Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Glenoaks Nursing Center
Docket No. A-13-32
Decision No. 2522
June 28, 2013

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Glenoaks Nursing Center (Glenoaks or Petitioner) challenges the November 19, 2012 decision of an Administrative Law Judge (ALJ) upholding the determination of the Centers for Medicare & Medicaid Services (CMS) to impose remedies for Petitioner's noncompliance with requirements for long-term care facilities participating in the Medicare program. *Glenoaks Nursing Ctr.*, DAB CR2660 (2012). CMS made its determination based on the results of a January 2011 complaint survey of Glenoaks conducted by the Mississippi State Department of Health (state survey agency). Following an in-person hearing, the ALJ concluded that Glenoaks was not in substantial compliance with Medicare participation requirements at 42 C.F.R. §§ 483.25(h), 483.13(c) and 483.75(l)(1) from December 24, 2010 through February 17, 2011; that CMS's determination that the facility's noncompliance posed immediate jeopardy to resident health and safety from December 24, 2010 through January 27, 2011 was not clearly erroneous; and that the civil money penalties (CMPs) that CMS imposed on Glenoaks – $3,550 per day for the period of immediate jeopardy and $150 per day for the noncompliance following abatement of the immediate jeopardy (January 28 through February 17, 2011) – were reasonable.

After carefully and thoroughly considering all of Petitioner's arguments on appeal, we affirm the ALJ Decision for the reasons set forth below.

Legal Background

The Social Security Act (Act)[1] sets forth requirements for nursing facility participation in the Medicare or Medicare programs and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act § 1819.

[1] The current version of the Act can be found at http://www.ssa.gov/OP_Home/ssact/ssact-toc.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross-reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table.

The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements set out in the Part 483 regulations.

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities (SNF) are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. The regulations require that each facility be surveyed once every twelve months, and more often if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a), 488.308. Survey findings are reported in a Statement of Deficiencies (SOD). A "deficiency" is a defined as a "failure to meet a participation requirement specified in the Act or [42 C.F.R. Part 483]." 42 C.F.R. § 488.301. Section 488.301 defines "substantial compliance" as "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.* Any "deficiency that causes a facility to not be in substantial compliance" constitutes "noncompliance." *Id.*

CMS may impose various remedies on a facility that is found not to comply substantially with the participation requirements, including per-day CMPs for the number of days that the facility is not in substantial compliance, and a denial of payment for new Medicare admissions (DPNA) during the period of noncompliance. 42 C.F.R. §§ 488.406, 488.417, 488.430(a). A per-day CMP may accrue from the date the facility was first out of substantial compliance until the date it is determined to have achieved substantial compliance. *Id.* § 488.440(a)(1), (b). For noncompliance determined to pose immediate jeopardy, CMS may impose per-day CMPs in amounts ranging from $3,050-$10,000 per day. *Id.* § 488.408(e)(2)(i), (ii). For noncompliance at less than the immediate jeopardy level, CMS may impose per-day CMPs in amounts ranging from $50-3,000 per day. *Id.* § 488.408(d)(1)(iii).

In general, when a facility has been found not to be in substantial compliance with the participation requirements, the facility must submit a plan of correction (PoC) that is acceptable to CMS or the state survey agency. 42 C.F.R. §§ 488.402(d), 488.408(f). If CMS accepts a noncompliant SNF's PoC, the facility must then timely implement all of the steps that it identified in the PoC as necessary to correct the cited problems. *Cal Turner Extended Care Pavilion*, DAB No. 2030, at 18-19 (2006); *see also Meridian Nursing Ctr.*, DAB No. 2265, at 21 (2009), *aff'd*, *Fal-Meridian, Inc. v. U.S. Dep't of Health & Human Servs.*, 604 F.3d 445 (7th Cir. 2010) (2009); *Lake Mary Health Care*, DAB No. 2081, at 29 (2007). A noncompliant facility "is not considered to be [back] in substantial compliance until a determination has been made, through a revisit survey or based on 'credible written evidence' that 'CMS or the State can verify without an on-site

visit,' that the facility returned to substantial compliance." *Omni Manor Nursing Home*, DAB No. 2431, at 6 (2011) (*citing or quoting* 42 C.F.R. § 488.454(a)(1)), *aff'd, Omni Manor Nursing Home v. U.S. Dept. of Health & Human Servs.*, No. 12-3223, 2013 WL 323001 (6th Cir. Jan. 28, 2013); *see also Oceanside Nursing & Rehab. Ctr.*, DAB No. 2382, at 20 (2011)).

The Board has previously held that the noncompliance found during a survey is "presumed to continue until the facility demonstrates that it has achieved substantial compliance." *Taos Living Ctr.*, DAB No. 2293, at 20 (2009). The regulations and prior Board decisions also make clear that a facility's "noncompliance is deemed to be corrected or removed only when the incidents of noncompliance have ceased and the facility has implemented appropriate measures to ensure that similar incidents will not recur." *Florence Park Care Ctr.*, DAB No. 1931, at 30 (2004); *see also Oceanside* at 20. Moreover, the facility "bears the burden of showing that it returned to substantial compliance on a date earlier than that determined by CMS," and the Board "has rejected the idea that CMS must establish a lack of substantial compliance during each day in which a remedy remains in effect." *Owensboro Place & Rehab. Ctr.*, DAB No. 2397, at 12 (2011). In *Brian Ctr. Health & Rehab./Goldsboro*, DAB No. 2336 (2010), the Board explained that the facility's burden in demonstrating when the immediate jeopardy was abated "is, in essence, a determination that the level of noncompliance continued to present immediate jeopardy" to residents. DAB No. 2336, at 7. Thus, a "determination by CMS that a SNF's ongoing compliance 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 . . . ." *Id.* at 7-8.

Factual Background[2]

Glenoaks is a Mississippi SNF that participates in the Medicare and Medicaid programs. ALJ Decision at 1. On January 28, 2011, the state agency completed a complaint survey of Glenoaks (January survey). The incident that led to the January survey was the elopement of a 73 year-old female resident who, for privacy reasons, is identified as Resident 1 (R1).

R1 was admitted to the facility on December 13, 2010 with multiple diagnoses, including Alzheimer's dementia with behavioral disturbance, delusions, anxiety, altered mental status, hearing loss, and diabetes mellitus. CMS Ex. 11, at 1, 3. She was ambulatory and alert but had impaired decision-making skills. *Id*. at 3; CMS Exs. 17, at 1; 19, at 3-4. A

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

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.

R1's plan of care and other facility records indicate that that on December 17, 2010, R1 was assessed as a risk for elopement due to wandering behavior and confusion. CMS Exs. 16; 20, at 6. Her plan of care was updated to include the following staff interventions: monitoring doors for complete closure; frequently checking door alarms for proper working order; indicating to staff that R1 was at risk for elopement by putting a green identification bracelet on her; ensuring that R1 wore the green identification bracelet *at all times*; placing green stickers on the spine of R1's chart and Activities of Daily Living (ADL) record to identify her as an elopement risk; and including R1's name and photograph in the facility's elopement book, which was kept at the nurses' station. CMS Ex. 20, at 6-7.

Sometime during the morning of December 24, 2010, R1 exited the facility unsupervised and without staff knowledge. While taking a work break in the "day room," some of the facility's staff happened to observe R1 walking around outside of the facility. The staff immediately notified two Licensed Practical Nurses who 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 one-to-one supervision with 15-minute visual checks. CMS Ex. 12; P. Exs. 22, at 2-3; 24, at 2; 28, at 2; 29, at 2; 32, at 6-7.

On December 27, 2010, Glenoaks discharged R1 to the Senior Care Unit at George Regional Hospital. Glenoaks indicated that it took this action because it was not a "lock-down alzheimer's unit" and had "limited options in dealing with R1's behavior." CMS Ex. 12, at 1, 13-14; 23, at 10. Glenoaks self-reported the December 24 elopement to the state survey agency, which then conducted the January survey to investigate that incident. CMS Ex. 12, at 1, 4; P. Ex. 1, at 5.

Based on the January survey findings, CMS determined that Petitioner failed to: 1) maintain clinical records that are complete and accurate in violation of 42 C.F.R. § 483.75(l)(1); 2) 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); and 3) implement written policies and procedures to prevent neglect of its residents in violation of 42 C.F.R. § 483.13(c). CMS cited the clinical records deficiency at scope-

and-severity level "E" (a pattern of no actual harm with the potential for more than minimal harm). CMS cited the second two deficiencies at scope-and-severity level "J" as constituting immediate jeopardy to resident health and safety. CMS further determined that the noncompliance with sections 483.25(h) and 483.13(c) was at the immediate jeopardy level beginning on December 24, 2010, that Glenoaks did not abate the immediate jeopardy until January 28, 2011, and that the facility's noncompliance continued at a lower level of scope-and-severity after January 28, 2011. CMS Ex. 1, at 12. As a result of a revisit survey conducted on March 30, 2011, CMS found that Petitioner returned to substantial compliance on February 18, 2011.

In letters dated March 11, 2011 and April 5, 2011, CMS imposed a CMP of $3,550 per day for the period of noncompliance at the immediate jeopardy level (December 24, 2010 through January 27, 2011) and $150 per day for the period of noncompliance that was not at the immediate jeopardy level (January 28, 2011 through February 17, 2011). In addition, CMS withdrew approval of Petitioner's nurse aid training and competency evaluation program (NATCEP) for a period of two years.

Petitioner then requested a hearing before an ALJ to challenge CMS's determination that it was not in substantial compliance with Medicare participation requirements and imposition of the proposed remedies. CMS submitted the written direct testimony of one witness, a registered nurse identified by the initials LC, who had conducted the January survey. CMS Ex. 48. Petitioner submitted written direct testimony for eleven witnesses. P. Exs. 22-32. CMS elected not to cross-examine any of the facility's witnesses. Glenoaks cross-examined CMS's sole witness during a video hearing on November 29, 2011.

The ALJ Decision

The ALJ sustained all of CMS's determinations of noncompliance. First, he concluded that Petitioner was not in substantial compliance with 42 C.F.R. § 483.75(l)(1) because the facility did not have any documentation in R1's medical records that it had monitored R1's green identification bracelet that helped identify her as an elopement risk. The ALJ next concluded that the facility was not in substantial compliance with 42 C.F.R. § 483.25(h) because the facility did not take all reasonable measures to secure all of its exits to prevent residents who were elopement risks from leaving the facility unnoticed. The ALJ also concluded that the facility was not in substantial compliance with 42 C.F.R.§ 483.13(c) because it did not develop and implement written policies and procedures addressing its door keypad lock codes to protect residents at risk of eloping.

In addition, the ALJ concluded that CMS's determination that the facility's noncompliance with sections 483.25(h) and 483.13(c) posed immediate jeopardy to resident health and safety was not clearly erroneous. The ALJ further concluded that CMS's determination concerning the duration of the immediate jeopardy period and of the overall period of noncompliance was not clearly erroneous. Finally, the ALJ concluded that the amount of the per-day CMPs imposed – $3,550 per day for the period of immediate jeopardy (December 24, 2010 through January 27, 2011) and $150 per day for the period of noncompliance following abatement of the immediate jeopardy (January 28, 2011 through February 17, 2011) – were reasonable.

Standard of Review

The Board's standard of review on a disputed finding of fact is whether the decision is supported by substantial evidence on the record as a whole. *Guidelines for Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs* (Board Guidelines), available at http://www.hhs.gov/dab/divisions/appellate/guidelines/prov.html. The "substantial evidence" standard is deferential. Substantial evidence "does not mean a large or considerable amount of evidence, but 'rather such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.'" *Pierce v. Underwood*, 487 U.S. 552, 565 (1988), *quoting Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938); *Johnson v. Comm'r of Soc. Sec.*, 529 F.3d 198, 200 (3d Cir. 2008); *Hartranft v. Apfel*, 181 F.3d 358, 360 (3d Cir. 1999). "Substantial evidence" is "more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971), *quoting Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938). In an adequately developed factual record, substantial evidence may be "something less than the weight of the evidence, and the possibility of drawing two inconsistent conclusions from the evidence does not prevent an administrative agency's finding from being supported by substantial evidence." *Consolo v. Fed. Maritime Comm'n*, 383 U.S. 607, 620 (1966). Under the substantial evidence standard, the reviewer must examine the record as a whole and take into account whatever in the record fairly detracts from the weight of the evidence relied on in the decision below. *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 488 (1951).

The Board's standard of review on a disputed conclusion of law is whether the ALJ's decision is erroneous. Board Guidelines.

Analysis

Glenoaks argues that the facility was in substantial compliance with participation requirements at all times. Alternatively, Glenoaks contends that if it was noncompliant with those requirements, any period of immediate jeopardy ended on December 24, 2010

when it changed the keycode to the front door entrance, instructed staff not to disclose the new code to visitors, began to escort visitors from the facility, and began one-to-one supervision of Resident 1. P. Ex. 1, at 6.

As discussed below, we reject the Glenoaks's contention that it was in substantial compliance at all times; the ALJ's conclusion that Glenoaks was not in substantial compliance with sections 483.25(h) and 483.13(c) is supported by substantial evidence in the record and free from legal error.[3] We also affirm the ALJ's conclusion regarding the duration of the immediate jeopardy period and conclude that Glenoaks did not meet its burden of demonstrating by a preponderance of the evidence that it was back in substantial compliance earlier than February 18, 2011. Finally, we affirm the ALJ's conclusion that the CMP amounts imposed were reasonable.

A. The ALJ's conclusion that Glenoaks was not in substantial compliance with 42 C.F.R. § 483.25(h) is supported by substantial evidence in the record and is free from legal error.

Section 483.25(h) is a subpart of the quality of care regulation at section 483.25, which states that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." Section 483.25(h) imposes specific obligations upon a facility related to accident hazards and accidents, as follows:

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

Numerous Board decisions have explained the requirements under section 483.25(h)(2). For example, the Board has held that section 483.25(h)(1) requires that a facility address foreseeable risks of harm from accidents "by identifying and removing hazards, where possible, or, where the hazard is unavoidable because of other resident needs, managing the hazard by reducing the risk of accident to the extent possible." *Maine Veterans' Home – Scarborough*, DAB No. 1975, at 10 (2005). In addition, the Board has held that section 483.25(h)(2) requires that a facility take "all reasonable steps to ensure that a

[3] Accordingly, we need not address the ALJ's conclusion that the facility was not in substantial compliance with section 483.75(l)(1) at the non-immediate jeopardy level. Even if we were to reverse that conclusion about this deficiency, the amount of the per-day CMP imposed would not be affected.

resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents." *Briarwood Nursing Ctr.*, DAB No. 2115, at 5 (2007), *citing Woodstock Care Ctr. v. Thompson*, 363 F.3d 583, at 589 (6th Cir. 2003) (facility must take "all reasonable precautions against residents' accidents"), *affirming Woodstock Care Ctr.*, DAB No. 1726 (2000) . A facility must also "provide supervision and assistance devices that reduce known or foreseeable accident risks to the highest practicable degree, consistent with accepted standards of nursing practice." *Century Care of Crystal Coast*, DAB No. 2076, at 6-7 (2007), *aff'd, Century Care of Crystal Coast v. Leavitt*, 281 F. App'x 180 (4th Cir. 2008).

The regulations permit facilities some flexibility in choosing the methods they use to provide supervision or assistive devices to prevent accidents, so long as the chosen methods constitute an adequate level of supervision for a particular resident's needs. *Windsor Health Care Ctr.*, DAB No. 1902, at 5 (2003), *aff'd, Windsor Health Care Ctr. v. Leavitt*, 127 F. App'x 843 (6th Cir. 2005). In choosing its methods, a facility is obligated to anticipate reasonably foreseeable accidents that might befall a resident and take steps – such as increased supervision or the use of assistance devices, for example – calculated to prevent them. *Aase Haugen Homes, Inc.*, DAB No. 2013 (2006).

Section 483.25(h) does not make a facility strictly liable for accidents that occur, but does place an "affirmative duty [on facility staff] to intervene and supervise . . . behaviorally impaired residents in a manner calculated to prevent them from causing harm to themselves and each other." *Vandalia Park*, DAB No. 1940, at 18 (2004), *aff'd, Vandalia Park v. Leavitt*, 157 F. App'x 858 (6th Cir. 2005). As the Board stated in *Josephine Sunset Home*, DAB No. 1908, at 13 (2004), the "mere fact that an accident occurred does not, in itself, prove that the supervision or devices provided must have been inadequate to prevent it." On the other hand, it is not a prerequisite to finding noncompliance under section 483.25(h)(2) that any actual accident have occurred or be caused by the inadequate supervision. *Woodstock Care Ctr.* at 17. The occurrence of an accident is relevant to the extent the surrounding circumstances shed light on the nature of the supervision being provided and its adequacy for the resident's condition. *St. Catherine's Care Ctr. of Findlay, Inc.*, DAB No. 1964, at 12-14 (2005) (accident circumstances may support an inference that the facility's supervision of a resident was inadequate).

The regulation speaks in terms of ensuring that what is "practicable" and "possible" to do is done. What is thus required of facilities is not prescience but reason and professional judgment in assessing what can be done to make residents (given their special needs) safe, through removing accident hazards, providing appropriate devices, and ensuring adequate supervision. *Josephine Sunset Home* at 14-15; *Briarwood Nursing Ctr.* at 11-12.

1. R1's elopement was a reasonably foreseeable risk.

The ALJ found that it was reasonably foreseeable that R1 would elope because Petitioner had prior warning that: 1) R1 was acting in a confused state; and 2) R1 was exhibiting increasing signs of elopement behavior (i.e., wandering) for days prior to her elopement. ALJ Decision at 7-9. Petitioner contends that R1's wandering behavior does not automatically mean that R1 would progress to elopement attempts because R1 had no prior history of elopement or exit seeking behavior. Reply (R.) Br. at 3-4, 6. This argument is without merit.

Entries in the facility's Daily Skilled Nurse's Notes, general nursing notes, Social Progress Notes, and R1's care plan demonstrate that the facility knew or should have known that R1 was a foreseeable elopement risk. Entries in the Daily Skilled Nurse's Notes from December 14 through December 23, 2010 consistently describe R1 as confused, ambulating throughout the facility, and requiring reorientation and redirection. CMS Ex. 20, at 19-38. Prior to her elopement, these notes contain an entry record at 9:30 a.m. on December 24 indicating that R1's wandering behavior was worsening as she was found "ambulating in hall"; "has confusion and requires redirection, which can be difficult at times." *Id*. at 40.

In addition to R1's state of confusion and wandering behavior, R1 had expressed a desire or reason to leave the facility. For example, an entry dated December 17 at 6:50 p.m. states that R1 "has not attempted any elopement this shift but has voiced the need to get home because [her] husband had an accident which she heard about in [a] phone call in her room." CMS Ex. 18, at 5. A December 18 nursing note states that R1 "has been walking up and down the hall, asking 'How is my husband? Did he have a wreck in my car?'" CMS Ex. 20, at 28. A December 19 nursing note states that R1 informed staff she was "going home soon." *Id*. at 30. A December 21 nursing note describes R1 as "ambulating in [the] hall confused," and telling staff that "she is looking for her purse and must find it." *Id*. at 34.

Similarly, the social services staff documented awareness of R1's elopement risks. Social Progress Notes on December 13 - 15 show that R1 was confused, required redirection and verbal cues, was "ambulating throughout the facility," and was "an elopement risk" who needed to be "observed/redirected as indicated." CMS Ex. 22, at 1. On December 20, R1 was noted to have "episodes of disorganized thinking" and "documented episodes of delusions" *Id*. at 2-3. Specifically, the social services staff noted the incidents on December 16, when she thought that she had received a telephone call in the concession stand, and on December 17, when R1 heard "voices [that] she needs to get home because her husband had an accident which she heard about in a phone call in her room." *Id*. at 3. The notes again recorded that R1 is "noted wandering about facility often. She is an elopement risk." *Id*.

The facility's own records thus show that within the 10 days before R1 eloped from the facility, she was confused, exhibited wandering behaviors within the facility, suffered delusional episodes, frequently required reorientation as to time and location and with increasing difficulty, and was known to be a high risk for elopement. Furthermore, these records show that on several occasions, R1 had expressed a desire to leave the facility and go home. Petitioner's own records amply support the ALJ's finding that R1 was displaying "increasing signs" of elopement prior to December 24. ALJ Decision at 10. Although R1's wandering behavior and medical condition do not "automatically" mean that she would attempt to elope from the facility, the ALJ could reasonably conclude that facility knew or should have known that it was reasonably foreseeable R1 could attempt to elope or was a high risk to do so. The facility has not pointed to any evidence in the record that either compels a different conclusion or that the ALJ failed to address in reaching that conclusion.

2. The facility failed to take all reasonable measures to mitigate the reasonably foreseeable risk to residents identified as a risk for elopement.

Having determined it was reasonably foreseeable that R1 was at risk for elopement, the question becomes did the facility take all reasonable measures to mitigate that risk.

The ALJ found that Petitioner primarily relied upon a keycode lock system for all six of its exit doors to prevent residents at risk for elopement from leaving the facility unnoticed, yet freely gave the keycodes to visitors. ALJ Decision at 6, 9. The ALJ concluded that by disseminating the door codes to visitors, Petitioner failed to take all reasonable measures to keep residents at risk for elopement secure. *Id*. at 9.

The facility contends that even if R1's elopement was foreseeable, it took reasonable measures in order to provide adequate supervision of its residents. The facility maintains that after R1 was assessed as an elopement risk on December 17, its interventions were reasonable and appropriate given what was foreseeable at the time. Request for Review (RR) at 2, 14-15, 24; R. Br. at 6. For example, the facility placed R1's name and photograph in an elopement book that was kept at the nurse's station. CMS Ex. 6, at 2; CMS Ex. 20, at 6-7. The facility also put green stickers on the outside of R1's chart, placed a green identification bracelet on her wrist and updated her care plan to include redirection and monitoring. CMS Ex. 20, at 6-7, 12.

The facility has six exit doors and all exit doors are electronically locked with a keypad that required a five-character keycode to open them. CMS Ex. 48, at 2; P. Exs. 8, at 7; 31, at 2; RR at 23. The facility's "Wandering/Elopement/Resident's at Risk" policy also requires staff to check all keypads and doors every shift "to ascertain that they are in

proper working order and doors are securely latched" and to log these checks. CMS Ex. 6, at 3, 4; P. Ex. 31, at 2, 3; CMS Ex. 44. Thus, Petitioner argues that "[t]he system in place between the door locks and the monitoring [of R1] was sufficient to the Facility and its residents' individual circumstances and needs, including R1." RR at 24.

Petitioner raised these same arguments before the ALJ, and we agree with the ALJ's conclusion that the facility did not take all reasonable measures to secure its exits to mitigate the foreseeable risk of elopement by its residents. The facility had the discretion to select means of protecting its high-risk residents from elopement, but it was obligated to ensure that its choices were implemented in a manner that adequately protected them. In this case, Glenoaks chose to rely on its keycode locks and green bracelets to visually identify high-risk residents. ALJ Decision at 6, 9; CMS Ex. 48, at 2-3. The facility did not adopt such alternatives as an electronic monitoring or Wanderguard system. P. Ex. 31, at 1-2. The facility design did not include a nurse's station or staffed reception desk near the primary exit door. There is no evidence in the record indicating that the facility has any video camera system, and there were no audible door alarms in use to alert staff when someone had exited the building. CMS Ex. 48, at 2. Having elected to rely on its chosen methods as the sole means of preventing or detecting elopements, Glenoaks needed to effectively and consistently utilize those measures. Substantial evidence in the record supports the ALJ's conclusion that the facility failed to do so.

Petitioner acknowledges that prior to R1's elopement, staff and facility visitors were freely given the code to the front door so they could leave the facility on their own. ALJ Decision at 6, 9. Based on this fact, the ALJ concluded that the facility's reliance on the keycode locks on the exit doors as its primary system to protect its residents at risk for elopement was not an adequate intervention and that this system was not secure and placed elopement prone residents at risk. *Id*. at 9. The facility did recognize the importance of keeping the keycodes confidential after R1's elopement by requiring staff not to share the codes in the future. Indeed, the facility's Quality Improvement (QI) Committee met on December 28 and decided that the keycodes to *all* of the facility's exits should be changed. P. Ex. 1, at 5. The facility acknowledges that, in fact, it did not change the keycodes to the other exits until the survey on January 28, and that it still provided the keycode to at least the rear door until that date. R. Br. at 9; CMS Ex. 3, at 55, 74. Thus, we conclude that the facility's mishandling of the keycodes alone is sufficient to uphold the ALJ's conclusion that the facility was not in substantial compliance with section 483.25(h). *See Kenton Healthcare LLC*, DAB No. 2186, at 26 (2008) (Board found that the effectiveness of door locks is "at best questionable" where codes are freely disseminated).

The ALJ could reasonably conclude that the facility's other measures were not adequate to protect its residents at risk for elopement from leaving the facility unnoticed. ALJ Decision at 10. The use of an identification bracelet on R1 and a green sticker on the binder of her chart, even with the placement of her name on an elopement list, and her photograph in a notebook (P. Ex. 36) at the nurses' station, were not adequate to protect R1 from elopement given that the front door was not monitored by either a staffed station or electronic or video means. Despite increasing signs that R1 was an elopement risk, there is also no evidence that the facility actively monitored R1's movements, or otherwise took any steps to limit R1's access to the front door or the other exit doors.[4]

R1's care plan to address her risk for elopement required facility staff to "monitor [the exit] doors for complete closure" and "to insure that resident is wearing all identification bracelets [at] all times." CMS 20, at 6, 7. The facility's policy was for the Social Services Director (SSD) to check residents at risk for elopement once a week to see if they are wearing the bracelet and record her observations in a booklet in her office. P. Ex. 27, at 2; CMS Ex. 8. The ALJ found that Petitioner's policy requiring that 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*.[5] ALJ Decision at 10. Despite Glenoaks's assertions, the evidence is equivocal whether R1 was actually wearing her green identification bracelet at the time she eloped, and the ALJ made no finding of fact on this issue. Assuming that R1was wearing the bracelet at the time of her elopement, no staff were located near the front door to monitor the doors and R1's whereabouts and prevent her from leaving the facility unattended. Additionally, the facility's staff checked to make sure that the door locks were operational and the doors closed only once a shift at most, and the ALJ reasonably found that such precautions were undercut by the staff freely sharing the keycodes with visitors. *Id*.

[4] For example, the facility maintains that R1 "was properly and successfully redirected *at each instance* of wandering." RR at 15 (emphasis added). Although, the record reflects instances of successful redirection of R1 by facility staff, it does not show any consistent frequency of monitoring the resident. Therefore, it is impossible to conclude that the recorded incidents of confusion and wandering followed by redirection are the only times the resident was in need of supervision. Thus, R1's ability to leave the facility undetected shows that staff redirection of R1 was not always undertaken successfully.

[5] Petitioner presented evidence that on December 22, SSD recorded that R1 was wearing her green arm band. CMS Ex. 8, at 2. The SSD's progress notes of her interview with R1 on December 20 state that the green identification bracelet was intact. However, there is no documentation in R1's medical file that anyone other than the SSD checked R1 to ensure that she was wearing the bracelet.

Petitioner further argues that prior to R1's elopement, the facility posted a sign outside the door asking visitors not to let residents out. P. Ex. 6. However, this intervention was not adequate to mitigate a foreseeable risk of elopement.[6] As the ALJ reasonably observed, a resident could be taken for a visitor. ALJ Decision at 10. The ALJ found that R1 could easily be mistaken for a visitor rather than a resident. CMS Ex. 3, at 31; CMS Ex. 10, at 4. A further weakness of the system was revealed by the facility's acknowledgement that "R1 is presumed to have exited through the front door behind a delivery man who propped the door open while delivering packages." RR at 23. Indeed, one of the facility's CNAs told the surveyor that – "It was normal for the UPS man to leave the door blocked open when he has a lot of packages." CMS Ex. 3, at 45.

Petitioner argues that the ALJ held it to an unreasonable standard and that he "contravened . . . beneficial public policy" by ceasing "to allow [its residents] access to family and friends." RR at 23-24. In effect, according to Petitioner, the ALJ held it strictly liable for R1's elopement. *Id.* at pp 13-14 . However, the facility mischaracterizes the ALJ's findings. The ALJ did not find that the facility was required to limit or bar visitors' access, nor did he apply a strict liability standard. Rather, the ALJ correctly focused on whether the facility had taken all reasonable measures to mitigate the foreseeable risk of resident elopement. The facility was still free to, indeed obliged to, maintain its residents' access to visitors, but to do so in a manner that did not unreasonably endanger residents. Contrary to Petitioner's contention, furthermore, the ALJ did not rely solely on the fact that R1 had eloped from the facility in concluding that the facility was not in substantial compliance with section 483.25(h). Instead, the circumstances of the resident's exit, combined with the ample notice shown in the facility records of her high risk for elopement, and the obvious defects in the facility's planning for her supervision and security, led to the ALJ's conclusion.

Thus, the ALJ's conclusion that the facility was not in substantial compliance with section 483.25(h) is supported by substantial evidence in the record and is free from legal error.

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[6] The signs posted outside of the facility's exits read:

ATTENTION

We thank you for visiting Glenoaks Nursing Center. We all must work together to keep our residents safe.

PLEASE DO NOT OPEN THE DOOR FOR ANY RESIDENT OR LET
THEM OUT. WE ASK THAT YOU GET THE NURSE IF THIS OCCURS.
PLEASE BE SURE THE DOOR CLOSES SECURELY WHEN YOU EXIT.
WE ARE DEPENDING ON EVERYONE'S HELP TO KEEP OUR
RESIDENTS SAFE. THANK YOU.

P. Ex. 6.

B. The ALJ's conclusion that Glenoaks was not in substantial compliance with 42 C.F.R. § 483.13(c) is supported by substantial evidence in the record and is free from legal error.

Section 483.13(c) states that long-term care facilities such as Glenoaks "must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property." The term "neglect" is defined in CMS's regulations as a "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 42 C.F.R. § 488.301. CMS's interpretive guidelines indicate that the policies and procedures required by section 483.13(c) have certain key elements, including "prevention" (a goal that requires timely assessment and care planning), "reporting" (which involves, among other things, analyzing problematic incidents "to determine what changes are needed, if any, to policies and procedures to prevent further occurrences"), and "investigation" (having procedures to investigate various types of incidents). State Operations Manual, App. PP (guidelines for tag F226).

Noncompliance with section 483.13(c) can be based on either failure to develop policies or procedures adequate to prevent neglect, or failure to implement such policies. *See, e.g., Miss. Care Ctr. of Greenville*, DAB No. 2450, at 9-11, 13-15 (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 that were adequate to protect residents at risk of elopement), *aff'd Miss. Care Ctr. of Greenville v. U.S. Dep't of Health & Human Servs.*, No. 12-60420, 2013 WL 1173947 (5th Cir. Feb. 7, 2013); *Liberty Health & Rehab of Indianola, LLC*, DAB No. 2434 (2011) (finding noncompliance with section 483.13(c) and section 483.25(h)(2) where facility had a policy prohibiting neglect but failed to implement policies intended to protect residents from elopement).

Here, the ALJ concluded that Petitioner was not in substantial compliance with section 483.10(c) because it did not develop and implement written policies and procedures adequate to protect its residents who were identified at risk of elopement. ALJ Decision at 10. The ALJ found that 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. *Id*. at 11. The ALJ further found that "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." *Id*. at 10-11.

Petitioner argues that it had developed and had in place a set of policies and procedures to prevent and respond to residents identified as at risk for elopement. RR at 24-25. These policies included a "Wandering Resident Drill" policy, "Wandering: Elopement/Resident's at Risk" policy, "Visual Checks - Resident" policy, "Door Alarm

Check" policy, "Elopement" policy, "Abuse/Neglect Reporting Resident" policy, and "Identification of Patients - Armbands/Photos" policy. CMS Ex. 6. These policies included steps for: training and preparing staff for elopement events; assessing, identifying and monitoring residents to prevent elopement (including the use, monitoring, and documentation of green armbands for elopement); and responding in the event of an elopement. RR at 24-25.

This argument is without merit. As previously discussed, the facility primarily relied upon keypad-coded door locks for the exit doors to deter residents at risk from elopement from leaving the facility unattended. The Board has previously held that if a facility relies on devices such as keypad-coded door locks to assist in preventing elopements, then the facility must make sure that it has established policies and procedures for these interventions and those policies must address how those devices will be used. *Mississippi Care Ctr. of Greenville* at 12.

However, none of the facility's policies address the keypad-coded door locks for the exit doors, who had access to these codes, or how often these codes would be changed. Indeed, none of these policies address the critical issue of instructing visitors not to share the codes with residents. These omissions are central to the ALJ's finding, given the facility's acknowledgement before the ALJ (and before us on appeal) that the door codes were routinely provided to visitors. As the ALJ correctly found, the lack of written policies and procedures addressing the keypad lock codes meant that they did not function as intended to deter residents from exiting the facility without supervision. ALJ Decision at 11.

The facility does not address the ALJ's finding other than arguing that it had other policies to protect its at-risk residents from eloping. Notwithstanding these additional policies, the facility relied upon the keypad system as its primary mechanism for protecting its residents at risk for elopement. In this context, the facility's failure to develop policies and procedures regarding the dissemination and confidentiality of the keycodes indicates the facility failed to implement its anti-neglect policy. For example, as the Board stated in *Miss. Care Ctr. of Greenville*, quoting the ALJ's decision, "[t]he fact that the facility made daily checks of the doors to see if they are locked is not relevant once it had routinely provided the access code for these locks to visitors to the facility." DAB No. 2450, at 11.

The ALJ concluded Petitioner did not provide any evidence that at the time of R1's elopement, the facility had effective policies and procedures that addressed: 1) employee access to the door codes; 2) employee dissemination of these codes; 3) changing the door codes when needed; or 4) warnings to not give away the door codes or let residents out.

The facility's failure to develop such policies is sufficient to uphold the ALJ's conclusion that Petitioner was not in substantial compliances with section 483.13(c).[7]

Accordingly, the ALJ's conclusion that Glenoaks was not in substantial compliance with section 483.13(c) is supported by substantial evidence in the record and is free from legal error.

C. The ALJ did not err in concluding Glenoaks failed to show that CMS's immediate jeopardy determination was clearly erroneous.

Immediate jeopardy exists when a facility's noncompliance "has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination that a deficiency constitutes immediate jeopardy must be upheld unless the facility is able to prove that the determination is clearly erroneous. 42 C.F.R. § 498.60(c)(2); *Woodstock Care Ctr.* at 39 (2000). The "clearly erroneous" standard means that CMS's immediate jeopardy determination is presumed to be correct, and the burden of proving the determination clearly erroneous is a heavy one. *See, e.g., Maysville Nursing & Rehab. Facility*, DAB No. 2317, at 11 (2010); *Liberty Commons Nursing & Rehab Ctr. – Johnston*, DAB No. 2031, at 18 (2006), *aff'd, Liberty Commons Nursing & Rehab Ctr. – Johnston v. Leavitt*, 241 F. App'x 76 (4th Cir. 2007). When CMS issued the nursing facility survey, certification, and enforcement regulations, it acknowledged that "distinctions between different levels of noncompliance . . . do not represent mathematical judgments for which there are clear or objectively measured boundaries." 59 Fed. Reg. 56,116, 56,179 (Nov. 10, 1994). "This inherent imprecision is precisely why CMS's immediate jeopardy determination, a matter of professional judgment and expertise, is entitled to deference." *Daughters of Miriam Ctr.*, DAB No. 2067, at 15 (2007).

Petitioner does not directly challenge the ALJ's conclusion that CMS's determination that the facility's noncompliance posed immediate jeopardy was not clearly erroneous. Instead, Petitioner contends that "at all times [it was] in substantial compliance with [sections 483.25(h) and 483.13(c)], the only [deficiencies] cited at an [immediate jeopardy] level." RR at 31. Thus, Petitioner maintains "[a]ny findings of [immediate jeopardy] were clearly erroneous and should be overturned." *Id*. Because we previously

[7] Because we uphold the ALJ's conclusion that Petitioner was not in substantial compliance with section 483.13(c) because it did not develop policies and procedures adequate to protect residents at risk for elopement, we need not decide whether the facility was also noncompliant with that regulation based on a failure to implement policies and procedures. However, as the ALJ recognized, "Petitioner's elopement policy and R1's care plan required that all doors be monitored for closure." ALJ Decision at 9; *see* CMS Exs. 6, at 2-3; 20, at 6. By failing to do so, we note the facility arguably failed to effectively implement its own elopement policy and R1's plan of care.

concluded that the ALJ's conclusion that the facility was not in substantial compliance with these two regulatory provisions is supported by substantial evidence in the record, we do not need to address the facility's argument any further.

In any event, we agree with the ALJ that Petitioner did not carry its heavy burden to show that CMS's immediate jeopardy determination was clearly erroneous. Although CMS determined that R1 was not harmed during her elopement on December 24 (CMS Ex. 1, at 13), immediate jeopardy, as the ALJ correctly noted, does not require a showing of actual harm under the regulation but, only a likelihood of serious harm. ALJ Decision at 11; *see also Dumas Nursing & Rehab., L.P.*, DAB No. 2347, at 19 (2010), citing *Life Care Ctr. of Tullahoma*, DAB No. 2304, at 58 (2010), *aff'd, Life Care Ctr. of Tullahoma v. Sebelius*, 453 Fed. App'x 610 (6th Cir. 2011).

We also agree with the ALJ that the "danger of R1's elopement was obvious and well known by Petitioner prior to and at the time of R1's elopement." ALJ Decision at 11. As previously discussed, the facility's own documentation amply demonstrates that R1 was a high risk for elopement and that she had exhibited behavior that was characterized as "wandering" and "confused." As the surveyor testified, "[e]lopement posed a serious threat to Resident 1's health and safety . . . [because she] was confused, at risk for falls [and from] wandering away from the facility and into the street." CMS Ex. 48, at 3. R1 was also at risk for hyperglycemic (high blood sugar) or hypoglycemic (low blood sugar) episodes with symptoms that include thirst, blurry-vision, fatigue, confusion, and an unsteady gait when walking. *Id*. R1was found in the facility's parking lot, which was located adjacent to a public road. CMS Ex. 5, at 2. In addition, the weather history for the facility area on December 24, 2010 indicated that the temperature at 10:56 a.m. was 51.1 degrees Fahrenheit. CMS Ex. 1, at 13; CMS Ex. 41, at 3. Even though facility staff on December 17 and 20 fortuitously observed and helped retrieve R1 within a short period of time after her elopement, R1 was made vulnerable to dangers that presented a likelihood of serious harm, including the possibility of wandering into the road and being struck by a car, falling or getting lost, and being exposed to cold weather conditions without proper garb. *See Kenton Healthcare, LLC* at 23-24 (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).

As previously discussed, we also agree with the ALJ that Petitioner's inadequate elopement prevent policies and procedures affected all residents identified as elopement risks. ALJ Decision at 12. The facility acknowledges that it was aware that the keycode for the front door was routinely shared with visitors. The facility further acknowledges that as late as January 28, 2011, a visitor could still obtain the keycode for the facility's

back door while at the facility or by calling in advance to obtain it. R. Br. at 9. The facility's failure to protect the confidentiality of the keycodes not just to the front door, but to other facility exits as well, created a situation that presented a likelihood that other high-risk facility residents could suffer serious injury or harm if they left the facility unsupervised.

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

D. The ALJ committed no error in sustaining CMS's determination regarding the duration of the immediate jeopardy period, and Glenoaks did not carry its burden of demonstrating that it was back in substantial compliance sooner than the date determined by CMS.

The Board has long held that CMS does not need to establish noncompliance on each day for which it imposes a CMP. *See*, *e.g.*, *Regency Gardens Nursing Ctr.*, DAB No. 1858, at 7-11 (2002) and cases cited therein.[8] The Board in *Cary Health & Rehab. Ctr.*, DAB No. 1771 (2001), explained that noncompliance is presumed to continue until the facility demonstrates that it has achieved substantial compliance. DAB No. 1771, at 23-24; see also *Park Manor Nursing Home*, DAB No. 2005, at 26 (2005), *aff'd*, *Park Manor v. U.S. Dep't of Health & Human Servs.*, 495 F.3d 433 (7th Cir. 2007). Furthermore, in *Brian Ctr. Health & Rehab./Goldsboro*, the Board explained that a "determination by CMS that a SNF's ongoing compliance remains at the level of immediate jeopardy during a given period constitutes a determination about the 'level of noncompliance' and, therefore, is subject to the clearly erroneous standard of review under section 498.60(c)(2)." DAB No. 2336, at 7-8. In other words, the facility's burden of demonstrating clear error in CMS's immediate jeopardy determination also "extends to overcoming CMS's determination as to how long the noncompliance remained at the immediate jeopardy level." *Azalea Court*, DAB No. 2352, at 17 (2010), citing *Brian Ctr. Health &Rehab./Goldsboro* at 7. 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 [immediate] 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).

[8] As the Board pointed out in *Regency Gardens*, the congressional purpose in providing for alternative remedies short of termination was to allow CMS to apply pressure to motivate facilities to solve problems quickly and so protect residents without disrupting placements unnecessarily. *See*, *e.g.*, H.R. Rep. No. 100-391(1), at 470-77 (1987); 59 Fed. Reg. at 56,116-17, 56,177-78. Thus, the Board stated that, consistent with that purpose, "a non-compliant facility is required to promptly file for CMS's approval a plan stating when and how the facility will correct the conditions violating participation requirements and is not entitled to have the remedies lifted unless and until the facility **demonstrates** that substantial compliance has been achieved." *Regency Gardens* at 11 (emphasis added), *citing* 42 C.F.R. §§ 488.401, 488.402(d).

1. The ALJ correctly concluded that CMS's determination regarding the duration of the immediate jeopardy period was not clearly erroneous.

CMS determined that Glenoaks was noncompliant with sections 483.25(h) and 483.13(c) at the immediate jeopardy level from December 24, 2010 through January 27, 2011. The ALJ concluded that that determination was not clearly erroneous. He based that conclusion upon two findings. First, the ALJ found that the facility'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." *Id.*, citing CMS Ex. 1, at 6 (emphasis added). However, the ALJ observed that "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." *Id*., citing P. Br. at 14-15; *see also* CMS Ex. 3, at 55; P. Ex. 32, at 7. Second, the ALJ found that although the facility's 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, the surveyor observed on January 28, 2011 a visitor telling Petitioner's maintenance supervisor that she knew the current code to open and enter through one of the facility doors. ALJ Decision at 13-14. The ALJ found that both the surveyor and the maintenance supervisor tested the code the visitor gave them and were able to confirm that the code opened the door. *Id*. at 14, citing CMS Ex. 3, at 74. The ALJ concluded that: "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." ALJ Decision at 14.

Petitioner argues that the "ALJ failed to recognize there was no immediate likelihood of serious harm to R1 after December 24, 2010." RR at 33. Petitioner points to actions which it says it took to reduce any risks. For example, the facility changed the keycode to the front door entrance, instructed staff not to disclose the new front door code to visitors, escorted visitors from the facility, and placed R1 in one-to-one supervision during waking hours, with visual checks until she was discharged on December 27, 2010. RR at 20; P. Ex. 1, at 6. These arguments are without merit.

The Board has consistently held that immediate jeopardy is abated "only when the facility has implemented necessary corrective measures so that there is no longer any likelihood of serious harm." *Life Care Ctr. of Bardstown*, DAB No. 2479, at 35 (2012), *citing Pinehurst Healthcare & Rehab. Ctr.*, DAB No. 2246, at 15 (2009). In *Fairfax Nursing Home, Inc.*, the Board stated that "a finding of immediate jeopardy is not contingent on a finding that each individual incident placed a resident at such a degree of potential or risk of serious harm that there was a likelihood of harm to that specific resident at that particular time. . . . Findings about incidents related to individual residents are not themselves the deficiencies that must be corrected – the deficiency is the

underlying failure to meet a participation requirement evidenced by the incident." DAB No. 1794, at 13-14 (2001), *aff'd*, *Fairfax Nursing Home v. Dep't of Health & Human Servs.*, 300 F.3d 835 (7th Cir. 2002), *cert. denied*, 537 U.S. 1111 (2003). In other words, it is not sufficient for a facility to abate immediate jeopardy by addressing the deficiency with respect to the condition of one resident. Instead, the facility needs to address and correct the conditions underlying the noncompliance that created the immediate jeopardy.

Here, the ALJ found that although the facility changed the keycode for the front door on December 24, the facility did not change the keycode combinations for the remaining five exit doors until the complaint survey on January 28, 2011. As the ALJ noted, changing the keycodes for all of the exit doors was one of the requirements of the facility's own PoC to achieve compliance. ALJ Decision at 13. Petitioner argues that it was not required to change the keycodes for all of the doors at the time of the survey because it had only provided the surveyors with its credible Allegation of Compliance containing that measure on January 28. RR at 32. Petitioner further argues that a facility does not have to implement every measure contained in the plan of correction in order for immediate jeopardy to be abated. It merely has to implement sufficient measures to effectively eliminate the likelihood of serious injury, harm, impairment, or death to a resident. *Id*. at 32-33, citing *Cogburn Nursing Ctr. – Huntsville*, DAB CR1798 (2008).

While it is true that, in some circumstances, immediate jeopardy may be abated by measures short of those required to regain full compliance, here the facility failed to address the underlying situation that resulted in immediate jeopardy, i.e., the lack of control over the ability of high-risk residents to exit the facility unsupervised through doors that were either propped open or opened by visitors with keycode access. As previously discussed, the facility's QI Committee met on December 28 and decided that the keycodes to *all* of the facility's exits should be changed. P. Ex. 1, at 5. Until the facility completed this task, the ALJ reasonably concluded that the likelihood of serious harm to residents at risk for elopement had not been eliminated.

The SOD also states that on December 24, 2011 the facility disseminated a note that read: "Attention Staff. Front Door code has been changed for resident safety. Do not give **this code** out to anyone other than staff. Staff members are to let visitors out. No exceptions." CMS Ex. 1, at 22 (emphasis added). It is undisputed that the facility did not apply this measure to the other facility exits until January 28 during the complaint survey, i.e., the facility did not change the keycodes and instruct staff not to share keycodes for other exit doors until that day. CMS Exs. 44; 45; 3, at 74; RR at 23-24. Even then, the facility did so only after the surveyor discovered that a visitor was aware of a keycode to another facility exit that was able to open the door.

Petitioner contends that the back door is not a "main thoroughfare for the Facility" and that there is only a keypad on the inside of the door, not on both sides of the door as in the case of the main entrance. RR at 21; R. Br. at 8. Petitioner further contends that the back door codes are insignificant to the duration of the immediate jeopardy because "the individual needs of the at-risk residents in the Facility were already being met through other interventions such that even without changing the door codes[,] there would be no immediate likelihood of serious harm." R. Br. at 13. This argument is also not persuasive.

Although not a primary point of egress and ingress, a resident can still use these exits to leave the facility unnoticed or without staff supervision.[9] Just because a resident's primary means of ambulation is via wheelchair does not mean the resident is prevented from leaving the facility. Indeed, if a resident in a wheelchair were to leave the facility unsupervised, the consequences to resident safety could be catastrophic. *See, e.g., Southridge Nursing & Rehab. Ctr.*, DAB No. 1778 (2001) (resident in wheelchair eloped from facility and was injured after his wheelchair rolled down a hill into a weedy field). The facility's argument is also undercut by the fact that it placed signs at each of these exits asking visitors not to let residents out, thus itself recognizing that these other exits present a concrete risk of being used by a resident to leave the facility. RR at 21; P. Ex. 6.

In any case, the facility does not know exactly how R1 was able to leave the facility or through which door she may have exited. Nonetheless, Petitioner argues that "R1 is presumed to have exited through the front door behind a delivery man who propped the door open while delivering packages." RR at 23. However, the facility points to no evidence in the record to support this proposition and none of its employees testified that they actually observed R1 leave the facility. Thus, it is also possible that R1 left the facility through an exit other than the front door. In any event, if the facility's "presumption" were in fact true and R1's elopement was not the result of the keycodes being freely shared with visitors, then the facility has not shown that it took **any** steps to remedy this problem from reoccurring.

Finally, the facility points out that at the time of the complaint survey, there were only two other residents who had been assessed for potential elopement and each primarily relied on a wheelchair for ambulation. R. Br. at 13. This circumstance, according to Petitioner, made it less likely that these residents would be able to leave the facility unnnoticed. Even if somehow wheelchair bound residents were less likely to elope

[9] The facility argues that only the front door was used by visitors and the back door was clearly and directly visible from the nurse's station. R. Br. at 9. However, the record contains only a map of the floor plan of the facility. P. Ex. 8, at 7. There is no testimonial or other documentary evidence to support a conclusion that staff were stationed continuously to monitor the back door. And, as noted, at least one visitor knew how to leave via the back door.

through doors other than the front door, Petitioner's argument overlooks the possibility that between December 24 and the time of the survey, a new resident could have been admitted to the facility who was at risk for elopement or that a current resident could develop such a risk. Thus, Petitioner's failure to secure those doors continued to present immediate jeopardy to any mobile resident at high risk of elopement. Furthermore, Petitioner did not show that the close one-to-one supervision which it instituted for R1 was extended to other high-risk residents.

In summary, given the nature and scope of the noncompliance demonstrated by R1's elopement, CMS could reasonably determine that a likelihood of serious injury or harm continued to exist at Glenoaks at least until all of the doors were secured. Accordingly, the ALJ did not err in concluding that the facility had failed to meet its heavy burden of demonstrating that CMS's determination about the duration of the period of immediate jeopardy was clearly erroneous.

2. Glenoaks did not meet its burden of demonstrating by a preponderance of the evidence that it returned to substantial compliance prior to February 18, 2011.

CMS determined that Glenoaks remained out of substantial compliance with section 483.25(h) and 483.13(c) at a level of scope-and-severity below immediate jeopardy from January 28 through February 17, 2011. The ALJ concluded that determination "was not clearly erroneous." ALJ Decision at 14. In so doing, the ALJ applied the wrong standard of review. The "clearly erroneous" standard applies to an ALJ's review of the duration of the period of noncompliance at the immediate jeopardy level, not to a review of the duration of the noncompliance itself (as opposed to whether the level of noncompliance continued at the immediate jeopardy level). *See Brian Ctr.*, DAB No. 2336, at 7-8. As discussed above, the correct legal standard is whether a facility has shown by a preponderance of the evidence that it returned to substantial compliance at a date earlier that CMS determined. *See Golden Living Ctr. – Foley*, DAB No. 2510, at 3, 28-29, 31 (2013). However, we find this error to be harmless because, as discussed below, we conclude that the facility did not show that it had returned to substantial compliance at a date earlier than CMS had previously determined.

Petitioner argues that it came into compliance "when it completed in-servicing its staff on the [December 24, 2010] policy changes and additional measures related to door code distribution and no longer allowing visitors to leave the building unattended." RR at 36. Having sustained the ALJ's conclusion that the facility did not abate CMS's determination of immediate jeopardy until January 28, 2010, the question now before us is whether the facility demonstrated that it returned to substantial compliance sometime *after* January 28, 2011 and *before* February 18, 2011. Thus, the various in-service

trainings to staff, and the facility's December 28 QI Committee meeting, prior to January 28, 2011 are not relevant. However, even if they were relevant to the duration of the noncompliance at the non-immediate jeopardy level, we conclude that the in-service training and QI Committee meeting would not support a conclusion that the facility returned to substantial compliance prior to February 18, 2011.

Before the ALJ, the facility submitted three in-service training signature sheets as evidence to support its assertion that it completed its staff training by December 28, 2011. P. Ex. 5. The ALJ concluded that that two of these trainings were conducted prior to the December 24, 2010 elopement (December 1 and 13, 2010). ALJ Decision at 14, citing P. Ex. 5, at 1-4. They were obviously ineffective. Therefore, the ALJ properly concluded that these documents do not support Petitioner's assertion that it completed training to staff by December 28 in response to R1's elopement. P. Ex. 5, at 1-4. The ALJ further concluded that the third training sheet dated December 27, 2010 shows that just nine staff attended that training, significantly fewer than the number of staff Petitioner employed. ALJ Decision at 14; P. Ex. 5, at 5.

Although the facility does not challenge the ALJ's findings regarding the in-service training on December 1 and 13, it does contend that for the December 27 in-service training, the ALJ considered only the sign-in sheet from the session held at 3:15 p.m. and failed to consider the sheet from a 2:00 p.m. session, which listed 43 names. RR at 36, citing P. Ex. 5, at 4. The facility also contends that the ALJ ignored the sign-in sheets for an in-service training session held on December 28, 2010, which listed 37 names. RR at 36, citing CMS Ex. 39, at 10-11. Our review of these documents indicates that the sign-in sheet at P. Ex. 5, at 4 is undated and appears to be related to the in-service training conducted on December 13 (located on the prior exhibit page – P. Ex. 5, at 3) rather than the December 27 session located on the next page of the exhibit (P. Ex. 5, at 5).[10] In addition, page 4 of these sign-in sheets (P. Ex. 5, at 4) does not list any topics of that in-service training. Although page 5 (P. Ex. 5, at 5) states "Elopement In-service procedure, recognizing residents who are potential elopement, Q15 minute checks[,]" these topics do not appear to specifically address the December 24 elopement or the facility's response to it. The sign-in sheets purportedly for the December 28 in-service session (located at CMS Ex. 39, at 10-11) list topics entirely unrelated to the December 24 elopement or the facility's response to it. Accordingly, the exhibits have no probative value regarding the in-service training provided on December 27 and 28, 2010.

[10] For example, the sign-in sheet at P. Ex. 5, at 4 lists a start time of 2:00 p.m. and a completion time of 3:00 p.m. In contrast, the sign-in sheet at P. Ex. 5, at 5 lists a start time of 3:15 p.m. and a completion time of 3:45 p.m. If the training sessions were the same, as Petitioner contends, then it would be reasonable to expect that the sessions would run approximately the same length of time. In addition, the sign-in sheets have a different format and appearance.

Moreover, the SOD states that the in-service provided on December 28 regarded "the confidentiality of **front door codes** to ensure resident's [sic] did not exit facility without supervision." CMS Ex. 1, at 29 (emphasis added). However, as discussed, the facility's QI Committee recommended and represented that the keycodes to all door exits had been changed (even though they were not changed until January 28). P Ex. 1, at 5; CMS Ex. 1, at 30. Since the December 28 in-service did not train staff on changing and maintaining the confidentiality of the keycodes on the five other facility exits, it would not suffice to show that the facility returned to substantial compliance at a date earlier than CMS determined.

The facility next argues that the ALJ further erred by not considering another staff-wide in-service training conducted on January 10, 2011 (with make-up sessions on January 11 and 12, 2011). RR at 36, citing CMS Ex. 39 at 2-5, 7-9. Again, however, the record regarding this training indicates that the facility focused on informing "all staff that door codes have been changed to [the] **front door** and ONLY staff members should know these codes." CMS Ex. 39, at 3, 5 (emphasis added). Thus, the January in-service trainings suffer from the same fatal flaw as the December 28 training.

The facility further argues that the "ALJ incorrectly held that Petitioner did not complete training on these topics until [February 7, 2011] . . . ." RR at 36. However, Petitioner does not point to any evidence in the record to support this assertion, other than the in-service trainings previously discussed. The SOD supports the ALJ's observation that CMS considered the facility's "more comprehensive in-service training" provided to its staff on February 7, 2011 as more relevant in determining when the facility returned to substantial compliance rather than the prior in-service trainings that occurred on December 28, 2010 and January 10-11, 2011. ALJ Decision at 14, citing CMS Ex. 1, at 13. We find this conclusion reasonable given the narrow focus of the earlier sessions already discussed above.

The SOD also states that, although the facility abated the immediate jeopardy on January 28, the facility remained out of substantial compliance until its QI Committee reviewed and evaluated the effectiveness of the measures adopted under the PoC. CMS Ex. 1, at 10-11. As part of the PoC, the facility's administrator and/or designee was required, among other things, to randomly observe visitors exit the facility three times a week for one month to ensure anyone attempting to exit the building had a facility staff member unlock the door. In addition, the facility's administrator was to report findings to the QI Committee in order "to review all interventions; determine [the] effectiveness and

frequency of continued audits based upon [the] results achieved."[11] CMS Ex. 1, at 14. Because the facility only submitted its PoC to the state agency on January 28, 2011, it appears that the earliest date that the facility would have been able to complete all of the required remedial actions would have been January 28, 2011. Nevertheless, CMS determined that the facility returned to substantial compliance, effective February 18, after its QI Committee met on February 16, 2011 "to discuss specific survey issues" and implementation of the new policies. *Id*.

The facility contends that the ALJ should have concluded that the QI Committee met on December 28, 2010, not February 16, 2011 to discuss issues related to R1's elopement and implementation of new policies. RR at 36, citing P. Ex. 4; P. Ex. 32, at 7.[12] Obviously the QI Committee could not have discussed the results of the survey during its December 28 meeting because it had not occurred yet. As previously discussed, the facility represented that the QI Committee "met and reviewed the [December 24, 2010] incident and the interventions the Facility intended to implement." P. Ex. 1, at 5; *see also* CMS Ex. 1, at 30. At that meeting, the QI Committee "decided the Administrator would change **all door codes** monthly or more frequently if needed" and that those measures had been implemented between December 24-28. *Id*. (emphasis added). However, as discovered during the complaint survey, the door codes had not in fact been changed for all exits, contrary to the resolution of the QI Committee. The essential point of the SOD comment was that the facility needed to review the results of the survey, not just the December 24 incident. Clearly, the survey exposed additional findings of noncompliance beyond those discussed during the post-elopement QI meeting, i.e., facility's failure to document green armbands and implement its anti-neglect policy, as well as the discovery that the QI Committee's earlier recommendations were not implemented. Thus, like the in-service trainings on December 28, 2010 and January 10-12, the pre-survey activities of the QI Committee do not demonstrate that the facility returned to substantial compliance earlier than February 18, 2011.

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[11] The PoC also contained a requirement for the facility's Director of Nursing (DON) and/or designee to "observe all residents identified to be at risk for elopement daily for one (1) week[,] then three (3) times a week for two (2) weeks to ensure [the] green [identification] bracelet is in place and documented in the [Medical Administration Record] MAR." CMS Ex. 1, at 14. The DON was then required to report the results of the audit to the QI Committee for it to review the effectiveness of the interventions and the frequency of continued audits based upon the results achieved. *Id*.

[12] In support of its assertion, Petitioner cites to its Exhibit 4. However, this Exhibit is simply a sign-in sheet that does not convey any information about what occurred during the meeting. The sign-in sheet states that: "The QI committee met and discussed findings from [left blank in original document] and those areas that have been corrected. New findings discussed *as attached* and given to the appropriate Dept. Head to be monitored and corrected by next week." P. Ex. 4 (emphasis added). It is not possible to discern what the QI committee actually discussed since the exhibit does not contain the attachment or otherwise provide any additional details about the meeting.

For these reasons, we conclude that the facility did not meet its burden of demonstrating by a preponderance of the evidence that it had returned to substantial compliance at a date earlier than CMS determined.

E. The ALJ's conclusion that a $3,550 per-day CMP for the period of immediate jeopardy and $150 per-day CMP for the period of non-immediate jeopardy noncompliance is reasonable, supported by substantial evidence, and free of legal error.

An ALJ (or the Board) determines de novo whether a CMP is reasonable based on facts and evidence in the appeal record concerning the factors specified in section 488.438. *See* 42 C.F.R. § 488.438(e), (f); *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 21 (2010), *aff'd, Senior Rehab. & Skilled Nursing Ctr. v. Health & Human Services*, 405 F. App'x 820 (5th Cir. 2010); *Lakeridge Villa Healthcare Ctr.*, DAB No. 2396, at 14 (2011). Those factors are: 1) the SNF's history of noncompliance; 2) the SNF's financial condition – that is, its ability to pay a CMP; 3) the severity and scope of the noncompliance, and "the relationship of the one deficiency to other deficiencies resulting in noncompliance"; and 4) the SNF's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. 42 C.F.R. §§ 488.438(f), 488.404(b), (c)(1). With respect to the culpability factor, however, "[t]he absence of culpability is not a mitigating circumstance in reducing the amount of the penalty." *Id.* § 488.438(f)(4). Once an ALJ has determined that CMS had a valid legal basis (namely, the existence of noncompliance) to impose a CMP, the ALJ (or the Board on appeal) may not reduce that CMP to zero or below the regulatory minimum amount. *Id.* § 488.438(e)(1); *Somerset Nursing & Rehab. Facility*, DAB No. 2353, at 26-27 (2010); *modified on other grounds, Somerset Nursing & Rehab. Facility v. U.S. Dep't of Health & Human Servs.*, 502 F. App'x 513 (6th Cir. 2012).

The ALJ concluded that the $3,550 per-day CMP for the period of immediate jeopardy and the $150 per-day CMP for the period of non-immediate jeopardy were reasonable. In this conclusion, the ALJ recited the regulatory factors discussed above but focused primarily on the first and third regulatory factors. The ALJ first found that the facility had a history of noncompliance with 42 C.F.R. § 483.25, the quality of care regulation, based upon a deficiency cited during a survey conducted in February 2009 (at a scope and severity level of "D"). ALJ Decision at 15. The ALJ also found that Petitioner was previously noncompliant with section 483.75(l)(1) that was cited during a March 2008 survey (at a scope and severity level of "D."). CMS Ex. 47, at 1. Regarding the third regulatory factor, the ALJ stated that, among other things, that: "The deficiencies cited here are serious, constituting immediate jeopardy for [noncompliance with participation requirements involving accidents and hazards and treatment of residents]." ALJ Decision at 15.

The ALJ also correctly noted "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." *Id*. ALJ further observed that: "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)." *Id*., citing 42 C.F.R. §§ 488.438(a)(1)(i), (d)(2). Similarly, the ALJ found that the $150 per-day CMP for the period of noncompliance at the less-than-immediate jeopardy level "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)." *Id*., citing 42 C.F.R. § 488.438(a)(1)(ii).

The Board has long recognized that: "Unless a facility contends that a particular regulatory factor does not support that CMP amount, the ALJ must sustain it." *Coquina Ctr.*, DAB No. 1860, at 32 (2002). Here, Petitioner does not challenge the ALJ's findings regarding the facility's prior history of noncompliance or the seriousness of its deficiencies at issue. Petitioner also does not contend before the ALJ (or even on appeal before us) that any particular regulatory factor did not support the CMP amounts. Instead, the facility maintains its position that because the immediate jeopardy was abated on December 24, 2010, "any CMP amounts continuing beyond that date must be lowered to an appropriate [non-immediate jeopardy] level." RR at 37. We previously sustained the ALJ's determination about the existence and duration of the facility's noncompliance at the immediate jeopardy level. Thus, we conclude that the ALJ did not err in determining that the $3,550 per-day CMP and the $150 per-day CMP were reasonable for the time periods imposed.

Conclusion

For all of the foregoing reasons, we affirm the ALJ Decision.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Stephen M. Godek
Presiding Board Member