Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Glenoaks Nursing Center,
(CCN: 25-5181),

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-423

Decision No. CR2660

Date: November 19, 2012

DECISION

Glenoaks Nursing Center (Petitioner or the facility) challenges the determination of the Centers for Medicare and Medicaid Services (CMS) that it was not in substantial compliance with Medicare program participation requirements. Petitioner also challenges CMS's imposition of a civil money penalty (CMP) of $3,550 per day from December 24, 2010 through January 27, 2011, and $150 per day from January 28 through February 18, 2011. For the reasons discussed below, I sustain CMS's imposition of the CMPs.

I. Background

Petitioner is a nursing facility, located in Lucedale, Mississippi, that participates in the Medicare and Medicaid programs. The Mississippi Department of Health (state agency) completed a complaint survey at Petitioner's facility on January 28, 2011 and a revisit survey on March 30, 2011. Based on the findings of the January 28, 2011 survey, CMS found that Petitioner was not in substantial compliance with three program deficiencies: F224 (staff treatment of residents) and F323 (accidents and supervision), and F514 (clinical records). CMS cited both F224 and F323 at a scope and severity level of "J,"

constituting immediate jeopardy to resident health and safety and cited F514 at a scope and severity level of "E," constituting a pattern of no actual harm with the potential for more than minimal harm. CMS determined that immediate jeopardy was abated on January 28, 2011 and lowered the scope and severity of the deficiencies to a "D" level, constituting no actual harm with the potential for more than minimal harm. CMS Ex. 1, at 12. CMS found that Petitioner returned to substantial compliance during its March 30, 2011 revisit survey. By letters dated March 11, 2011 and April 5, 2011, CMS notified Petitioner that it was imposing the enforcement remedies of a CMP of $3,550 per day from December 24, 2010 through January 27, 2011, $150 per day from January 28, 2011 through February 18, 2011, and withdrawal of approval of Petitioner's nurse aid training and competency evaluation program (NATCEP) for a period of two years. CMS Ex. 2, at 2, 4-7.

By letter dated April 28, 2011, Petitioner requested an Administrative Law Judge (ALJ) hearing, disputing the CMS determination that it was not in substantial compliance with program requirements and imposition of the proposed remedies. Petitioner's request was received at the Civil Remedies Division, assigned to me for hearing and decision, and on May 4, 2011, I issued an Acknowledgment and Initial Prehearing Order.

CMS filed 48 proposed exhibits, marked as CMS Exs. 1-48. Petitioner filed 39 proposed exhibits, marked as P. Exs. 1-39. During a prehearing conference on October 12, 2011, there being no objections raised, I admitted CMS Exs. 1-48 and P. Exs. 1-39 into the record.

CMS filed the written direct testimony of Lauree Chase, RN as one of its proposed exhibits. CMS Ex. 48. Petitioner filed the written direct testimony of eleven witnesses: Lori Rogers, LPN (P. Ex. 22); Jacqueline Knight, CNA (P. Ex. 23); Kim Wright (P. Ex. 24); Elisha Buker, LPN (P. Ex. 25); Jana Miller, RN (P. Ex. 26); Jordan Maples (P. Ex. 27); Shirley Fairley (P. Ex. 28); Chardai Grant, RN (P. Ex. 29); Wanda Khan, RN (P. Ex. 30); Angela Hillman, RN (P. Ex. 31); and Teresa Crabtree (P. Ex. 32). CMS elected not to cross-examine any of Petitioner's witnesses; however, Petitioner requested to cross-examine the CMS witness, Ms. Chase. On November 29, 2011, I convened a video hearing, and Ms. Chase was produced for cross-examination. CMS Ex. 48; Tr. at 8-50. A transcript of the proceedings was prepared.[1] Both parties filed post-hearing briefs (CMS Br. and P. Br.) and post-hearing replies (CMS Reply and P. Reply).

[1] The parties reviewed the transcript for errata. Petitioner filed its proposed corrections on March 8, 2012, and the transcript is amended to reflect Petitioner's two proposed corrections.

II. Discussion

A. Issues

The issues presented are:

1. Whether Petitioner was in substantial compliance with the Medicare participation requirements of:

    a. 42 C.F.R. § 483.75(*l*)(1) (F514) pertaining to Clinical Records;

    b. 42 C.F.R. § 483.25(h) (F323) pertaining to Accidents and Supervision; and

    c. 42 C.F.R. § 483.13(c) (F224) pertaining to Staff Treatment of Residents;

2. If so, whether CMS's determination of immediate jeopardy level noncompliance is clearly erroneous; and

3. Whether the CMPs that CMS imposed are reasonable.

B. Applicable Law

The Social Security Act (Act) sets forth requirements for a long-term care facility's participation in the Medicare program and authorizes the Secretary of Health and Human Services (the Secretary) to promulgate regulations implementing those statutory provisions. Act § 1819 (42 U.S.C. § 1395i-3). The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. §§ 488.301, 488.330.

The state agency or CMS conduct surveys of nursing facilities to determine whether they are in compliance with the requirements of Part 483. If a facility is found to be not in substantial compliance then CMS has the authority to impose one or more of the enforcement remedies listed in section 1819(h) of the Act (42 U.S.C. § 1395i-3(h)) and 42 C.F.R. § 488.406, including a per day CMP and loss of NATCEP such as that imposed in this case. Remedies are applied on the basis of scope and severity of the noncompliance found during surveys. 42 C.F.R. § 488.402(b). The factors to be considered by CMS when selecting remedies are set forth at 42 C.F.R. § 488.404.

C. Findings

The incident that led to the January 2011 complaint survey stems from the elopement of one of Petitioner's residents who, for privacy reasons, is identified as Resident 1 (R1). CMS Exs. 48, at ¶ 5; 5, at 1. On December 24, 2010, R1 exited Petitioner's facility unsupervised and without staff knowledge. Some of the Facility's staff while taking a work break in "the day room," happened to observe R1 through the window, walking around outside of the facility. The staff immediately notified LPN Lori Rogers and LPN Ednita Fountain. The LPNs secured R1 and returned her through the front door between 11:15 a.m. and 11:30 a.m. Facility staff assessed R1 for injuries, notified her family and physician, and placed her on 1:1 supervision with 15-minute visual checks starting at 11:30 a.m. P. Exs. 22, at ¶ 6; 24, at ¶ 4; 28, at ¶ 4; 29, at ¶ 6; 32, at ¶ 13; CMS Ex. 23, at 1. On December 27, 2010, the facility discharged R1 to the Senior Care Unit at George Regional Hospital. CMS Exs. 12, at 2; 23, at 10. Petitioner's administrator explained to R1's daughter that, while the facility did have door code alarms, it was not a "lock-down alzheimer's unit," and it had "limited options in dealing with R1's behavior." CMS Ex. 12, at 13.

Based on the survey findings, CMS alleges that Petitioner: failed to maintain clinical records that are complete and accurate in violation of 42 C.F.R. § 483.75(*l*)(1) (F514); failed to ensure that R1 and other residents, whom Petitioner identified as at risk for elopement, received adequate supervision in violation of 42 C.F.R. § 483.25(h) (F323); and failed to implement written policies and procedures to prevent neglect of its residents in violation of 42 C.F.R. § 483.13(c) (F224). CMS Ex. 1.

Petitioner contests all three deficiencies. Request for Hearing; P. Br. at 2. My findings of fact and conclusions of law are set forth below in the discussion captions of this decision.

1. Petitioner was not in substantial compliance with 42 C.F.R. § 483.75(*l*)(1) (F514) (Clinical Records) because it did not properly document that staff monitored R1's arm band that helped identify her as an elopement risk.

CMS maintains that Petitioner was in violation with the requirements of 42 C.F.R. § 483.75(*l*)(1) during the January 2011 survey. The regulation provides in pertinent part:

> The facility must maintain clinical records on each resident, in accordance with accepted professional standards and practices that are complete, accurate, readily accessible, and systematically organized.

The Statement of Deficiencies (SOD) alleges that Petitioner fell short of its obligation to meet this requirement with respect to two residents, R1 and R2, who Petitioner identified

as at risk for wandering. The surveyor cited Petitioner for noncompliance because Petitioner had no documentation in the residents' medical records that it monitored the placement of green arm bands/bracelets, which Petitioner used to alert people that certain individuals were elopement risks. CMS Ex. 1, at 33.

At the time of the survey R1 was a 73-year-old woman who had been admitted to Petitioner's facility on December 13, 2010 with diagnoses including Alzheimer's, dementia with behavior disturbance, paranoid state, altered mental status, anxiety, hearing loss and diabetes mellitus. She was ambulatory and alert but had impaired daily decision-making skills. R1 had moderate difficulty hearing and required the use of a hearing aide. CMS Exs. 11, at 1, 3; 17, at 1, 2, 3; 19, at 3-4; 48, at 3. Her plan of care, dated December 17, 2010, shows that she wandered and was at risk for elopement. An Elopement Risk Assessment, dated December 17, 2010, identified R1 as a "significant risk" for elopement and notes that she should receive frequent monitoring. CMS Exs. 16, at 2; 20, at 6. R1's Minimum Data Set (MDS), dated December 20, 2010, describes R1 as having severe cognitive impairment with wandering behavior. CMS Ex. 17, at 1. A History and Physical report dated December 22, 2010, identifies R1's chief complaint as "[p]rogressive confusion with dementia." CMS Ex. 23, at 1. A psychological services initial evaluation note, dated December 16, 2010, states that R1 was referred to Petitioner's facility due to occasional wandering and restless behavior. CMS Ex. 15, at 1.

R1's plan of care included the following staff interventions: monitoring doors for complete closure; checking door alarms for proper working order frequently; keeping picture and face sheet in elopement book; indicating to staff that she is at risk for elopement resident with the placement of a green arm band; ensuring the resident was wearing identification bracelets *at all times* (i.e. green armband); placing green stickers on the spine of the resident's chart and ADL record to identify her as an elopement risk; and including R1's name on the facility's elopement list, which is kept at the nurses' station.[2] CMS Exs. 20, at 6-7; 34, at 36.

At the hearing, Lauree Chase, RN, the state agency surveyor who conducted the January 2011 complaint survey and drafted the SOD, explained that during the survey she interviewed facility staff, and several staff informed her that on the morning of December 24 "they were not aware or did not know if [R1] had an armband on." Tr. at 21, 23. Surveyor Chase testified that the failure to document in the resident's medical record that R1's green arm band was monitored for placement was the only issue with this

[2] CMS claims that Petitioner had three other elopement prone residents – R2, R3, and R4 – and that each had been care planned with the same interventions of a green arm band, monitoring doors for closure, and redirection. However, I find that I do not need to address the facts related to R2, R3, and R4 because the facts and events related to the care of R1 provide a sufficient basis for CMS's determination of noncompliance and fully support the proposed penalty in this case.

deficiency. Tr. at 37. In her written declaration, she stated that during the survey she interviewed Petitioner's Social Service Director (SSD), Jordan Maples. She noted that SSD Maples told her that she was the only staff member who checked residents for placement of the green arm bands and that she checked them once per week. CMS Ex. 48, at ¶ 11. In her direct testimony, SSD Maples explains that the facility uses the green arm bands as an additional means of visually identifying residents who are identified as elopement risks. P. Ex. 27, at ¶ 4. SSD Maples stated that she maintains an ID Bracelet book which stays in her office, and she also confirmed Surveyor Chase's testimony when she noted that facility policy required that the green arm bands be checked for proper placement by her once per week. P. Ex. 27, at ¶¶ 5, 6; *see also* CMS Ex. 3, at 27 (surveyor notes).

Petitioner maintains that the green arm band was one of many interventions the facility was employing to identify residents at risk of elopement. P. Br. at 2. Petitioner argues that there are no federal regulations that require the facility to document the monitoring of resident identification bracelets each shift. P. Reply at 11. Petitioner states that its facility policy requires that the identification bracelets be checked one time per week and that facility staff did monitor and document in accordance with the facility policy. Petitioner presented evidence that on December 22, SSD Maples checked and confirmed that R1 was wearing her green arm band. P. Ex. 27, at ¶ 6; CMS Ex. 8, at 2. Petitioner also presented declarations from several of its staff who stated that on December 24 they noticed that R1 was wearing her green arm band. P. Exs. 32, at ¶ 13; 28, at ¶¶ 4, 5; 24, at ¶ 5; 23, at ¶¶ 7, 8; CMS Ex. 29, at 12.

Facility reliance on the green arm band was critical as a means for staff and visitors to identify all elopement prone residents and to ensure resident safety. Petitioner did not maintain an electronic monitoring system, and there were no audible door alarms to let staff know when someone exited. Petitioner instead relied upon a keycode lock system used for all six of its exit doors. Staff and facility visitors were given the code to the front door so they could leave the facility on their own. Petitioner did not have a staffed reception desk near the facility's front door. If a resident was not wearing a green arm band, then staff could easily assume that the resident was not at risk for elopement.

R1 was identified as at high risk of elopement, she was exhibiting wandering behaviors, she articulated a desire to leave the facility, and her care plan specifically required staff to check that she was wearing her green arm band *at all times.* Even accepting that R1 was wearing her green arm band on December 24, Petitioner did not present any evidence documenting adherence to the staff intervention identified in R1's care plan that specifically required staff to ensure "that R1 is wearing all identification bracelets at all times." CMS Ex. 20, at 7. The monitoring requirement for R1, identified by her interdisciplinary team that included the staff who assessed R1 and who cared for R1, clearly requires more than the once per week documentation and monitoring that Petitioner's facility policy provided.

2. Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h) (F323) (Accidents and Supervision).

The regulation at 42 C.F.R. § 483.25(h) is part of the quality of care regulation at section 483.25 requiring that a facility ensure —

> (1) The resident environment remains as free of accident hazards as is possible; and
>
> (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

While section 483.25(h)(2) does not make a facility strictly liable for accidents that occur, it does require the 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. *Golden Age Skilled Nursing & Rehab. Ctr.*, DAB No. 2026, at 11 (2006), *citing Woodstock Care Ctr. v. Thompson*, 363 F.3d 583, 589-90 (6th Cir. 2003) (sustaining the Departmental Appeals Board (Board) and ALJ's holding that a skilled nursing facility must take "all reasonable precautions against residents' accidents"). A facility is permitted the flexibility to choose the methods of supervision it uses to prevent accidents, but the chosen methods must be adequate under the circumstances, and whether supervision is "adequate" depends on the resident's ability to protect himself or herself from harm under the circumstance. *Golden Living Ctr. – Riverchase*, DAB No. 2314, at 8 (2010).

a. Petitioner did not take all reasonable measures to adequately supervise a resident who was a known elopement risk because she was able to exit the facility unnoticed.

R1's care plan states R1 "will not suffer harm or injury [as a result of her] wandering behaviors." Considering R1 was able to exit the facility unnoticed while exhibiting high risk elopement behaviors for days prior to her elopement demonstrates Petitioner did not provide adequate supervision pursuant to 42 C.F.R. § 483.25(h)(2).

Petitioner maintains that R1's elopement was "not reasonably foreseeable" and that it took all reasonable measures to address any risk. P. Br. at 12. Specifically, Director of Nursing (DON) Angela Hillman, RN, stated that when R1 was admitted to Petitioner's facility, she interviewed R1 and her family to complete the pre-admission screening (PAS). She stated that "[a]t that time, the family told me that R1 had no history of wandering or elopement." P. Ex. 31, at ¶ 7.

Petitioner does not dispute that R1 was cognitively impaired. Nonetheless, Petitioner contends R1 was free from harm because R1 made no prior attempts to elope, she just momentarily exited the building, and within five minutes of her exiting, facility staff returned R1 to the facility. P. Br at 1. Although Petitioner asserts that R1 had no prior history of elopement or exit seeking behavior, the evidence shows that days before the actual elopement, R1 was noted as "confused" and exhibited wandering behaviors within the facility.

For example, there are entries in the Daily Skilled Nurse's Notes on December 14, 15, 16, and 17, 2010 that describe R1 as confused. CMS Ex. 20, at 22, 24, 26. A December 18 nursing note states that R1 walked up and down the hall asking where her husband was and whether he had a car accident. CMS Ex. 20, at 28. A December 19 nursing note states that R1 informed staff she was going home soon. CMS Ex. 20, at 30. A December 20 nursing note describes R1 as confused and requiring redirection. CMS Ex. 20, at 32. A December 21 nursing note describes the resident as "confused" and notes that she was walking around stating she was looking for her purse and that she must find it. CMS Ex. 20, at 34. A December 22 nursing note describes R1 as "confused." CMS Ex. 20, at 36. On December 23, a nursing note describes R1 as being confused and a "high elopement risk given her [degree] of cognition and Alzheimer's." CMS Ex. 20, at 38.

As additional evidence, in the general nurses' notes, there are entries that also show R1 was confused and required frequent re-orientation and monitoring. A December 13 entry recorded at 10:50 a.m. states that R1 is oriented but has confusion and requires redirection with verbal cues. It then notes that R1 is "requiring almost constant redirection." Later that day, an 8:05 p.m. entry states that R1 "has been confused and trying to locate her husband." CMS Ex. 18, at 1, 3. On December 14, an entry at 8:00 p.m. notes that R1 remained confused and required frequent re-orientation to her room number and location. Then on December 16, an entry at 6:30 p.m. states that R1 was seen by the SSD that day ambulating throughout the facility. The note further states that "resident is an elopement risk and is observed/re-oriented as indicated." The note also explains that R1 had been ambulating throughout the facility, was confused, and staff were unable to reorient her to place and time. It further notes that R1 left the dining room several times through the meal stating that she had "a telephone call [at] the concession stand." CMS Ex. 18, at 4. There also is an entry that tells staff to monitor and observe R1 throughout the shift. CMS Ex. 18, at 4-5. An entry on December 17 at 6:50 p.m. states that R1 "has not attempted any elopement this shift but has voiced the need to go home as her husband had an accident which she heard about in [a] phone call in her room." The note says "continuing to monitor." CMS Ex. 18, at 5.

A review of the Social Progress Notes for R1, as reported by SSD Maples, shows that on December 13 and 14, R1 was confused, and a December 15 note says that the resident

was "ambulating throughout the facility" and that she "is an elopement risk and is observed." A December 20 entry states that R1 "has episodes of disorganized thinking" and "documented episodes of delusions" and that she is "noted wandering about facility often." CMS Ex. 22, at 1-3.

The staff entries outlined above, all within days of R1's elopement, establish that Petitioner had prior warning that: (1) R1 continued in a confused state; and (2) R1 was at high risk for elopement. Yet, Petitioner did not institute additional supervisory measures to prevent R1 from eloping from the facility.

b. Petitioner did not take all reasonable measures to secure its exits to prevent residents who were elopement risks from leaving the facility unnoticed.

Petitioner does not dispute that R1 left the building unsupervised on December 24. Petitioner also does not dispute where R1 was found after she left the facility. CMS Ex. 12, at 3, 4. Rather, Petitioner contends that R1's elopement was not reasonably foreseeable and that it took all reasonable measures in order to provide adequate supervision of its elopement risk residents. P. Br. at 12. In her direct testimony, DON Hillman states that the facility implemented several interventions to protect residents at risk of elopement. In addition to the green arm band intervention discussed previously, these interventions included checking and maintaining keycode locks on all doors as well as frequent monitoring of the residents. DON Hillman states that the facility has a protocol of visual checks and increased monitoring, which was implemented for isolated incidents of exit-seeking. The facility has six exit doors and all exit doors are electronically locked with an interior keypad. A five-character keycode must be punched into the keypad in order to open any of these doors. DON Hillman states that every day, on each shift, staff check of all keypads and locks and then log these checks. P. Ex. 31, at ¶¶ 4, 6.

However, as Surveyor Chase explains, Petitioner's six exit doors were not alarmed and Petitioner did not maintain a staffed reception desk. Although there is a keypad on all six exit doors, the key code is freely given to visitors. She states that by pushing a button visitors can enter the front door. The other five doors require a code be entered into a keypad from the outside and inside. CMS Ex. 48, at ¶ 8.

Petitioner's elopement policy and R1's care plan required that all doors be monitored for closure. CMS maintains that Petitioner's use of keycode locks the exit doors as its primary system to protect its residents at risk of elopement was not an adequate intervention because the code to the door was freely given to visitors so they could exit the facility without staff assistance. I agree with CMS that this system was not secure and placed elopement prone residents at risk.

Petitioner maintains that all coded exit doors are checked each shift every day to ensure they are secure and functioning properly. Petitioner maintains that a staff log establishes that staff checked the exit doors to ensure they were functioning properly. Petitioner admits that it gave some of its door codes out to visitors before December 24, 2010, but it stopped this practice following R1's elopement. P. Reply at 9; CMS Ex. 44.

CMS correctly points out, though, that the staff log only started on January 11, 2011, and states, "Check all door alarms every shift, sign off if no problems noted, or notify maintenance if any problem exists." CMS Ex. 44, at 4. Before then the logs were simply titled, "Door Alarm Check" or "Door Alarm Check List" and they did not indicate which doors staff actually monitored. CMS Ex. 44, at 1-3. Even if facility staff were monitoring all doors for closure on every shift, Petitioner's system was insufficient to meet the needs of its elopement prone residents because it was freely sharing its access code with visitors. Petitioner counters that it placed signs on the exit doors advising visitors to not allow residents out of the facility. Nonetheless, some residents can be easily mistaken for a visitor. In fact, R1's physician and a facility staff noted that R1 could easily be mistaken for a visitor instead of a resident. CMS Br. at 7-8; CMS Exs. 3, at 31; 10, at 4. And this is how Petitioner surmises R1 was able to exit the facility on December 24 behind a delivery person who was leaving the facility.

3. Petitioner was not in substantial compliance with 42 C.F.R. § 483.13(c) (F224) because it did not develop and implement policies and procedures to protect residents at risk of eloping.

A facility must develop and implement written policies and procedures prohibiting mistreatment, neglect, and abuse of residents and the misappropriation of residents' property. 42 C.F.R. § 483.13(c). Noncompliance with section 483.13(c) can be based on either failure to develop policies or procedures adequate to prevent neglect, or it can be based on failure to implement such policies. *See, e.g.*, *Mississippi Care Ctr. of Greenville,* DAB No. 2450, at 14-15 (2012) (finding noncompliance with section 483.13(c) where facility that relied on its exit door lock code and security camera systems to prevent elopement failed to develop written policies and procedures, adequate to protect residents at risk of elopement).

Petitioner did not develop and implement written policies and procedures adequate to protect its residents who were identified at risk of elopement. This deficiency is closely related to the previously discussed F514 and F323 deficiencies involving accurate records and adequate supervision.

Petitioner's policy requiring identification bracelets be checked one time per week did not comport with R1's care plan requirement that staff ensure she was wearing the identification bracelet at all times. Also, despite increasing signs that R1 was at risk for

elopement, Petitioner did not implement any policy or procedure to adequately supervise R1 to prevent her from leaving the facility unnoticed.

Further, Petitioner had no written policies or procedures to prevent residents at risk of elopement from obtaining the door lock keypad codes or from following visitors out the doors. Specifically, Petitioner has not provided evidence that at the time of the incident, the facility had effective policies and procedures that addressed: (1) employee access to the codes; (2) employee dissemination of these codes; (3) changing the codes when needed; or (4) warnings to not give away the codes or let residents out. The lack of written policies and procedures addressing the door keypad lock codes meant that the keypad lock codes did not function as intended to deter residents from exiting the facility without supervision. This was demonstrated when R1 was able to follow a visitor out the front door of the facility without anyone noticing.

4. CMS's determination that Petitioner's deficiencies posed immediate jeopardy was not clearly erroneous.

Immediate jeopardy exists when a facility's noncompliance "has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination that a deficiency constitutes immediate jeopardy must be upheld unless the facility is able to prove that the determination is clearly erroneous. 42 C.F.R. § 498.60(c)(2); *see also Beverly Health Care Lumberton*, DAB No. 2156, at 4 (2008), *citing Woodstock Care Ctr.*, DAB No. 1726, at 39 (2000), *aff'd, Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 (6th Cir. 2003). The "clearly erroneous" standard means that CMS's immediate jeopardy determination is presumed to be correct, and the burden of proving the determination clearly erroneous is a heavy one. *See, e.g., Owensboro Place & Rehab. Ctr.*, DAB No. 2397, at 9 (2001), *citing Azalea Court*, DAB No. 2352, at 16-17 (2010), *aff'd, Azalea Court v. HHS*, 2012 WL 2913808 (11th Cir. July 18, 2012).

Here, CMS alleges that Petitioner's actions in regards to F323 and F224 amounted to a scope and severity level of "J," constituting immediate jeopardy to resident health and safety. Petitioner did not carry its burden to show that CMS's immediate jeopardy determination was clearly erroneous. Immediate jeopardy does not require actual harm but, as the regulatory definition indicates, only a likelihood of serious harm. *See, e.g., Kenton Healthcare, LLC*, DAB No. 2186, at 23-24 (2008) (upholding an immediate jeopardy determination, in part, because there was a likelihood of serious harm to impaired residents who briefly eloped and were found unharmed in facility's parking lot). Although there is no evidence that R1 was harmed during her elopement on December 24, the likelihood of harm was manifest. The danger of R1's elopement was obvious and was known by Petitioner prior to and at the time of R1's elopement. R1's risk for elopement, wandering, and confusion were well documented in her clinical record. I agree with Surveyor Chase's opinion that R1's health and safety were seriously

threatened because she was "confused, at risk for falls, [at risk for] wandering away from the facility and into the street." *See* CMS Ex. 48, at ¶13;

Petitioner maintains that immediate jeopardy can only be cited in a "crisis situation." Petitioner contends that the conditions at its facility did not pose any danger to its residents' health and safety. Request for Hearing at 5, *citing* State Operations Manual (SOM) § 3010 and Appendix Q, Section 1; P. Br. at 16. I reject this argument here, as the Board has rejected similar arguments in other cases, because while ALJs and the Board may find the SOM instructive, they are bound by the regulatory definition in 42 C.F.R. § 488.301, not by the SOM. In *Foxwood Springs Living Ctr.*, DAB No. 2294, at 9 (2009), the Board explained that "[w]hile the SOM may reflect CMS's interpretations of the applicable statutes and regulations, the SOM provisions are not substantive rules themselves." In *Agape Rehab. of Rock Hill*, DAB No. 2411, at 19 (2011), the Board noted that section 488.301 does not define immediate jeopardy as a "crisis situation," and it does not require an ALJ to find a "crisis situation" in order to uphold a CMS determination that a petitioner's noncompliance was "likely to cause, serious injury, harm, impairment, or death to a resident."

Even if the regulations did define immediate jeopardy as a "crisis situation," I would have no trouble finding a crisis situation here in light of the facts surrounding R1's elopement and Petitioner's inadequate elopement prevention interventions, policies and procedures, which affected all its residents assessed as elopement risks. Petitioner does not explain why R1's being outside the facility without supervision did not present a crisis situation. Petitioner attempts to minimize the situation by explaining it had a system in place to prevent elopement and that R1's elopement was a "one-time, isolated incident." Request for Hearing at 5.

Under the circumstances outlined above, and given R1's cognitive and physical impairments, including her lack of safety awareness, there was a clear likelihood of serious harm to R1 while she was outside the facility. Once she eloped from the facility, she was at risk for wandering beyond the perimeter of the building into the parking lot, or even beyond the parking lot onto the street adjacent to Petitioner's property, and thus was at risk of being struck by a motor vehicle. A facility map shows the facility's location to the adjacent area and public road, and it also shows the door R1 was believed to have exited the building and its proximity to Petitioner's parking lot. CMS Ex. 5. Moreover, CMS showed there were chilly temperatures in the area around the time of R1's elopement ranging from 51 to 61 degrees Fahrenheit. CMS Ex. 41, at 2, 3, 5.

Regardless of whether staff happened to find R1 within a few minutes, R1 was still exposed to dangers that presented a likelihood of serious harm or death. R1's clinical record shows that she was not capable of judging what was safe and unsafe without supervision outside the facility, and had staff not happened to spot her while on break,

she likely would have been seriously harmed from the threats of vehicle traffic, falls, weather and untreated medical conditions.

5. CMS's determination of the duration of Petitioner's noncompliance is not clearly erroneous.

The Board has made it clear that the facility bears the burden of showing that it returned to substantial compliance on a date earlier than that determined by CMS and has rejected the idea that CMS must establish a lack of substantial compliance during each day in which a remedy remains in effect. *Kenton Healthcare, LLC,* DAB No. 2186, at 24-25; *Lake Mary HealthCare*, DAB No. 2081, at 30 (2007). Similarly, the facility's burden of demonstrating clear error in CMS's immediate jeopardy determination "extends to overcoming CMS's determination as to how long the noncompliance remained at the immediate jeopardy level." *Azalea Court,* DAB No. 2352, at 17, *citing Brian Ctr. Health & Rehab./Goldsboro,* DAB No. 2336, at 7 (2010). As the Board held in *Brian Center*, "[a] determination by CMS that a [facility's] ongoing [noncompliance] remains at the level of immediate jeopardy during a given period constitutes a determination about the 'level of noncompliance,' and therefore, is subject to the clearly erroneous standard of review under section 498.60(c)(2)." *Brian Ctr.*, DAB No. 2336, at 7-8.

The Board has also held that "[t]he burden is on the facility to show that it timely completed the implementation of [its] plan [of correction] and in fact abated the jeopardy (to reduce the applicable CMP range) or achieved substantial compliance (to end the application of remedies)." *Lake Mary,* DAB No. 2081, at 29, *citing*, *e.g.*, *Spring Meadows Health Care Ctr.*, DAB No. 1966 (2005). Here, CMS found Petitioner was not in substantial compliance, at an immediate jeopardy level, from December 24, 2010 to January 27, 2011 and did not return to substantial compliance until February 18, 2011. Thus, it is not incumbent on CMS to justify these dates but rather on Petitioner to show an earlier date of abatement and return to substantial compliance.

I do not find CMS's determination that Petitioner did not abate immediate jeopardy until January 28, 2011 to be clearly erroneous. Petitioner's plan of correction, signed March 11, 2011, states "[t]he administrator and/or designee will change *all* door codes at least once a month and more frequently if needed." CMS Ex. 1, at 6 (emphasis added). Petitioner acknowledges that on December 24, 2010, the date of the incident, staff only changed the keycode lock on the front door, thus failing to address any changes to the five other exit doors. This failure resulted in the extension of the immediate jeopardy time period. P. Br. at 14-15; *see also* CMS Ex. 3, at 55; P. Ex. 32, at 7.

Immediately after R1's elopement, the facility administrator informed staff that the facility would no longer be providing codes to visitors or family and that a staff member must let out all visitors. P. Ex. 32, at 7. Nonetheless, on January 28, 2011, during a revisit survey, Surveyor Chase observed a visitor telling Petitioner's maintenance

supervisor that she knew the current code to open and enter through one of the facility doors. Both Surveyor Chase and the maintenance supervisor tested the code the visitor gave them and were able to confirm that the code opened the door. CMS Ex. 3, at 74. As a consequence of Petitioner either not changing all door codes or continuing to share the door codes with visitors, it clearly did not secure its facility nor did it implement the corrective actions in order to abate the immediate jeopardy before January 27.

As for Petitioner's continued noncompliance at a non-immediate jeopardy level, Petitioner argues that it came into compliance once it completed in-service training to staff on the policy changes and additional measures that it implemented starting December 24, 2010. Petitioner says it completed this training on December 28, 2010. Petitioner also maintains that its Quality Improvement Committee met on December 28, 2010, to discuss the elopement incident and all related issues. P. Br. at 21.

As evidence to support its assertion that it completed its staff training by December 28, 2011, Petitioner presents three in-service training signature sheets. P. Ex. 5. However review of these documents show that two of these trainings were conducted prior to the December 24, 2010 elopement (December 1 and 13, 2010). Therefore, these documents do not support Petitioner's assertion that it completed training to staff by December 28 in response to R1's elopement. CMS Ex. 5, 1-4. The December 27, 2010 training sign-in sheet shows that just nine staff attended the training, much less than the number of staff Petitioner employed. CMS Ex. 5, at 5.

Before CMS considered Petitioner back in substantial compliance, it considered the more comprehensive in-service training Petitioner provided to staff on February 7, 2011. In this training, Petitioner instructed all staff that only staff would know the exit codes and there was an immediate reporting requirement when non-staff were observed using one to exit the facility. CMS Ex. 1, at 13. Further, CMS considered that Petitioner's Quality Assurance Committee met on February 16, 2011 to discuss specific survey issues and implementation of the new policies. CMS Ex. 1, at 14. Therefore, I find CMS's determination was not clearly erroneous.

6. CMS's determination of the amount of CMP is reasonable.

In determining whether the CMP imposed here is reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f), which include: (1) the facility's history of compliance; (2) the facility's financial condition; (3) the factors specified at 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 at 42 C.F.R. § 499.404 include: (1) the scope and severity of the deficiency; (2) the relationship of the 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.

Here, Petitioner has a history of noncompliance with 42 C.F.R. § 483.25 (F323). Petitioner had a quality of care deficiency under this requirement during a survey conducted in February 2009 when it was cited for that deficiency at a scope and severity level of "D" and also a prior violation of 483.75(*l*)(1) (F514) found during a March 2008 survey, which was cited at a scope and severity level of "D." CMS Ex. 47, at 1. Petitioner has not argued its inability to pay the CMP, and, unless a facility contends that a particular regulatory factor does not support the CMP amount, the ALJ must sustain it. *Coquina Ctr.*, DAB No. 1860 (2002). The deficiencies cited here are serious, constituting immediate jeopardy for F224 and F323, and the potential for more than minimum harm for F514.

I find that the $3,550 per day CMP from December 24, 2010 through January 27, 2011, is much less than the maximum that CMS could have imposed upon Petitioner for immediate jeopardy-level deficiencies. In fact, it is in the very low end of the CMP range for immediate jeopardy level deficiencies ($3,050 per day to $10,000 per day). 42 C.F.R. §§ 488.438(a)(1)(i), (d)(2). I find further that the $150 per day CMP from January 28, to February 18, 2011, is also at the very low end of the CMP range for non-immediate jeopardy level deficiencies ($50 per day to $3,000 per day). 42 C.F.R. § 488.438(a)(1)(ii).

Accordingly, I find the CMPs that CMS imposed are reasonable. Further, the state is required by law to withdraw any approval given, or to deny any approval sought, by Petitioner to conduct a NATCEP for a period of two years because the CMP imposed here was in excess of the $5,000. *See* 42 C.F.R. §§ 483.151(b)(2) and (e)(1).

IV. Conclusion

I conclude that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h) (F323) pertaining to Accidents and Supervision, 42 C.F.R. § 483.13(c) (F224) pertaining to Staff Treatment of Residents, and 42 C.F.R. § 483.75(*l*)(1) (F514) pertaining to Clinical Records. Further, Petitioner has not shown that CMS's determination that the violations posing immediate jeopardy to the health and safety of facility residents was clearly erroneous, and I conclude the CMP that CMS imposed was reasonable.

/s/
Joseph Grow
Administrative Law Judge