Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Lee County Care and Rehabilitation Center
(CCN: 18-5337),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-09-526

Decision No. CR2282

Date: November 22, 2010

DECISION

I find that Lee County Care and Rehabilitation Center (Petitioner) was not in substantial compliance with 42 C.F.R. § 483.25(h). I also sustain as reasonable the Centers for Medicare and Medicaid Services (CMS) imposition of civil money penalties (CMP) of $3,550 per day from March 20 through March 26, 2009.

I. Background

Petitioner participates in the Medicare and Medicaid programs pursuant to sections 1819, 1919, and 1866 of the Social Security Act (Act) and by its implementing regulations at 42 C.F.R. Parts 483 and 488. Regulations at 42 C.F.R. Part 498 govern its right to hearing.

On March 23 through March 25, 2009, the Kentucky state survey agency conducted an abbreviated survey and found that Petitioner was not in substantial compliance with Tag F323 – accidents and supervision under the quality of care regulation at 42 C.F.R. § 483.25(h). CMS Ex. 1. Based on the survey finding, CMS notified Petitioner that this non-compliance constituted immediate jeopardy to residents' health and safety and demonstrated substandard quality of care. On April 1, 2009, the state survey agency conducted a partial extended survey and determined that the immediate jeopardy and the substandard quality of care conditions had been removed on March 27, 2009. CMS

imposed a CMP in the amount of $3,550 per day for the period of March 20 through March 26, 2009. CMS Ex. 4.[1]

I conducted a hearing on June 29-30, 2010, and the parties received a transcript (Tr.) of the proceeding. Ms. Alice Elaine Randolph, the state surveyor, testified on behalf of CMS. Petitioner elicited testimony from Janine Lehman, RN, expert witness, and Caddis Hudson, Petitioner's Director of Nursing (DON). CMS offered, and I admitted, CMS Exhibits (CMS Exs.) 1 through 25. Tr. at 24. Petitioner offered, and I admitted, Petitioner Exhibits (P. Exs.) 1-33. Tr. at 27. The parties submitted posthearing briefs (CMS Br. and P. Br.).

II. Applicable Law

The regulatory requirements for long-term care facilities that participate in the Medicare and Medicaid programs are set forth at 42 C.F.R. Part 483. Facility compliance with the participation requirements is determined through a survey and certification process. Sections 1819 and 1919 of the Social Security Act (Act); 42 C.F.R. Parts 483, 488, and 498. State survey agencies perform the survey and certification process on behalf of the Secretary and CMS. Under Part 488, CMS may impose a CMP against a facility that is not complying substantially with participation requirements. 42 C.F.R. §§ 488.406, 488.408, 488.430. The penalty may start accruing as early as the date that the facility was first out of compliance and runs until the date substantial compliance is achieved or the provider agreement is terminated.

"Deficiency" is defined as a facility's "failure to meet a participation requirement specified in the Act or in part 483, subpart B." 42 C.F.R. § 488.301. The term "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." *Id.* "Noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." *Id.* "Immediate jeopardy" means "a situation in which the provider's noncompliance . . . has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." *Id.*

The regulations specify that a CMP that is imposed against a facility on a per day basis will fall into one of two broad 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 constitute immediate jeopardy to a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. § 488.438(a)(1)(i), (d)(2). The lower range of 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

[1] A discretionary denial of payment for new admissions (DPNA), effective May 5, 2009, and a termination of Petitioner's provider agreement on October 1, 2009, never went into effect, because the facility returned to substantial compliance on March 27, 2009. CMS Ex. 6.

potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). There is only a single range of $1,000 to $10,000 for a per instance CMP that applies whether or not immediate jeopardy is present. 42 C.F.R. §§ 488.408(d)(1)(iv), 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 a CMP. Act § 1128A(c)(2); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing before an ALJ is a de novo proceeding. *The 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 it 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 found if a successful challenge would affect the amount of the CMP that CMS could collect or impact upon the facility's nurse aide training program. 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." 42 C.F.R. § 498.60(c)(2). This includes CMS's findings of immediate jeopardy. *Woodstock Care Center 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.[2] *See*, *e.g*., *Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). ALJ Review of a CMP is governed by 42 C.F.R. § 488.438(e).

The standard of proof or quantum of evidence required is a preponderance of the evidence. CMS has 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 Hillman Rehab. Ctr.*, DAB No. 1611 (1997), *aff'd, Hillman Rehab. Center v. United States Dep't of Health and Human Servs., Health Care Fin. Admin.,* No. 98-3789, 1999 WL 34813783 (D.N.J. May 13, 1999); *Cross Creek Health Care Center,* DAB No. 1665 (1998); *Emerald Oaks*, DAB No. 1800; *Batavia Nursing and Convalescent Center,* DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Center v. Thompson*, 129 F. App'x 181 (6thCir. 2005); *Batavia Nursing and Convalescent Inn,* DAB No. 1911 (2004).

---

[2] Such a challenge is only applicable where CMS has imposed a per day CMP within the upper range. There is no such challenge available if a per instance CMP is imposed.

III. Issues, Findings of Fact, and Conclusions of Law

A. Issues

The issues in this case are whether:

Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h) that the resident environment remain as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents;

CMS's determination that Petitioner's noncompliance with the requirements of 42 C.F.R. § 483.25(h) constituted immediate jeopardy was clearly erroneous; and

The CMPs imposed are unreasonable.

B. Findings of Fact and Conclusions of Law

I make the following findings of fact and conclusions of law (Findings), set forth below as separate headings in bold and italics, to support my decision in this case.[3]

1. Petitioner was not in substantial compliance with the requirements of 42 C.F.R. § 483.25(h).

This case involves a single deficiency. Specifically, CMS maintains that Petitioner violated section 483.25(h) by failing to provide Resident 1 (R1) with adequate supervision to prevent his elopement on March 20, 2009.

R1, an 83 year-old male, was diagnosed as suffering from Dementia, Alzheimer's type. CMS Br. at 5; CMS Ex. 3, at 2. R1 had a moderately-impaired cognition level, an unsteady gait, and was identified to be an elopement risk and at risk for falls. CMS Ex. 18, at 8, 19, 21, 42. R1 had decreased endurance and was to wear oxygen-providing equipment. *Id*. at 46. However, R1 refused to wear oxygen-providing equipment. *Id*.

R1 had made a previous unsuccessful elopement attempt when he tried to leave the facility through an exit door on October 25, 2008, several days after he was first

---

[3] I have reviewed the entire record, including all the exhibits and testimony. Because the Federal Rules of Evidence do not control the admission of evidence in proceedings of this kind (*See* 42 C.F.R. § 498.61), I may admit evidence and determine later, upon a review of the record as a whole, what weight, if any, I should accord that evidence or testimony. To the extent that any contention, evidence, or testimony is not explicitly addressed or mentioned, it is not because I have not considered the contentions. Rather, it is because I find that the contentions were not supported by the weight of the evidence or by credible evidence or testimony.

admitted. CMS Ex. 8, at 11; CMS Ex. 18, at 8. The facility assessed R1 as an elopement risk. *Id*. Petitioner's Director of Nursing (DON), Ms. Caddis Hudson, testified that R1 was an elopement risk. Tr. 371. Petitioner describes R1's previous elopement attempt as "normal exit seeking behaviors for the first four or five days after his admission to the nursing home but those behaviors ceased once he became adjusted to his surrounding." P. Br. at 2.

On March 20-21, 2009, at some time between 10:00 p.m. and 12:30 a.m., R1 left the facility undetected and unsupervised. Upon discovering that R1was missing, the facility staff initiated a search both inside and outside the building, which was located near a river and a railroad track. Tr. at 61-63. Staff at the facility was unaware of R1's location from at least 12:30 a.m. until 10:00 a.m. on March 21, 2009, a period of nine and one-half hours, when R1 was found by police and a local rescue squad in a field approximately one half-mile away from the facility. CMS Ex. 14. R1 was taken to the hospital and treated for hypothermia because he had a core temperature of 94.2 degrees Fahrenheit. R1 had sustained bruising to his left eye and abrasions to his nose and left forearm. CMS Ex. 19, at 21. R1 returned to the facility on March 24, 2009. CMS Ex. 8, at 83-84. The Resident Abuse Investigation Report indicated that when R1 was questioned about how he got out of the building, R1 replied that someone let him out, and R1 stated to his daughter that "he was going coon hunting." CMS Ex. 14, at 4. The Resident Abuse Investigation Report concluded that the "resident likely left the facility unattended on 3/20/09 after 9:30 p.m., as this was the last reported time the resident was seen by staff . . . it is thought that resident could have followed a visitor out the front door . . . [the resident] could not have left the building through any of the exit doors without staff being aware, that is why it is suspected he left via the front door exit following others out."[4] *Id.* at 8.

All the exits to the facility had functioning alarms. Tr. at 100-01, 301. Petitioner agrees that the only way to exit the building absent an emergency was through the front door. P. Br. at 5; Tr. at 302. The external front door opened from the outside onto a small anteroom, that in turn had an interior lock that opened into the front lobby. Tr. at 306-07; P. Exs. 7-9. The external front door had a magnetic lock that was alarmed at all times, but it could be disarmed by entering a pre-set code into a nearby keypad. The magnetic lock could also be deactivated by pushing a green door-release button that was located on the rear of the receptionist's counter in the lobby. The receptionist's desk was staffed from 8:00 a.m. until 8:00 p.m. Tr. at 305. After 8:00 p.m., the receptionist's desk was not attended, and no one was assigned to monitor the front green release button at the

---

[4] Petitioner asserts that R1 was in the building at 10:00 p.m. because the Elopement/Wandering Monitoring Form was initialed by Elizabeth Stamper, a Certified Medical Technician, who relied on the report of an unidentified nursing assistant that R1 was in the facility. P. Br. at 2; P. Ex. 30; Tr. at 340, 379-81. Neither Ms. Stamper nor the nursing assistant who reported seeing R1 at 10:00 p.m. testified at the hearing. The midnight box on the Elopement/Wandering Monitoring Form was blank, because, during midnight rounds, R1 could not be located.

receptionist's counter. P. Br. at 7. The surveyors determined that certain residents and visitors had at times used the green door-release button at the receptionist's counter to open the front door for persons entering or leaving the facility. Tr. at 39-40. It is undisputed that, on the evening of March 20, 2009, there was heavy traffic at the front door and lobby area because there were numerous visitors to the facility in connection with the death of another resident.

There is almost no direct evidence to establish how R1 left the facility: no staff member, resident, or visitor has been identified as a direct witness to the event. R1's own statement, however reliable it may be, does not entirely settle the question. Prior to R1's elopement, the front door had an alarm release button that was accessible to anyone who was tall enough, such as R1, to push it. Tr. at 373. Petitioner had a special secure unit, the Seasons wing, where those residents most at risk for elopement resided. R1 was not considered to be a "significant enough elopement risk to warrant confinement on the Seasons wing." P. Br. at 4-5; Tr. at 215, 293. Walking rounds by staff at shift change, 11:00 p.m. to 11:15 p.m. on March 20, 2009, were not done because one of the aides for the night shift was late to work. Tr. at 334; CMS Ex. 8, at 13. Petitioner's elopement policy required that residents at risk for elopement be checked every two hours, which was the same time interval for checking residents who were not at risk for elopement. Tr. at 36. The facility moved R1's room twice shortly before the elopement. R1's room was moved on March 11, 2009, and then again on March 14, 2009. CMS Ex. 8, at 13, 15. R1 suffered and displayed some confusion as a result of the moves. *Id*. Petitioner describes R1 as moderately confused. P. Br. at 2. Also, R1 was dressed in a hat and a jacket while he was moving around the facility the evening that he eloped and could have easily blended in with others leaving the facility. Tr. at 40.

After the elopement, Petitioner implemented corrective measures. Petitioner installed a locked box over the door-release button. The receptionist was given possession of the sole key to the locked box over the door-release button, and the door-release button was deactivated when the receptionist was not on duty. The keypad code was changed. Residents at risk for elopement were monitored hourly instead of every two hours. All residents at risk for elopement were reassessed. New, larger photographs of elopement-risk residents were placed in the Elopement Books. Staff members were "in-serviced" regarding new procedures. Most of the staff members were "in-serviced" on March 21 and 22, 2009. The sign-in sheets for the in-service training, however, were all dated March 21, 2009. As a result, the facility conducted the training again for all employees on March 24-26, 2009. A Quality Assurance meeting was held on March 25, 2009. The facility's Plan for Removal of Jeopardy stated that "all corrective actions [were] completed [on] 3/26/09." P. Br. at 23. It is undisputed that the in-service training was not entirely completed until March 26, 2009.

The Board has explained the requirements of 42 C.F.R. § 483.25(h)(2) in numerous decisions. *Golden Living Centers for Medicare & Medicaid Services (CMS) – Riverchase*, DAB No. 2314, at 6-7 (2010); *Eastwood Convalescent Center.,* DAB No. 2088 (2007); *Liberty Commons Nursing and Rehab. - Alamance,* DAB No. 2070 (2007);

Century Care of Crystal Coast, DAB No. 2076 (2007), *aff'd, Century Care of the Crystal Coast*, 281 F. App'x 180 (4th Cir. 2008); *Golden Age Skilled Nursing & Rehab. Center*, DAB No. 2026 (2006); *Estes Nursing Facility Civic Center*, DAB No. 2000 (2005); *Northeastern Ohio Alzheimer's Research Center*, DAB No. 1935 (2004); *Woodstock Care Center*, DAB No. 1726 (2000), *aff'd*, *Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). Section 483.25(h)(2) does not make a facility strictly liable for accidents that occur, but it does require 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. *Woodstock Care Center v. Thompson*, 363 F.3d at 589 (noting a nursing home must take "all reasonable precautions against residents' accidents").

I can reasonably infer from the facts in this case that, because of inadequate supervision by the facility staff, R1 was able to leave the facility unattended sometime between 10:00 p.m. and 12:30 a.m. either by pushing the door-release button himself or leaving with other people at the same time that they left.

Petitioner contends that it provided adequate supervision to prevent R1 from eloping from the facility. First, Petitioner notes that photographs of all residents assessed as elopement risks were placed in an Elopement Book that was kept at all nursing stations and at the receptionist's counter. Second, Petitioner asserts that all residents at risk for elopement were monitored every two hours. Third, it points out that all exit doors were alarmed, and the employees were not to disclose the keypad code. Neither Petitioner's administrator nor the DON was aware that residents or visitors were using the green door-release button to exit or let others into or out of the facility. Fourth, according to Petitioner's expert nurse witness, Ms. Lehman, the change of shift rounds were not intended to check on residents at risk for elopement but to give the next shift an overview of the current state of the unit. Tr. at 218-22. Therefore, according to Petitioner, the fact that the shift rounds were not performed on the evening of March 20, 2009, did not affect or impair the supervision that R1 received, especially since the Elopement/Wandering form required monitoring every two hours, including at 10 p.m. and midnight.

The evidence, however, requires that I disagree with Petitioner's position. I am not persuaded by Petitioner's arguments and assertions that it adequately supervised R1. On the contrary, I find CMS's arguments to be persuasive and supported by the weight of the evidence.

Facilities are required to take all reasonable measures to protect its residents from accident hazards that are known or that are foreseeable. It is not reasonable — and it is certainly not prudent — to leave a functioning door-release button unmonitored and accessible to virtually any passers-by, including residents at risk for elopement. It is not reasonable to allow visitors or residents to use the functioning door-release button in a situation where the front door area is not monitored by a staff person who can prevent residents at risk for elopement from exiting on their own or following others out of the front door. The surveyors determined that certain residents and visitors had, at times,

used the green door-release button at the receptionist's counter to open the front door for persons entering or leaving the facility. Tr. at 39-40. Petitioner does not dispute this fact. At most, Petitioner argues that the administrator and the DON were unaware that residents or visitors were using the green release button to leave or enter the facility. But particularly on the night at issue, that state of unawareness is difficult to understand. Simply put, the facility's staff and management should have known that visitors and residents and non-residents routinely used the door-release button when the receptionist was not at her station.

On the evening of March 20, 2010, the parties agree that there was a great deal of traffic at the front door area because of people coming to visit a dying resident and leaving afterward. R1 suffered from increased confusion because his room had been moved twice, first on March 11, 2009 and again on March 14, 2009. R1 had previously attempted to elope shortly after he first was admitted to the facility. During his first elopement attempt R1 displayed "normal exit seeking behaviors." P. Br. at 2. A demented resident, assessed as an elopement risk and experiencing increased confusion after two recent room changes, requires supervision *adequate to the situation* if an elopement is to be prevented, especially if that situation arises at a time of high traffic when the receptionist's desk is not attended. In addition, it is undisputed that the staff knew that R1 was wearing a hat and jacket the evening of March 20, 2009, further complicating the situation by making it easy for him the blend in with others leaving the building. It is evident that Petitioner's staff did not provide adequate supervision to R1.

No staff member had seen R1 since the 10:00 p.m. elopement check. The nurse who signed the elopement form at 10:00 p.m. did not see R1 but relied on an unnamed staff person's report of seeing R1. The Resident Abuse Investigation Report concluded that the "resident likely left the facility unattended on 3/20/09 after 9:30 p.m., as this was the last reported time the resident was seen by staff" and that R1 probably "left via the front door exit following others out." CMS Ex. 14, at 8. It is undisputed that no staff person reported seeing R1 from at least 10:00 p.m. until 12:30 a.m. and that during that time R1 exited the facility unattended. It is therefore undisputed that R1 was not supervised during this time period, since no staff member reports having seen R1 during that time period.

Petitioner maintains that numerous interventions were in place to prevent elopements. Petitioner's arguments are unavailing. Having pictures in an elopement book at the receptionist's counter is not an effective intervention *if there is no receptionist on duty*. Having alarmed and locked exits is not an effective intervention *if the door-release button is accessible and known to visitors and residents*. Having a door-release button under the control of the receptionist is not an effective intervention to prevent elopements *if the release button is not deactivated after the receptionist is no longer on duty, and no one else is monitoring the door-release button and the door*. Even if Petitioner's employees never intentionally disclosed the keypad code, the alarm feature could be circumvented simply by pressing the green door-release button.

Petitioner points to the testimony of its expert witness that Petitioner's facility was more secure than other nursing homes in Kentucky, since Petitioner had a keypad-activated alarm on the front magnetic lock and did not disclose the code to visitors or residents. P. Br. at 6. However, Ms. Lehman, Petitioner's expert, compared Petitioner to those nursing homes that post the keypad code in plain site by the door. As Ms. Lehman did not provide any other information concerning these other nursing homes and did not address the issue of leaving a release button activated, accessible, and unattended, I find Ms. Lehman's opinion to be of little weight in this matter.

The evidence demonstrates that Petitioner monitored all its residents every two hours, whether they were elopement risks or not. Prior to the survey, Petitioner did not monitor its residents at risk for elopement more frequently that it monitored those not at risk for elopement. Monitoring all elopement risk residents every two hours is not an effective intervention when the evidence shows that R1, who was obviously at the front door area, was not supervised for at least two and one-half hours during a time when there was a great deal of traffic near the front door and lobby area, and the receptionist was not on duty to monitor who exits and leaves the facility.

The heart of Petitioner's noncompliance is its failure to take obvious and easy protective measures. Petitioner had obvious alternatives available: to supervise its residents adequately; to deactivate or to lock the door-release button when no one was available to monitor the button and the front door; or to monitor the button and front door continuously. And although it may be a point more abstract than concrete here, precisely because the alternatives available were so obvious and easy, Petitioner's noncompliance does not hinge necessarily on the elopement of R1. Even had R1 not eloped, the hazard caused by the failure of Petitioner and its staff to properly supervise its residents and to monitor the front door and the release button would have existed. Nor was the hazard diminished by the fact that a similar event had not occurred in the past.[5] I find that Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h).

2. CMS's determination that the facility's noncompliance posed immediate jeopardy to resident health and safety is not clearly erroneous.

Immediate jeopardy exists if a facility's noncompliance has caused, or is likely to cause, "serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination as to the level of a facility's noncompliance (which would include an immediate jeopardy finding) must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a heavy burden to show no immediate jeopardy and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing*

[5] Petitioner asserts that R1 was the first resident to elope in 40 years. P. Br. at 1.

Home, DAB No. 1962, at 11 (2005); *Florence Park Care Center*, DAB No. 1931, at 27-28 (2004).

I find that the finding of immediate jeopardy was not clearly erroneous. There is no question that Petitioner's noncompliance placed R1 and other residents at risk for elopement in immediate jeopardy. Here, the failure of Petitioner to adequately supervise R1 and monitor the door-release button and front exit door to the facility resulted in his elopement from the facility. As a result of the elopement, the whereabouts of R1 remained unknown for at least nine and one-half hours, from 12:30 a.m. until 10:00 a.m. on March 21, 2009. Without question, R1 was unsupervised during this time, and he was finally found nine and one-half hours after his elopement a half-mile from the facility. While R1 suffered from bruising to his left eye, abrasions to his nose and left forearm, the most serious harm R1 sustained was hypothermia. R1's core temperature taken at the hospital was 94.2 degrees Fahrenheit. CMS Ex. 19, at 21. It is fortuitous that he did not suffer more serious harm, since the facility is located in a wooded area near a railroad track and a river and the weather was cold. Tr. at 44, 341. R1, an 83-year old male who suffered from Dementia, Alzheimer's type, was also accessed to be at risk for falls. Clearly, the likelihood of serious harm or death to R1 was great due to his dementia and his risk for falls. Once he had eloped from the facility, he was at risk for, among other things, being struck by a motor vehicle or a train, falling, and hypothermia, as well as drowning in the nearby river.

3. The penalty imposed is reasonable.

To determine whether the CMP is reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f), which are: (1) the facility's history of noncompliance; (2) the facility's financial condition; (3) factors specified in 42 C.F.R. § 488.404; and (4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort, or safety. The absence of culpability is not a mitigating factor. The factors listed in 42 C.F.R. § 488.404 include: (1) the scope and severity of the deficiency; (2) the relationship of deficiency to other deficiencies resulting in noncompliance; and (3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

In reaching a decision on the reasonableness of the CMP, I must consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiency found, in light of the above factors. I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Center*, DAB No. 1848, at 21 (2002).

CMS has imposed a penalty of $3,550 per day from March 20 to March 26, 2009, which is at the low end of the penalty range for situations of immediate jeopardy ($3,050-$10,000). CMS does not cite facility history as a factor that justifies a higher CMP, and Petitioner does not argue that its financial condition affects its ability to pay the penalty.

Petitioner was culpable, because it failed to institute obvious measures to prevent elopement. I have also considered the remaining necessary factors.

Further, I have considered the duration of the CMP. Petitioner has the burden of proving that it achieved substantial compliance on a date earlier than that determined by CMS. Petitioner contends that it did everything necessary to remove the immediate jeopardy by March 21, 2009, in that the keypad code was changed, a locked box was placed over the release button, the release button was deactivated when the receptionist was not on duty, and elopement rounds were conducted hourly instead of every two hours. P. Br. at 28. However, at the hearing the DON testified that Petitioner had completed the "in-servicing" of 95 per cent of its staff but had not yet "in-serviced" those staff members who worked as needed. Tr. at 392. Petitioner completed all the steps necessary to remove the immediate jeopardy, and its entire staff was "in-serviced" by March 26, 2009. CMS Ex. 3 at 13; Tr. at 390. Petitioner's "Plan for Removal of Jeopardy" indicated that the completion date to remove the immediate jeopardy was March 26, 2009. In light of all the factors involved and reviewing the duration of the CMP, I find that CMS's imposition of a CMP in the amount of $3,550 per day from March 20 to March 26, 2009 was reasonable.

IV. Conclusion

For the reasons discussed above, I find that Petitioner's facility was not in substantial compliance with the Medicare requirements and that its noncompliance posed immediate jeopardy to resident health and safety. I affirm as reasonable the penalty imposed.

/s/
Richard J. Smith
Administrative Law Judge