Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Van Duyn Home and Hospital
Docket No. A-10-104
Decision No. 2368
March 24, 2011

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Van Duyn Home and Hospital (Van Duyn) appeals the July 23, 2010 decision of Administrative Law Judge (ALJ) Steven T. Kessel, upholding the imposition of civil money penalties (CMPs) totaling $127,600 and other remedies by the Centers for Medicare & Medicaid Services (CMS). The allegations at issue center on whether Van Duyn adequately assessed the risks facing two moderately impaired residents who repeatedly left the facility, adequately care planned for those risks, and, more generally, developed an effective policy regarding medical passes for its residents to leave the premises.

For the reasons explained below, we uphold the ALJ's conclusions that Van Duyn was not in substantial compliance with the applicable Medicare participation requirements and that CMS's immediate jeopardy determination was not clearly erroneous. We therefore sustain the imposition of the remedies proposed by CMS and upheld by the ALJ, with the exception of the per-day amount of the immediate jeopardy CMP which we reduce to $5,500 per day to reflect our review of the record.

Undisputed facts[1]

Van Duyn is a county-owned skilled nursing facility (SNF) in New York State which participates in the Medicare program. A Medicare compliance survey was conducted at the facility on May 29, 2009. The surveyors determined that the facility was not in substantial compliance with three requirements set out in federal regulations at 42 C.F.R. §§ 483.25(h), 483.75, and 483.75(i). CMS determined that conditions at Van Duyn constituted immediate jeopardy from the date of the survey through June 10, 2009 and imposed a CMP of $9,650 per day for that period, totaling $125,450. CMS also

[1] This section summarizes for the benefit of the reader the background of the case and facts found by the ALJ or in the record that are not disputed on appeal, but should not be considered as making or modifying any findings of fact. Disputed facts are discussed in the analysis below.

determined that immediate jeopardy was then abated, but that Van Duyn continued not to be in substantial compliance through July 23, 2009. CMS imposed a $50 per-day CMP from June 11 through July 23, 2009, totaling $2,150. In addition to the CMPs, CMS imposed a denial of payment for new Medicare admissions for the period beginning June 4, 2009 through July 23, 2009 and determined that Van Duyn was no longer authorized to conduct a nurse aide training, certification and education program.

All three noncompliance findings arose from the same set of facts relating to two residents of the facility. The main events relating to Residents # 1 and # 2 are not disputed, although the parties dispute how the facility's handling of the events should be evaluated.

Resident # 1 was a wheelchair-bound 49-year old male admitted to Van Duyn in November 2008 from the hospital with diagnoses including seizure disorder, basal ganglia cerebral vascular accident, subdural hematoma, malnutrition, and alcohol abuse. He had a history of living on the streets and staying in a homeless shelter. The facility assessed him as displaying impaired judgment with moderately impaired decision-making and regularly resistant to care.

Resident # 2 was a 53-year old female who required a motorized wheelchair and was dependent on staff for transferring, eating and toileting. She is identified in Van Duyn's records as the girlfriend of Resident # 1. *See, e.g.*, CMS Ex. 18. She was admitted on February 23, 2007 with diagnoses including stroke, amputation of her right arm, diabetes, and alcohol abuse. She was assessed with moderately impaired cognitive skills, sometimes resistant to care, socially inappropriate and verbally abusive behavior, and having poor impulse control with intrusive behaviors.

On the afternoon of May 16, 2009, Resident # 1 left the facility without permission and returned that evening drunk. Resident # 2 accompanied him. She had a medical pass to leave the premises with a companion but was to return by 4:30 PM for medication and blood sugar testing. Nursing notes and the Administrator's declaration indicate the residents were advised that the sheriff would be contacted if the residents were not back by 5 PM. CMS Ex. 34, at 1. When they returned at 6:20 PM, Resident # 2 appeared to have consumed alcohol offsite based on odor, red eyes and slurred speech. The sheriff was apparently not called.

On May 18, 2009, both residents again left the facility. Resident # 2 returned in the afternoon with a container of alcohol which she said belonged to Resident # 1. Resident # 1 spent the night at a homeless shelter and did not return to Van Duyn until 7:30 PM the following day, smelling of alcohol.

On May 20, 2009, both residents again departed, saying they would return at about 6 PM. Resident # 2 returned but again Resident # 1 did not. After contact with the sheriff's office, the facility learned that Resident # 1 was again at the homeless shelter. When

staff went to retrieve him the next morning, Resident # 1 had already left the shelter. Shelter staff indicated that Resident # 1 would not be permitted to spend any more nights there. Resident # 1 returned only after having ended up in the emergency room after a seizure and fall with injury.

During their absences from Van Duyn, the residents did not receive their prescribed medications.

Legal authorities

A SNF's participation in Medicare is governed by sections 1819 and 1866 of the Social Security Act and regulatory requirements in 42 C.F.R. §§ 483.1-483.75. Compliance with these requirements is verified by nursing home surveys conducted by state health agencies under agreements with CMS. 42 C.F.R. Part 488, subpart E. Survey findings are reported in a document called a Statement of Deficiencies (SOD). A "deficiency" is "any failure to meet a participation requirement." 42 C.F.R. § 488.301.

CMS may impose enforcement remedies on a SNF if it determines, on the basis of survey findings, that the facility is not in "substantial compliance" with one or more participation requirements. 42 C.F.R. § 488.402(b). A facility is not in substantial compliance when it has a deficiency that creates the potential for more than minimal harm to one or more residents. 42 C.F.R. § 488.301 (defining "substantial compliance" to mean the "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"). Under the regulations, the term "noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." *Id.*

The enforcement remedies that CMS may impose for a SNF's noncompliance include per-day civil money penalties (CMPs). 42 C.F.R. § 488.408(b). When CMS elects to impose a CMP, it sets the CMP amount based on, among other factors, the "seriousness" of the SNF's noncompliance. 42 C.F.R. §§ 488.404(b), 488.438(f). The level of seriousness is based on an assessment of scope (whether the deficiency is isolated, a pattern or widespread) and severity (the degree of harm, or potential harm, to resident health and safety posed by the deficiency. 42 C.F.R. § 488.404(b); SOM, App. P, sec. V. The highest level of severity is "immediate jeopardy," defined as "a situation in which the provider's noncompliance . . . has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301.

There are two ranges of per-day CMPs, with the applicable range depending on the scope and 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. §§ 488.438(a)(1)(i), 488.408(e)(1)(iii). The range for noncompliance that is not immediate jeopardy is $50-3,000 per day. 42 C.F.R. §§ 488.438(a)(1)(ii), 488.408(d)(1)(iii).

Section 483.25 of the applicable regulations sets out the quality of care to be provided to residents with the overarching requirement that residents receive "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." The subsection under which Van Duyn was cited relates to accidents and states that the facility "must ensure" that the "resident environment remains as free of accident hazards as is possible" and that "[e]ach resident receives adequate supervision and assistance devices to prevent accidents." 42 C.F.R. § 483.25(h).

Section 483.75 requires that a facility "must be administered in a manner that enables it to use its resources effectively and efficiently" to achieve the quality of care required by section 483.25. Subsection 483.75(i) requires the facility to designate a physician as medical director to be responsible for the "[i]mplementation of resident care policies" and the "coordination of medical care in the facility."

ALJ Decision

The ALJ found that CMS established, without effective rebuttal, that, after Resident # 1 left the facility without medical approval on May 16, 2009, the facility obtained a pass from a physician allowing Resident # 1 to leave unsupervised without first conducting a full assessment of the risks he would face or considering alternative interventions. ALJ Decision at 4-5. He further found that Van Duyn did not re-evaluate the decision to provide the pass or determine whether other interventions were required even after Resident # 1 violated the conditions on the pass when he left the facility on May 18, 2009. *Id*. at 5. Resident # 2 had a medical pass to leave the facility when accompanied but, the ALJ found, the facility did not reevaluate this plan, arrange for a more suitable companion than Resident # 1, or develop other interventions to protect her in light of the events of May 16-18. *Id*. at 6.

The ALJ concluded that Van Duyn's staff knew that Resident # 1's infirmities, alcoholism, self-destructive and uncooperative behaviors, and impaired ability to make rational judgments put him in serious danger without supervision but did not either define and assess these risks or develop a plan to address them, instead throwing up their hands and ignoring the problems. *Id*. at 7. He further concluded that this failure, and the similar situation around Resident # 2, were part of a pattern of failure reflected by the fact that Van Duyn had no system to track which residents had passes and what conditions those passes imposed, even though 218 of the residents had passes in their records. *Id*. at 6-7.

The ALJ rejected testimony from Van Duyn's Medical Director and another physician that the facility actually had in place a system to assess resident safety for issuance of out-on-pass (OOP) orders, consisting of an initial evaluation on admission, assessment by a nurse when a resident asked to leave and a consultation with the resident's physician. *Id*. at 7-8. The ALJ found the testimony not credible because his review of the residents'

records found no evidence of any explicit assessment of the risks involved even though the risks were obvious and dramatic. He also found that the physician affidavits, as well as that of other witnesses including Van Duyn's administrator, lacked any specifics about or reference to records reflecting staff performing such assessments according to a protocol, whether written or not. *Id*. at 9. The ALJ also stated that the issue was not whether the facility was obliged to restrict residents' freedom of movement in violation of their rights, but instead whether it took all reasonable steps to assess and protect its residents. Thus, he opined, if a SNF "is not a prison for mentally competent residents, neither is it a federally subsidized hotel or a group residence." *Id*. at 10. He considered the staff's response to events merely "ad hoc" and questioned how discussions with the residents could amount to counseling them on the risks involved in their leaving the facility when the risks had not been comprehensively assessed by the staff. *Id*. at 13.

The ALJ further concluded that the evidence demonstrating the absence of any effective assessment of the risks for residents on unsupervised leave from the facility or planning to minimize those risks as far as possible in violation of section 483.25(h) also proved the facility's noncompliance with the provisions on effective administration (section 483.75) and medical director responsibility (section 483.75(i)). The ALJ also concluded that Van Duyn had not shown that the immediate jeopardy determination was clearly erroneous or that the amount of the immediate jeopardy CMP was unreasonable.

Issues on Appeal

Van Duyn's overarching position is that, if balancing the medical needs of residents like Residents # 1 and # 2 with their entitlement as competent adults to decide their own care and lifestyle violates the regulations, CMS must provide advance guidance of this policy. Van Duyn argued that, if such a policy applies, public facilities would not be able to admit difficult residents for whom Van Duyn here served as the provider of last resort. Van Duyn asserts more specifically that the ALJ made a number of errors of law and also that he failed to weigh the evidence properly so that his findings were not supported by substantial evidence. Van Duyn also challenges the amount of the CMP imposed based on the determination of immediate jeopardy. We discuss these arguments below.[2]

[2] We note briefly two procedural points raised by Van Duyn. First, Van Duyn argues that the ALJ erred by mentioning only 20 exhibits proffered by Van Duyn when in fact it proffered 21. Van Duyn Br. at 6. Since the ALJ stated that he admitted all of the parties' exhibits without objection and since he discussed the declaration which was Van Duyn's 21st exhibit (ALJ Decision at 2, 7), it is clear to us that the error was merely clerical in nature and not prejudicial. Second, Van Duyn asserts that CMS's brief on appeal was not timely filed because it was dated 34 instead of 30 days after CMS's receipt of Van Duyn's brief. Van Duyn Reply Br. at 10. Van Duyn does not ask us to take any particular action based on this argument. We conclude that, while the date calculation is correct, the delay was not prejudicial, especially since Van Duyn not only filed a reply brief but was granted its request for oral argument allowing it a further opportunity to respond to CMS's arguments.

Standard of review

The Board's standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. The Board's standard of review on a disputed finding of fact is whether the ALJ decision is supported by substantial evidence on the record as a whole. *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/prov.html; *Batavia Nursing and Convalescent Inn*, DAB No. 1911, at 7 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 143 F. App'x 664 (6th Cir. 2005).

Analysis

1. *The legal standards applied by the ALJ to determine substantial compliance were correct and do not compel violation of residents' rights.*

Van Duyn argues that the ALJ Decision would require Van Duyn to restrict the freedom of its mentally competent residents in violation of Title II of the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. § 12132, and section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794(a), that apply to it as a public facility. Van Duyn Br. at 12-14. Van Duyn cites in this regard *Disability Advocates v. Paterson*, 653 F.Supp.2d 184 (E.D.N.Y. 2009), which held that even mentally ill residents of adult homes are discriminated against under the ADA when denied the greatest possible community integration. *Id*. at 13-14. Van Duyn also argues that requirements in the regulations regarding residents' rights themselves demonstrate that the facility has to balance safety concerns with the right to self-determination and the right to refuse a course of treatment, but that the ALJ improperly ignored the difficulty of achieving such balance. *Id*. at 15. In addition, Van Duyn points to residents' constitutional rights to due process and liberty (and several state laws) in regard to restricting a resident's choices absent appointment of a guardian. *Id*. at 15-17.

Much of Van Duyn's legal argument is directed against a straw man mischaracterization of the ALJ's legal reasoning. For example, Van Duyn argues that the "ALJ erred when he found that Appellant had a duty to prevent its mentally competent residents from leaving the facility . . . ." Van Duyn Br. at 11. The ALJ nowhere suggested that Van Duyn could or should prevent its residents from exercising choice, including the choice to refuse care or leave the facility. Van Duyn relies on several New York federal district court cases addressing "unnecessary segregation" of disabled nursing home residents or discrimination that may arise from lack of access to the community or rules constraining departures in violation of the ADA. *See* cases cited in Van Duyn Br. at 12-13. That reliance is misplaced. None of those cases hold that nursing facilities are required to stand by as residents whose disabilities put them in danger in the community leave the facilities, without assessing their risks, determining what interventions are necessary and

appropriate to their needs, or offering assistance to mitigate the risks, merely because such interventions and assistance may ultimately be refused.

Van Duyn goes so far as to argue that any "attempt to dissuade" a resident from leaving, even without any mention of "the extreme consequence of discharge," would be necessarily coercive and violate the self-determination and dignity of the resident. Van Duyn Reply Br. at 7. Similarly, Van Duyn claims that it has no "legal basis upon which to limit its residents' ability to leave the premises against medical advice," absent a court finding of incompetence. Van Duyn Br. at 16. No authority cited by Van Duyn supports this absolutist position. Indeed, if the ADA requirements to foster community integration where possible were construed in as extreme a manner as Van Duyn suggests, Van Duyn's own actions would clearly violate them. For example, Van Duyn asserts that it instructed the residents that it would call the sheriff if they did not return on time, restricted Resident # 1's access to his own funds, required Resident # 2 to have a companion when she exited the facility, and took other measures that arguably placed burdens on residents' freedom of movement. In oral argument, Van Duyn clarified its position as being that the facility may (and it contends Van Duyn did) impose "an escalating series of constraints and parameters" to set safe conditions for resident absences. Transcript of Oral Argument, November 17, 2010, at 19. This reformulation is entirely consistent with the ALJ's legal approach. We are thus left with the question of whether the evidence of record supports his conclusions that Van Duyn did not take adequate steps to achieve such a balance in the face of the residents' needs and the unfolding events (which we discuss in the next section of this decision).

Ultimately, both the ALJ's construction of the Medicare participation regulations and the ADA analysis, to the extent it has any relevance here, turn on simultaneously satisfying the residents' rights to services meeting their needs, including for protection from foreseeable risks of accidents, and to self-determination and access to the world outside the facility. We turn next to how those responsibilities apply in the context of providing adequate supervision to prevent accidents for residents seeking to temporarily exit the facility.

Van Duyn contends that the ALJ recited the correct legal standards for mitigating foreseeable accident risks but in fact applied a strict liability standard in evaluating what the facility had to do to prevent the residents from leaving or remove all hazards to them while off the premises. Van Duyn Br. at 28. The Board has held in the past that exiting the facility against advice is in essence a refusal of the care and supervision which the facility must otherwise provide to its residents. *Venetian Gardens*, DAB No. 2286, at 20 (2009). Van Duyn admits that, in the event a resident declines to comply with a facility's plan of treatment, the facility "is required to document the noncompliance and develop other interventions for the resident consistent with the resident's care plan." Van Duyn Br. at 15. Indeed, CMS's State Operations Manual (SOM), explains facilities' obligations to make sure that any such refusal is informed, that the basis for the refusal is addressed, and that alternatives are offered:

> [T]he facility should determine exactly what the resident is refusing and why. To the extent the facility is able, it should address the resident's concern. For example, a resident requires physical therapy to learn to walk again after sustaining a fracture hip. The resident refuses therapy. The facility is expected to assess the reasons for this resident's refusal, clarify and educate the resident as to the consequences of refusal, offer alternative treatment, and continue to provide all other services.

SOM, Appendix PP, at F115. This guidance implies a duty to assess what the potential consequences of refusal are and what alternatives could reasonably be offered that would not violate the resident's rights, which is the basis for the ALJ's review of whether the record reflected that Van Duyn identified the risks for each resident and offered alternative interventions.

The Board has also previously addressed the responsibilities of a facility in regard to risks to residents when they are outside the premises. A facility cannot, and is not expected to, control the environment outside the facility, but can and should plan for safe absences by considering the risks and circumstances involved for particular residents. Thus, the Board has in the past rejected any argument --

> that, if a competent resident exercises his right to leave the facility and place himself in danger, the facility has no responsibilities. The SOM, in discussing section 483.25(h), focuses mainly on the scope of facilities' responsibilities in situations where a mentally incompetent resident elopes, rather than on the welfare of competent residents who voluntarily and temporarily leave the facility and who choose to engage in unsafe activity outside the facility. However, the Board has previously stated, as to known departures by competent residents, that a facility has some obligation "to take steps to protect residents from harm when they temporarily [leave] the facility," by being aware of the circumstances of a resident's departure. Heritage Park Rehabilitation and Nursing Center, DAB No. 2231 (2009). The Board has also concluded that a facility should be aware of when a resident is expected to be returned to the facility and consider factors that would impact the resident's health and safety when away, such as the resident's need for medication. Eastwood Convalescent Center, DAB No. 2088 (2007). These conclusions were consistent with the goal of the quality of care provisions and with the facilities' own policies.

Venetian Gardens, DAB No. 2286, at 20-21.

The ALJ's analysis was consistent with the responsibility discussed in the quoted section when he explained that the case was not about restricting residents' freedom of movement but about Van Duyn's "failure to discharge its fundamental obligation to assess the risks that residents faced when they left its premises unaccompanied." ALJ

Decision at 10. Specifically, he held that Van Duyn "would not be liable for failing to protect its residents had it taken all reasonable steps to assess and protect them, and the residents, notwithstanding, had rejected the care that was offered to them." *Id*. We agree. The ALJ thus focused correctly on whether the facility actually identified risk factors that would plainly "impact the resident's health and safety when away" and then developed and offered interventions to mitigate those risks. The ALJ Decision belies Van Duyn's claim that the ALJ was actually using a "strict liability" standard or requiring Van Duyn to "remove all accident hazards" facing Resident # 1 while away from the facility. Van Duyn Br. at 28.

We note that Van Duyn also stresses its legal position that a "pass" must not be understood as "authorization" to leave the facility but rather as a medical judgment about ability to leave. Van Duyn Reply Br. at 5. Again, this argument mistakes the basis for the ALJ's opinion that Van Duyn ignored the risks to the residents instead of properly evaluating and planning for them. The ALJ expressly stated, and we agree, that the facility did not "have the authority to hold a resident against his or her will assuming that the resident shows sufficient mental competence to express a desire to leave the premises." ALJ Decision at 10. Thus, the ALJ did not hold that the facility must prevent residents from exiting unless they have a pass to authorize their departure. A pass issued by a physician may well serve as a useful record of competency and medical ability to leave, but obtaining such a pass does not exhaust the facility's responsibility to evaluate foreseeable risks and offer appropriate interventions to mitigate them, whether or not the residents choose to accept the offer of care.

Van Duyn further cites an Eleventh Circuit decision for the proposition that CMS improperly cited the facility "for having deficient procedures in place based on the mere fact that something bad happened to a resident when off facility grounds" because Van Duyn was unaware of any requirement to perform "specific resident assessments related to leaving the facility grounds." Van Duyn Reply Br. at 9, *citing Emerald Shores Health Care Assoc. v. U.S. Dept. Health & Human Servs., Ctrs. for Medicaid & Medicare Servs*., 545 F.3d 1292 (11th Cir. 2008). In *Emerald Shores*, the court concluded that a regulation requiring a facility to maintain an "effective" pest control program was too subjective to hold the facility liable under the circumstances of that case, at least absent more guidance from CMS or prior Board decisions. 545 F.3d at 1293-1300, discussing 42 C.F.R. § 483.70(h)(4). The court held that particular methods of pest control were not within the expertise of the "average nursing home administrator[]." *Id*. at 1300.

Emerald Shores is inapposite. The regulation at issue here requires facilities to provide each resident with the care and services necessary for their "highest practicable physical, mental, and psychosocial well-being," to do so in accordance with a "comprehensive assessment and plan of care," and to "ensure" that each resident receives "adequate supervision and assistance devices to prevent accidents." 42 C.F.R. § 483.25 and 483.25(h)(2). Longstanding principles applied in many Board cases make clear that one prerequisite to providing such care is taking account of foreseeable risks of accidents.

Golden Living Center – Riverchase, DAB No. 2314, at 7-8 (2010) , and cases cited therein; *Liberty Commons Nursing and Rehab - Alamance*, DAB No. 2070, at 3 (2007), *aff'd*, *Liberty Commons Nursing & Rehab Ctr.-Alamance v. Leavitt*, 285 F. App'x 37 (4th Cir. 2008); *Golden Age Skilled Nursing and Rehabilitation Center*, DAB No. 2026, at 11 (2006), *citing Woodstock Care Ctr. v. Thompson*, 363 F.3d 583, at 590 (6th Cir. 2003) (affirming *Woodstock Care Center*, DAB No. 1726 (2000) and holding, inter alia, that a SNF must take "all reasonable precautions against residents' accidents").

It should have come as no surprise to Van Duyn that it was expected to identify and plan for such risks, which is the sort of assessment for which the ALJ looked. Indeed, Van Duyn's witnesses do not assert that they were unaware of the need for such assessment of risks, stating instead that they had an unwritten protocol or procedures for such assessments. As we have noted, the Board has made clear in earlier decisions that the regulations require a facility to exercise reasonable foresight and planning in addressing the needs of its residents when they exit the facility. The Board has not previously, and we do not here, impose novel requirements for some special sort of assessment about resident departures or for preventing all unfortunate consequences of resident choices made when they are outside the facility.

Van Duyn further argues that the ALJ's analysis was flawed because he failed to recognize that the record demonstrates Resident # 1's only alternative to the medical supervision he was receiving at Van Duyn was to return to life on the streets (noting that even the homeless shelter had stated he would not be allowed to spend another night there). Van Duyn Br. at 17; P. Ex. 16, at 9; P. Ex. 17, at 5-6. Van Duyn contends that facilities like it would be unable to offer services to medically compromised but mentally competent individuals if the facility faced liability for the consequences of any poor decisions such residents might make. Van Duyn Br. at 17. The facility here was not held responsible for the poor decisions made by the two residents nor for the unfortunate consequences of those decisions. The facility rather was held responsible for <u>its own failures</u> to fully assess the particular risks of accidents and injuries that each resident faced leaving the facility on pass, to plan and offer reasonable alternatives to minimize the risks (especially as they became more obvious after each outing), and to document that the residents, despite being informed of the risks and alternatives, chose to refuse care.

2. Substantial evidence in the record as a whole supports the ALJ's findings evidencing noncompliance.

A. <u>We defer to the ALJ's determination as to the credibility of witnesses and as to the weight to be assigned to particular evidence</u>.

Van Duyn argues that the ALJ incorrectly made negative credibility determinations as to some of Van Duyn's witnesses without having observed them in person. Van Duyn Br. at 5-7, 33-34. In general, the Board defers to an administrative law judge's findings on

weight and credibility of witness "testimony" unless there are "compelling" reasons not to do so. *Koester Pavilion*, DAB No. 1750, at 15, 21 (2000). The testimony here was provided in written form and both parties agreed to waive an in-person hearing. ALJ Decision at 2. While a fact-finder's observation of witness demeanor may indeed be a factor in determining credibility, the Board has long recognized that an ALJ may properly consider many other factors even where the testimony is in writing, such as the "intrinsic logic and consistency" of the witness's statements, the existence of "corroborating or contradictory evidence in the record," and "whether a given witness has any self-interest or motive that might impact the direction of testimony." *Hillman Rehab. Ctr.*, DAB No. 1663, at 18-19 n.12 (1998); *aff'd*, *Hillman Rehabilitation Ctr. v. U.S. Dep't of Health and Human Servs.*, No. 98-3789 (GEB) (D.N.J. May 13, 1999); *see also Woodland Oaks Healthcare Facility*, DAB No. 2355, at 7 (2010)(applying deference to ALJ credibility determination concerning written statements of facility employees who did not testify).

The ALJ expressly did not credit testimony from Van Duyn's medical director, Dr. Becker, and a second physician, Dr. Katz. ALJ Decision at 7-8. He stated that they each asserted that the facility had in place a "protocol" to assess residents for safety on passes, which Dr. Katz called "comprehensive, well understood by the staff and effectively implemented with respect to Residents # 1 and # 2" (P. Ex. 21, at 6), and Dr. Becker described as "clearly defined procedures, which the staff understand and follow in practice " (P. Ex. 15, at 8). ALJ Decision at 7, 8. The ALJ explained that, not only did he find that the facility offered nothing to memorialize such protocols or procedures, but that he examined Resident # 1's care plans, nursing notes, elopement risk assessments, and social service progress notes with a view to testing the credibility of these accounts of such a systematic approach and found the testimony uncorroborated. *Id*. at 8.[3] Further, the ALJ states that his review of the testimony of Petitioner's administrator and other witnesses about the existence of a well-understood process to deal with the dangers facing departing residents was also unconvincing because of the lack of "specifics" and the absence of supporting documentation in the facility records of staff carrying out such a process as to Residents # 1 and 2. *Id*. at 9.

Van Duyn further argues that its witnesses' testimony should not be discredited "merely because of the witnesses' posture, defending against claims of noncompliance," or solely because they make "similar statements." Van Duyn Br. at 9. The short answer is that the ALJ did not rely on either of these factors in isolation, but considered a whole range of factors in determining the weight and degree of credibility he placed on the testimony.

[3] Arguably, the testimony was not wholly uncorroborated, since, as the ALJ noted, the witnesses testified to essentially the same thing. ALJ Decision at 9. If the facility in fact had a protocol or procedure for determining the dangers facing residents on pass and determining how to address or minimize them, one would expect the facility to be able to produce some corroborating documentary evidence to show its application in practice or to show that the staff was trained on the procedure.

Thus, we find that the ALJ relied on factors appropriate to consider in determining the credibility and weight to accord to testimony. We conclude that Van Duyn has not presented any compelling reason for us to disturb the ALJ's credibility determinations.

B. The evidence cited by Van Duyn does not undercut the ALJ's finding that the facility had no systematic process to assess risks and provide appropriate care alternatives to residents going out on pass.

As Van Duyn acknowledges, the ALJ did not base his conclusion that Van Duyn lacked a coherent system to assess the risks facing residents leaving on pass and to keep track of their needs simply on the absence of any written facility policies or protocols on this subject. ALJ Decision at 9. Van Duyn recognizes that the ALJ also relied in part on the admission to a surveyor by an assistant administrator that the facility did not have a "system in place that identified those residents with 'out on pass' orders." CMS Ex. 1, at 11; Van Duyn Br. at 31, citing ALJ Decision at 6. Van Duyn does not deny the admission was made but asserts that it was "taken out of context" in that, as discussed above, Van Duyn does not view an "out on pass order" as an authorization to leave the facility. Whether the pass is viewed as in itself authorization to leave is irrelevant to the issue of whether the facility had a responsibility to evaluate those residents who seek to leave in order to identify risks and offer alternatives to mitigate those risks. Having an "out on pass" order, at a minimum, would suggest that the resident may seek to leave and should therefore be assessed for foreseeable risks – and therefore the ALJ could reasonable infer from the facility's failure to be able to identify which residents have such orders that it was less likely that assessment and planning to prevent accidents was occurring in any systematic way.

Nevertheless, Van Duyn argues on appeal that the ALJ should have inferred the existence of an effective risk assessment process from examining its 24-hour reports, its recording of physician orders in resident charts, and the fact that 218 residents were found to have passes when the facility compiled a list during the survey. Van Duyn Br. at 31-32; CMS Ex. 1, at 11. The 24-hour report was not mentioned by Van Duyn's witnesses as part of any process of risk assessment or care planning for temporary absences. CMS submitted as an exhibit the 24-hour reports for May 15-23, 2009, covering the events at issue here. CMS Ex. 17. The documents, provided for one unit at the facility, appear to record names of residents, their code status, and their condition during three shifts, and include boxes to be marked to indicate if the resident is a new admission, has a skin condition, experienced a change in condition, had an infection or fall, or was out on pass or at the hospital. *Id*. The May 16 report records Resident # 2's departure with Resident # 1 with a note to call the sheriff if she does not return by 5 PM (as noted earlier) and her return at about 6 PM intoxicated. *Id*. at 1; *see also id*. at 4 and 7 for later dates and CMS Ex. 34, at 39-43 relating to Resident # 1's unit. Absent more specific testimony about the use of these log reports, the notations seem more in the nature of status or incident reports than assessment or planning documents. They do demonstrate, as Van Duyn states, "some evidence" of a "system in place for tracking its residents when out of the facility," or at

least tracking who was away, whether they had returned and in what condition. Van Duyn Br. at 32. However, they do not demonstrate a procedure existed to identify the individual resident's foreseeable risks when leaving on pass or record interventions considered or taken to address those risks in any way.

Van Duyn also argues that the ALJ should have inferred from the physicians' orders in the charts for Residents # 1 and # 2 that "each resident would have a similar notation within his or her medical chart if any order was issued by his or her attending physician." *Id*. All that such an inference would establish is that, if a physician issues an order, Van Duyn puts it in the resident's medical chart, a point that was not in dispute. We agree, moreover, with the ALJ that the presence of passes in the charts of 218 residents does nothing to establish "how or whether Petitioner's staff assessed these residents for safety." ALJ Decision at 9.

Van Duyn further points to its Wandering Resident Management and Elopement Prevention Policy and Procedure (elopement policy), which it claims is "similar to" the risk assessment procedure described by its witnesses for residents seeking to leave on pass. Van Duyn Br. at 33. The striking aspect of reviewing the elopement policy is precisely how dissimilar it is to the reported protocol or procedure for absences on pass alluded to in the testimony (even if it were accepted as credible). The Medical Director, Dr. Becker, describes the process for dealing with a resident's request to go out, as beginning with the nurse making the initial judgment whether the resident can leave safely and under what conditions, based on the existing clinical record and knowledge of the patient, and then "typically" consulting the attending or on-call physician to obtain orders "to address medication requirements, wound care issues, or other medical needs." P. Ex. 15, at 10. The result is said to be "an individualized plan for keeping the resident safe while out of the building." *Id*. at 11. While this could be characterized as a "process" in that Dr. Becker describes the nurse making a recommendation first and a physician then issuing an order, the decision-making process is framed as simply an exercise of the professional judgment of each person with general comments about what "pertinent considerations could include." *Id*. at 10.

The elopement policy, by contrast, specifies initial assessments with named instruments; regular reassessment quarterly, upon significant changes and at the onset of new behaviors; describes the sources from which information should be gathered to ensure an accurate assessment; gives an eight-step process for care planning and updating when behaviors increase or interventions are no longer effective, and provides for regular in-services and drills for staff. P. Ex. 14, at 9. A template for an individualized care plan to address wandering is attached, triggering evaluation of strengths, problems and needs, setting measurable goals with each step dated and initialed, and setting out more than two dozen potential approaches which can be selected. *Id*. at 10.

We do not hold that the facility was obliged to adopt the same level of detail in a policy addressing resident pass requests or that any such policy had to be in writing or require

documentation on particular forms. In the absence of a written protocol or procedure, however, the facility needed to show that its staff was aware of what was to be considered to evaluate individual risks, what approaches were available to address the risks, and how to apply those approaches to meet the residents' needs for supervision and protection from foreseeable accidents.

C. Substantial evidence in the record as a whole supports the ALJ's findings that Van Duyn did not substantially comply with 42 C.F.R. § 483.25(h) in its care of Residents # 1 and # 2.

Van Duyn argues that, contrary to the ALJ's conclusions, the weight of the evidence demonstrates that Van Duyn conducted appropriate risk assessments for Residents # 1 and # 2. Van Duyn Br. at 18. For Resident # 1, Van Duyn points to an elopement risk assessment done on November 10 and 19, 2008 and updated May 26, 2009; a Minimum Data Set (MDS) on April 27, 2009; a comprehensive care plan dated May 13, 2009 (showing no attempts or wish to leave) and updated May 26, 2009 to reflect "current elopements" with goals and approaches (particularly contact with outside resources such as Adult Protective Services). *Id*. at 18-21, and record citations therein. Van Duyn argues that similar documents appeared in Resident # 2's records, and each one should be viewed as "some evidence that Van Duyn conducted assessments of [both residents] on a regular basis to determine the level of supervision required by the residents to maintain their health and safety." *Id*. at 21, and record citations therein. Van Duyn agrees that none of them "standing alone and in isolation, being read out of context after-the-fact" might show a "comprehensive picture" of resident risk assessment but argues that a careful review of incident reports, nursing notes and social work progress notes in the record paints a fuller picture of Van Duyn appropriately assessing and managing the residents' needs for supervision and protection. *Id*. at 21-25 and record citations therein.

While, as we explain later, Van Duyn does identify some evidence not adequately addressed by the ALJ, substantial evidence in the record as whole supports the noncompliance finding. For example, Resident # 2 had a pass order in her record indicating that she could leave safely only with a companion in light of her extensive dependence on assistance. Regardless of whether the facility could reasonably have treated Resident # 1 as meeting this medical need for a companion when the two residents first left together on May 16 (despite his history of alcoholism and seizures and his own physical and cognitive limitations), the events of the following days should have made it evident that this arrangement did not protect Resident # 2 from entirely foreseeable accident risks. The Administrator testified that she considered the behavior of Residents # 1 and # 2 as reflecting that "they had tried to meet the parameters set for them" on May 16, despite their returning more than one hour late for medication. P. Ex. 17, at 9-10. She does not deny, however, that Resident # 1 was intoxicated or explain why that did not cause her to re-evaluate whether he could adequately meet Resident # 2's safety needs by himself. Any remaining doubt was eliminated after Resident # 2 again left the facility accompanied only by Resident # 1 on May 18 and returned alone,

showing signs of drinking and carrying a half-full liquor bottle. No new assessment or change of plans is recorded, and she left again with Resident # 1 on May 20 and again returned unaccompanied.

The Administrator states that, at all times, Resident # 2 "complied with the parameters the Facility had set for her," by way of explaining why no measures were taken to alter her pass order. P. Ex. 17, at 13. This response (even were it accurate) reflects the very thinking about pass orders that the facility's briefing decries, as if the question were whether Resident # 2 deserved to be disciplined. We find nothing in the documents cited by Van Duyn evidencing that staff responded to the obvious inability of Resident # 1 to serve the function of a companion for Resident # 2 given her safety needs, by assessing her risks in leaving with him, considering measures to offer alternative, safe approaches, or identifying whether she could be accompanied by an additional, competent person. We therefore conclude that substantial evidence in the record supports the ALJ's finding that Van Duyn did not meet the standards of section 483.25(h)(2) with regard to Resident # 2. ALJ Decision at 6.

The situation with Resident # 1 was undoubtedly difficult, given his history and his condition, and neither the ALJ nor we suggest that a simple solution was available. Nevertheless, the escalating problems that began on May 16 cried out for a well-thought-through assessment and coordinated plan to ensure his safety as much as possible, and the record reflects a response falling short of that. On May 16, when the resident sought to leave the facility, it is undisputed that the physician on call declined to sign a pass order, but the staff did not see any way to "stop him if he was intent on" leaving "short of physical restraint," and, after consulting the Administrator, allowed him to leave with Resident # 2. P. Ex. 17, at 9. The facility points to assessments completed when Resident # 1 was admitted in November 2008, including an elopement risk assessment, and the routine quarterly update completed April 27, 2009, as well as his care plan, to show that staff had identified and addressed his risks. Van Duyn Br. at 19; CMS Exs. 12, at 12-13; 16, at 1-4; 18, at 1. The surveyors reviewed each of these documents, as did the ALJ. CMS Ex. 1, at 2; ALJ Decision at 8. The records document the resident's deficits in impaired decision-making, need for supervision and resistance to care, and demonstrate that he was at risk for elopement. They do not, however, contain any discussion of what hazards the resident could be expected to face in the community in light of his deficits and needs or how those hazards could be mitigated. Nor do they indicate how Resident # 1 would be able to assist Resident # 2 in meeting her care needs while accompanying her away from the facility. The only reference to such outings in the care plan before the events at issue was to review with the resident, on readmission, rules and policies including those for being out-on-pass (and to repeat as needed). CMS Ex. 16, at 4.

The facility asserts, and CMS does not appear to dispute, that Resident # 1 did not seek to exit the facility from the time of his admission in November 2008 until May 16, 2009, which the Administrator describes as "one of the first warm sunny days in an unusually

rainy spring season." P. Ex. 17, at 8; Van Duyn Br. at 3. This may be relevant to the omission of specific approaches to his elopement risk in his care plan which stated that he had made no attempts and expressed "no wishes to leave at present." CMS Ex. 12, at 15. By May 17, however, as the ALJ emphasized, Resident # 1 had insisted on leaving without medical approval, had returned late and drunk, and had been "verbally abusive and threatening" to staff. ALJ Decision at 4. The facility then sought and obtained a pass order from the physician allowing Resident # 1 to leave on condition that he depart after breakfast and return by 4:00 PM. CMS Ex. 1, at 3. The ALJ inferred, in the absence of "any comprehensive analysis" showing the staff's reasoning, that Van Duyn decided to obtain the pass simply because Resident # 1 "would leave the premises with or without one." ALJ Decision at 5. The ALJ particularly emphasized that Van Duyn did not revisit the issuance or the terms of the pass even after Resident # 1 violated the terms on May 18. *Id*.

Van Duyn also alleges that Resident # 1's care plan shows risk assessment in the column marked "strength/problem/need." Van Duyn Br. at 14. The ALJ acknowledged that the care plan reflects staff discussion with Resident # 1 on May 18 about his behavior and the medical concerns. ALJ Decision at 8. The discussion of strength/problem/need gives salient facts about Resident # 1, such as his homelessness and lack of family support, history of alcohol abuse, impaired judgment, agitation and resistance to medication. CMS Ex. 16, at 2. The plan was updated to include the fact that he returned drunk and disruptive on May 16. *Id*.

The ALJ could not reasonably infer from a review of the approaches added to Resident # 1's care plan on May 18 and the social worker's notes of how she counseled him that the facility had performed no evaluation about his situation on leave or given no consideration to how to address it. It is not evident, however, that the care plan process included discussion of the foreseeable dangers (such as what might happen in the event of a seizure, what might happen if the resident became too drunk to safely transport himself, or what might happen to Resident #2 if Resident # 1 became incapacitated for either reason). In any case, by the end of the day on May 18, the facility clearly knew or should have known that the interventions listed in the care plan were inadequate. Yet, as the ALJ found, the record shows that the facility waited until after the further unfortunate events of May 20-22 before taking any meaningful additional steps to intervene.[4]

Van Duyn also points to evidence that both residents were offered care on their returns based on the 24-hour reports and the nursing notes. Van Duyn Br. at 22; CMS Exs. 17, 19, and 34. While these documents do record absences, and assessments and follow-up care based on the condition of the residents on return, Van Duyn does not demonstrate that they include assessments of the likelihood and risks relating to further absences or

[4] The attempt to reduce Resident # 1's spending money from $10 to $5 was ineffectual and not directly tied to the risks confronting him. CMS Ex. 16, at 1; CMS Ex. 21.

planning to forestall such absences or mitigate such risks. While Van Duyn asserts that it could reasonably be inferred from these records that its staff was "aware of risks facing the residents when away from the Facility and the capabilities of the residents to face such risks," we do not find that the ALJ was compelled to draw such an inference.

We conclude that these findings are supported by substantial evidence and suffice to demonstrate that Van Duyn was not in substantial compliance with section 483.25(h) in its care of the two identified residents.[5]

3. The ALJ did not err in concluding that CMS's determination that the noncompliance constituted immediate jeopardy was not clearly erroneous.

As the ALJ recognized, and Van Duyn does not dispute on appeal, CMS's determination of immediate jeopardy must be upheld unless clearly erroneous. ALJ Decision at 12. The Board has held that, under the applicable regulations, a facility challenging the determination that a deficiency rises to the level of immediate jeopardy has a "heavy burden" to overcome. *Woodland Oaks*, DAB No. 2355, at 16, quoting *Maysville Nursing & Rehabilitation Facility*, DAB No. 2317, at 11 (2010). Immediate jeopardy is present when noncompliance "has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.300.

Resident # 1's third departure from the facility ended with him in an emergency room with seizures and head injury. CMS Ex. 19, at 3-4. While it is impossible to know if he would have experienced a seizure if he remained at the facility, it was entirely reasonable for the ALJ to conclude that the facility's failure to adequately recognize and plan for the likelihood of such an outcome (or worse) when he was unsupervised and unmedicated on the street met the definition of immediate jeopardy. ALJ Decision at 12. We have found that Van Duyn did not provide the necessary care in the form of assessing risks, providing adequate supervision and care planning to mitigate risks, or documenting informed refusal of care. Even in the absence of this showing of actual harm to Resident # 1, we would find that both residents were likely to encounter serious injury or harm, given Resident # 1's impairments and alcohol abuse and Resident # 2's dependence on him, while out on pass, a likelihood increased in the absence of good risk assessment and planning. We therefore find no error in the ALJ's conclusion that Van Duyn failed to show that the immediate jeopardy determination was clearly erroneous.

As the ALJ noted, the remedies of denial of payment for new admissions and of a $50 per-day CMP after the immediate jeopardy was found to have been abated are reasonable

[5] We also uphold the ALJ's conclusion that the same facts demonstrate noncompliance with 42 C.F.R. § 483.74 (administration) and 42 C.F.R. § 483.75(i) (medical director), given the fundamental responsibilities of the administration and the medical director to ensure systems and policies protect residents' safety from foreseeable risks. ALJ Decision at 10-12.

as a matter of law. ALJ Decision at 13-15. We therefore summarily affirm this aspect of the ALJ Decision.

4. *The record does not support the reasonableness of the amount of the immediate jeopardy CMP.*

Van Duyn also challenges the ALJ's conclusion that the amount of the CMP imposed for immediate jeopardy is reasonable. Van Duyn Br. at 35-36; ALJ Decision at 14-15. The amount of $9,650 per day is almost at the maximum possible per-day CMP amount of $10,000, and the total for the 13 days of immediate jeopardy is $125,450. Van Duyn argues that the ALJ did not give sufficient weight to its financial condition to reduce the CMP and also presented factual arguments going to the premises on which the ALJ relied in finding the amount reasonable.

As to the financial arguments, the ALJ rejected the argument that the per-day amount should be reduced on the grounds that Van Duyn is a "a publicly operated facility that sustains actual operating losses." ALJ Decision at 15. The regulations spell out the factors to be considered in determining what CMP amount is reasonable to consist of: (1) the facility's history of noncompliance; (2) the facility's financial condition; (3) factors specified in 42 C.F.R. § 488.404 (including the seriousness of the noncompliance and the relationship among deficiencies); and (4) the facility's degree of culpability. 42 C.F.R. § 488.438(f). In weighing evidence on financial condition, the Board has consistently held that the "correct inquiry" is "whether the facility has adequate assets to pay the CMP without having to go out of business or compromise resident health and safety." *Gilman Care Center*, DAB No. 2362, at 6 (2010), quoting *Sanctuary at Whispering Meadows*, DAB No. 1925, at (2005); *see also Embassy Health Care Ctr.*, DAB No. 2327, at 12 (2010); *Milipitas Care Center*, DAB No. 1864 (2003). The Board explained that this inquiry reflects the rationale set out in the regulatory preamble:

> [I]t is a statutory requirement that a facility's financial condition be considered as a factor to determine the amount of the civil money penalty. We do not specify in the regulation what we will examine in determining the facility's financial condition, because these factors are unique for each facility. Therefore, it is the responsibility of the facility to furnish the information it believes appropriately represents its financial status. We consider a facility's financial condition in conjunction with the other factors specified in the rule when determining the amount of a civil money penalty, because **it is not our intent to put facilities out of business**, and the amount of the civil money penalty is determined on a case by case basis.

Gilman at 6, *quoting* 59 Fed. Reg. at 56,204 (emphasis added); *see also Windsor Health Care Center*, DAB No. 1902 (2003) ("The key factor in assessing financial condition is whether the facility has adequate assets to pay the CMP without having to go out of business or compromise resident health and safety").

Van Duyn argues that it presented evidence to show that the large CMP amount would cause "hardship" in its service delivery in the form of testimony from Ms. Sprague, the County Commissioner of the department that "supervises" Van Duyn. Van Duyn Br. at 35. Ms. Sprague's testimony emphasizes the high operating losses in 2006-08 and projected for the next three years, with any prospect of increased public funding (to pay the CMPs) unlikely given New York State's "brutal budget season." P. Ex. 19, at 6. Van Duyn points out that public tax funding is "not an endless supply of money." Van Duyn Br. at 36.

We recognize that the financial concerns raised by Van Duyn are not frivolous. The standard for reducing a CMP amount for inability to pay is based, however, not on the cash flow situation but on the reduction of assets to the point that a facility may not be able to continue to operate and provide care as a consequence of paying the CMP. The ALJ correctly found that Van Duyn "has offered no evidence to show that the penalties will actually jeopardize its survival or its ability to provide care to the residents of the facility." ALJ Decision at 15. The testimony about general State-wide pressures on county facilities and on health care budgets that may lead to layoffs does not establish that the CMP amount would be the proximate cause of Van Duyn having to close its doors or reduce its care.

We do, however, find the ALJ's discussion of why a CMP amount near the absolute maximum is justified insufficient. The ALJ simply states that "the seriousness of Petitioner's noncompliance is certainly adequate, without consideration of other factors, to sustain" this amount. ALJ Decision at 14. The ALJ does not explain what his basis was for this statement about "seriousness" or why he did not consider factors such as absence of prior history of noncompliance in the record or degree of culpability.

The ALJ mentions two specific observations in support of the amount of the CMP – that Resident # 1 was "obviously in harm's way" whenever he went out of the facility and that the failure to assess his risks was "just a symptom" of the absence of policies and procedures to ensure systematic and effective assessments of other residents. *Id*. We agree, as explained above, that both points are true, and therefore the conclusions that noncompliance occurred and reached the level of immediate jeopardy are well-founded. Nevertheless, we conclude that evidence in the record which the ALJ either disregarded entirely or dismissed without explanation fairly detracts from a conclusion that the amount imposed is reasonable.

We note that CMS acknowledged on appeal that "this is not an easy case," that Resident # 1 was "not a run-of-the-mill nursing home resident," and that his care would present "challenges to any skilled nursing facility" that admitted him. CMS Br. at 2. We agree with the conclusion that, having admitted him, Van Duyn had to "comply with federal requirements even with its most difficult residents," and we therefore have upheld the ALJ's conclusion that Van Duyn's care fell short. *Id*. We also agree, however, that the

situation with Residents # 1 and # 2 was difficult and did not lend itself to easy or obvious solutions.

The Administrator testified that the staff was aware of Resident # 1's history of alcohol abuse and homelessness because he had resided at the facility for about four months in a period prior to the current admission. P. Ex. 17, at 5; *see also* P. Ex. 19, at 3. The readmission was at the request of adult protective services after another nursing home and the homeless shelter had refused to take him, and multiple other placement attempts failed, with winter approaching. P. Ex. 19, at 3-4; P. Ex. 16 passim. The Administrator also testified, without contradiction, that for more than six months of his stay his seizures were significantly reduced, he did not drink, and he did not try to leave the facility. *Id*. at 6. She stated that, before the decision to "try Resident # 1 on a pass with limitations" on May 18, she consulted with his social worker and had the charge nurse confer with his physician (Dr. Nanavati). P. Ex. 17, at 11; *see also* CMS Ex. 20, at 2. All three indicate that encouraging independent function was a major goal. P. Ex. 17, at 11; P. Ex. 18, at 5; P. Ex. 20, at 2-3. While the ALJ correctly found that these efforts fell short of a direct evaluation of the risks facing the residents when on leave, we find that they nevertheless reflect some basis to believe the staff was aware of his risks and sought to balance his safety needs with his goal of independence, and that an interdisciplinary consultation did occur about whether and how he should be allowed to leave.

The limitations on the pass were designed to bring the residents back to the facility in time for medications and to ensure that the Administrator was notified if the residents did not return on time. P. Ex. 17, at 9-10; P. Ex. 20, at 2. The ALJ discounted these limitations because Resident # 1 did not comply with them. ALJ Decision at 13. The Administrator explained, however, that she did not view the late return on May 16 as noncompliant because it was "storming" and the residents were traveling by public bus. P. Ex. 17, at 9. The ALJ stated that the facility did not reassess whether Resident # 1 should have a pass after he failed to return on May 18. ALJ Decision at 13. His doctor actually discontinued the pass order for Resident #1 on May 21, 2009. P. Ex. 18, at 7; CMS Ex. 27, at 1. While not as prompt a response to the plain noncompliance of May 18-19 as should have been made, the withdrawal of the pass does reflect some reassessment of the appropriateness of the pass in light of events.[6]

The ALJ recognized that the staff provided counseling to the residents but concluded that such counseling could not be meaningful when the staff had not first performed an assessment of the risks. ALJ Decision at 13; *see also id*. at 8. It is not disputed that the nursing supervisor counseled Resident # 1 on May 16 about "Van Duyn's rules and the importance of keeping himself safe." P. Ex. 17, at 9. Ms. Vetter testified that she

[6] We do note that the Administrator explained that the physician discontinued the pass order so that Resident # 1 "would not be in a position to come and go as he pleased." P. Ex. 17, at 13. This formulation undercuts Van Duyn's argument, discussed earlier, that medical pass orders could not be viewed as authorizations to leave the facility.

counseled Resident # 1 on "the ramifications of his actions and the impact that his behavior would have on his ability to remain at the Facility." P. Ex. 20, at 5. Her progress notes show that she advised Resident # 1 on May 18 about the parameters on his pass, about limits on the funds he could withdraw, that the administration would be called if he returned after 5 PM, and that he must notify staff before leaving. CMS. Ex. 20, at 2. An incident report completed about the May 16 episode also reported that Resident # 1 was counseled about the "necessity of observing pass process." CMS Ex. 21, at 2. The plan of care after the May 16 episode indicates counseling about the dangers of alcohol abuse and of missing medications and medical care. CMS Ex. 16, at 2. The social worker reports that she discussed the pass parameters with Resident # 1 on May 18 and obtained his agreement to notify the staff when he left. P. Ex. 20, at 3.

While it is plain that such counseling did not have the desired effect of altering Resident # 1's behavior, we cannot agree that counseling is completely meaningless in the absence of a specific assessment of risks. The facility could not provide supervision to prevent accidents meeting the quality standards in the regulations without knowing what hazards were foreseeable, it is true. Nevertheless, the records do reflect awareness on the part of at least some staff members of the most prominent risks – particularly of a return to self-destructive behavior patterns – and that awareness could be expected to inform the efforts to counsel Resident # 1. The point is that counseling and other attempted interventions by Van Duyn, while inadequate to provide the required level of care, demonstrate a degree of concern for resident safety rendering the near-maximum CMP unreasonable.

The record also reflects some attempted interventions to mitigate risk that the ALJ did not address. For example, Resident # 1's care plan indicates that, before he left on May 18, he was provided with a bracelet showing Van Duyn's phone number. CMS Ex. 16, at 1. This would appear to be one reasonable intervention to ensure that the facility would be contacted in the event that Resident # 1 ran into difficulties. The social worker testified without contradiction that she consulted Resident # 1's health care proxy about his actions on May 18, 19, 20, and 21, and that she made a referral to adult protective services early in that week and a follow-up call on May 21st. These active efforts to recruit resources to deal with Resident # 1's behavior and safety are not consistent with the ALJ's statement that the "staff simply threw up their hands and ignored the problems the resident posed" or "made no effort to assess the resident for possibly effective interventions . . . ." ALJ Decision at 7.

Van Duyn further argues that the record of many conversations among the staff, outside professionals and the residents over the course of the events dealing with how to address safety prove that such conversation "would not have occurred in the fashion that they did," if there were not a "system" in place for risk assessment and planning. Van Duyn Reply Br. at 3. We do not agree that such conversations necessarily imply an underlying system or that they disprove the ALJ's finding that decision-making occurred in an ad hoc fashion. They do, however, again show some degree of involvement in trying to maintain resident safety in the face of challenging problems.

The ALJ's discussion of Van Duyn's responses to the residents' unsafe behavior seems to end with May 21 when Resident # 1 again failed to return. The evidence proffered by Van Duyn, however, does show further actions taken by the facility after that date and before the survey. Thus, an incident report dated May 22, 2009, addressed the events of May 18-22, reporting that the facility tried to get Resident # 1 back to the premises prior to his hospitalization and that, on his return, adult protective services was asked to the facility to meet with him and explained that, if he went out against medical advice again, they would seek guardianship of him and would likely have to place him in an out-of-state facility. CMS Ex. 21, at 11. Resident # 1 then signed a statement expressing understanding that he cannot use the facility as a "place to sleep" while ignoring "parameters for safety," agreeing "not to leave the premises," and acknowledging that further violations would lead to discharge. CMS Ex. 23. Resident # 1's care plan was amended on May 26 to reflect these steps, as well as the discontinuance of any pass order and restriction on release of any funds, and to reflect the updating of the health care proxy on May 20, 21, 23 and 26. P. Ex. 16, at 5. While none of these steps eliminated the noncompliance or even abated the immediate jeopardy, these interventions (taken before the involvement of the surveyors) cast a different light on the facility's attitudes than portrayed in the ALJ's comments.

Finally, the ALJ (and CMS) placed significant emphasis on the absence of a comprehensive list of all residents with pass orders, with the result that the assistant administrator was not able to accurately estimate the number of residents with pass orders. ALJ Decision at 6, 10. Maintaining a list of residents with pass orders and the applicable conditions could reasonably have been a means of ensuring that the foreseeable risks for each were identified and that reasonable precautions were fully explored to address them. There is, however, no independent requirement that the information be maintained in such a collective list or database rather than in individual clinical records. The ALJ went further and found that Van Duyn lacked "a system even to identify and keep track of its residents who were away on a pass." ALJ Decision at 10. This finding is not supported by substantial evidence. The record contains shift-to-shift communications sheets listing all residents on a unit and showing which ones have out-on-pass orders and under what parameters. CMS Ex. 13. The record also contains 24-hour reports (discussed earlier) which note, on each shift, when a resident is away from the facility such as "hospital" or "OOP." CMS Ex. 17. Nursing and social service progress notes discussed earlier also reflect that individual resident's clinical records documented when leave was requested, how the request was handled, and what the results were. None of these documents shows a systematic evaluation of individual risks while on leave or systematic planning of interventions with escalation in the face of failures. They do show systems to track which residents have pass orders and which residents were away on passes.

Balancing all of these considerations, we do not agree that the ALJ's statement about the "seriousness" of the noncompliance suffices to support the reasonableness of setting the CMP amount near the maximum. In some significant respects, the ALJ's findings

overstate the factual premises for that conclusion. Generally, we would expect to see multiple regulatory factors contributing to the imposition of a CMP of nearly $10,000 per day. The ALJ made no finding of culpability or of any prior history of noncompliance (and CMS did not argue on appeal that he erred by not making such findings). We conclude that the amount of the CMP is not reasonable.

For the reasons we have discussed at length, however, we concur that the noncompliance was widespread in that it involved a failure to have procedures in place to protect not only Residents # 1 and # 2, but also potentially the more than 200 other residents with pass orders. We therefore conclude that the CMP should be closer to the top than the bottom of the total spectrum of potential CMPs. We therefore reduce the CMP to $5,500 per day.

Conclusion

As explained above, we affirm the ALJ Decision and uphold the remedies imposed there, except that we modify the amount of the immediate jeopardy CMP to $5,500 per day.

_____/s/_____
Judith A. Ballard

_____/s/_____
Stephen M. Godek

_____/s/_____
Leslie A. Sussan
Presiding Board Member