resident 37 when he eloped.

With regard to Resident 3's behaviors, until he was assessed, care planned for, and supervised, his propensity for falling asleep with a lit cigarette or a plugged-in iron was likely to hurt either himself or someone else. Although Petitioner asserts that it was respecting Resident 3's rights as a competent adult by allowing him to smoke independently, that right ends where it conflicts with health and safety. As the Act provides, a resident is to receive services with reasonable accommodation of individual needs and preferences "except where the health or safety of the individual or other residents would be endangered . . . ." Act § 1819(c)(1)(A)(v)(I). It is self-evident that a lit cigarette dropped on an individual's lap can cause harm to that individual or dropped elsewhere can start a fire. Petitioner's failure to supervise Resident 3, or properly assess him for his smoking behaviors, constitutes immediate jeopardy. Petitioner did not even have smoking aprons available at the facility for those who needed them. Finally, Petitioner likely caused Resident 3's serious pressure sore injury by failing to: obtain a wound care consult for Resident 3; provide him with a seat cushion; and treat his pressure sores.

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[14] Petitioner also objects to the Board's position in *Daughters of Miriam Ctr.* that CMS need not present a prima facie case of immediate jeopardy because 42 C.F.R. § 498.60(c)(2) requires CMS's determination on the level of noncompliance to be upheld, unless it is clearly erroneous. Petitioner asserts this decision is at odds with APA requirements and should not be followed. However, Petitioner has not explained exactly how it is at odds or why I should not follow Board precedent. P. Br. at 18.

4. The duration of the noncompliance and the remedies imposed are reasonable.

In *Taos Living Ctr.*, DAB No. 2293 (2009), the Board stated:

> . . . [O]nce a facility is found to be out of substantial compliance, noncompliance is presumed to continue until the facility demonstrates that it has achieved substantial compliance. The Board has never held, however, that the presumption of continued noncompliance is unrebuttable or that findings of continuing noncompliance are an exception to the regulatory provision of hearing rights on findings of noncompliance resulting in enforcement actions. . . . [U]nder the regulations, CMS's determination of whether the evidence demonstrates that a facility returned to substantial compliance is subject to de novo review by an ALJ. . . . A finding that deficiencies have been corrected is not tantamount to a determination that a facility has achieved substantial compliance.

Taos Living Ctr., DAB No. 2293, at 20 (citations omitted). The decision also states:

> Under the survey, certification and enforcement regulations, an on-site revisit survey may . . . be necessary in order to verify that a facility has implemented its accepted PoC and returned to substantial compliance. 42 C.F.R. §§ 488.454(a)(1), 488.454(e); 59 Fed. Reg. 56,218-10; *see also* 42 C.F.R. § 488.440(h). It does not necessarily follow, however, that a facility's corrections and achievement of substantial compliance may not be established as of a date prior to such a revisit. . . . [S]ection 488.454(e) provides that if a facility can supply acceptable documentation "that it was in substantial compliance and was capable of remaining in substantial compliance, if necessary, *on a date preceding that of the revisit*," the remedy terminates on the date verified "as *the date that substantial compliance was achieved* and the facility demonstrated that it could maintain substantial compliance, if necessary."

Id. at 19-20 (emphasis in original).

CMS found that immediate jeopardy regarding the elopement issue began on January 27, 2008, when Resident 37 eloped, and continued until the facility began to address the wanderguard code issue and elopement protocols. Immediate jeopardy regarding smoking and the smoking assessment began as early as February 5, 2008, when the facility failed to conduct the additional smoking assessment for Resident 3, and continued

until the facility began supervising Resident 3's smoking. Specifically, CMS found that the immediate jeopardy was not abated until April 20, 2008, the date CMS states immediate jeopardy was alleged to be abated in Petitioner's plan of correction. P. Ex. 17. For the non-immediate jeopardy deficiencies, Petitioner alleged compliance in its plan of correction as of May 11, 2008. CMS found Petitioner back in compliance as of the date of the revisit on May 22, 2008.

In its briefs, Petitioner asserts with regard to the smoking deficiencies that "if there was any immediate jeopardy, it was immediately corrected by the facility." P. Br. at 10. Petitioner further contends with regard to the elopement issues that "alleged deficiencies" were "corrected immediately after the elopement." P. Br. at 11. Above, I found that the noncompliance was not corrected. Petitioner has not shown that the immediate jeopardy was abated earlier than April 20, 2008, or that it came back into substantial compliance earlier than the date of the revisit survey on May 22, 2008. As I sustained the deficiencies regarding Resident 37's elopement, I find that the period of immediate jeopardy here began on January 27, 2008. Moreover, other than the statement in the plan of correction with regard to the lower level deficiencies being in substantial compliance as of May 11, 2008, Petitioner failed to show that it was in compliance with all participation requirements any earlier than the date of the re-survey. P. Ex. 17.

CMS imposed: CMPs of $3,050 per day for the period of immediate jeopardy and $250 per day for the noncompliance that was not at the level of immediate jeopardy; a discretionary DPNA from April 26 through May 21, 2008; and loss of NATCEP. The $3,050 per day CMP for the immediate jeopardy noncompliance is the minimum per day CMP that can be imposed where I find immediate jeopardy. 42 C.F.R. § 488.438(a)(1). Thus, I do not need to consider the regulatory criteria for deciding what a reasonable penalty amount is. With regard to the penalties for the non-immediate jeopardy level noncompliance, the penalties range in amount from $50 to $3,000 per day. As CMS has imposed a penalty of $250 per day for that noncompliance, I must consider the regulatory criteria for deciding whether the CMP is reasonable. They include: the seriousness of a deficiency or deficiencies; the relationship of one deficiency to another; the facility's compliance history; the facility's culpability for a deficiency or deficiencies; and the facility's financial condition. 42 C.F.R. §§ 488.438(f)(1)-(4), 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)).

I have no evidence with regard to the facility's compliance history or financial condition. However, the deficiencies I have upheld are serious. Although the immediate jeopardy was removed as of April 20, 2008, the May 5, 2008 notice letter does not state that Petitioner was in substantial compliance with these deficiencies at that time. The deficiencies involve: the elopement of Resident 37; the failure by Petitioner to supervise, assess, and care plan for Resident 3's smoking; and the failure to consult and appropriately treat Resident 3's pressure sores. Moreover, the facility was culpable, in that it failed to take remedial measures to re-assess Resident 3's smoking after he was found asleep with a lit cigarette. There are also numerous deficiencies that Petitioner did

not address, and thus has effectively conceded, which involve issues including the facility's quality of care. P. Ex. 17. The CMP imposed, $250 per day, is at the low end of the allowable range for lower level CMPs. I find it to be reasonable.

Because Petitioner was not in substantial compliance with program requirements, I have no authority to review CMS's choice of remedies, including whether to impose a DPNA. *See* 42 C.F.R. § 498.3(b)(13); *see also* 488.408(g)(2). CMS imposed the DPNA from April 26, 2008 through May 21, 2008. CMS Ex. 31. If a facility is out of substantial compliance with any participation requirements, CMS has the discretion to impose a DPNA. 42 C.F.R. § 488.406. CMS was authorized to impose a DPNA whether or not the facility was out of substantial compliance for longer than three months.

Both parties assert that a loss of NATCEP was imposed, although the April 24, 2008 notice letter asserts only that the loss of NATCEP "may be applicable to your facility and you may receive further notification from the State." CMS Ex. 1, at 14; CMS Br. at 2; P. Response at 2. Sections 1819(f)(2)(B) and 1919(f)(2)(B) prohibit approval of NATCEP where a facility has been: subject to an extended or partial extended survey; assessed a CMP of not less than $5000, or subject to a DPNA, all of which occurred in this case.

V. Conclusion

As I have found Petitioner out of substantial compliance with participation requirements at a level of immediate jeopardy, I sustain the remedies that CMS imposed, including CMPs totaling $264,200, the DPNA from April 26 through May 21, 2008, and the loss of NATCEP.

/s/
Alfonso J. Montano
Administrative Law Judge