Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: November 21, 2007
Brightview Care Center,	
Petitioner,	Civil Remedies CR1491 App. Div. Docket No. A-07-9
- v. -	Decision No. 2132
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Brightview Care Center (Brightview, Petitioner), a long-term care facility, appealed the August 14, 2006 decision of Administrative Law Judge (ALJ) Anne E. Blair. Brightview Care Center, DAB No. CR1491 (2006) (ALJ Decision). The ALJ Decision granted summary disposition in favor of the Centers for Medicare & Medicaid Services (CMS), sustaining the CMS determinations that Brightview was not in substantial compliance with 42 C.F.R. § 483.25(h)(2) (requiring the facility to ensure each resident receives adequate supervision and assistance devices to prevent accidents); that its noncompliance was at the immediate jeopardy level; and that a per-instance civil money penalty (CMP) of $3,050 was reasonable. The finding of noncompliance with section 483.25(h)(2) was based on an Illinois Department of Public Health (IDPH, state survey agency) investigation and survey prompted by a report of one resident's elopement.

The parties stipulated to the facts before the ALJ, and filed cross motions for summary judgment (also referred to as summary disposition) based on those stipulated facts (stipulation of facts, SOF). The stipulated facts were supported by 26 joint exhibits, also submitted to the ALJ (Jt. Exs. 1-26). Now, on appeal, Brightview argues that the ALJ erred in granting summary

disposition for CMS without weighing the stipulated facts in the light most favorable to Brightview and without drawing all reasonable inferences from those facts in Brightview's favor. Petitioner's Request for Review and Brief in Support Thereof (P.R.R.) at 2-4, 6-14; Petitioner's Reply to CMS's Response to Petitioner's Request for Review and Brief in Support Thereof (Pet. Reply) at 2-5. Brightview stipulated to facts showing that a resident eloped from its facility. SOF 3, 4, 13-30. According to Brightview, however, if the ALJ had applied the summary disposition standard correctly, she would have determined that the resident eloped deliberately, rather than unintentionally. P.R.R. at 9-11; Pet. Reply at 7-9. A deliberate elopement, Brightview claims, was not foreseeable, and therefore not preventable despite the measures Brightview took to prevent elopements. P.R.R. at 10-14; Pet. Reply at 7-9, 12-13.

Brightview also argues that the Board's decision in Alden-Princeton Rehabilitation and Health Care Center, DAB No. 1978 (2005), supports its defense that the facility's receptionist had other duties and was not primarily responsible for ensuring that the resident did not elope. P.R.R. at 7-9; Pet. Reply at 3-7. Brightview also asserts that the ALJ contravened 42 C.F.R. § 483.75(o)(4)[1] by relying on evidence in Brightview's quality assurance (QA) committee records. P.R.R. at 4-6; Pet. Reply at 10-12. Additionally, Brightview argues that the ALJ erred in upholding the immediate jeopardy level finding and the amount of the CMP. P.R.R. at 14-16.

We conclude that the ALJ correctly granted CMS's motion for summary disposition despite not fully articulating the correct standard for summary disposition. In order to conclude that CMS must prevail as a matter of law, the ALJ was required to view the evidence in the light most favorable to Brightview and to draw any inferences favorable to Brightview that could reasonably be supported on the record. Applying the correct standard ourselves, we conclude that summary disposition in favor of CMS is appropriate even viewing the proffered evidence in the light most favorable to Brightview and drawing all reasonable inferences in Brightview's favor. Hence, any failure by the ALJ to make that process explicit caused no prejudice to Brightview.

Accordingly, we affirm the ALJ Decision, concluding that Brightview failed to comply substantially with the requirement at

[1] We cite to the 2006 Code of Federal Regulations throughout this decision; all the relevant regulations were unchanged during the times at issue here.

section 483.25(h)(2), that CMS's immediate jeopardy determination was not clearly erroneous, and that the amount of the per-instance CMP was reasonable.

Factual Background[2]

Brightview is a long-term care facility located in the city of Chicago, Illinois. ALJ Decision at 7. From May 8 to 16, 2003, state surveyors conducted an incident report investigation and partial extended survey of Brightview. Id. at 1. On the basis of this survey, CMS determined that Brightview had failed to comply substantially with the participation requirements stated at 42 C.F.R. §§ 483.25(h)(2) and 483.15(g) and determined that the section 483.25(h)(2) deficiency was at an immediate jeopardy level. Id.

Following a revisit survey on June 11, 2003, to investigate unrelated complaint allegations for which no additional deficiencies were found, and another revisit survey on July 23, 2003, Brightview was found to be in substantial compliance with the participation requirements, effective June 11, 2003. ALJ Decision at 1.

By letter dated August 12, 2003, CMS notified Brightview that the final remedies would be directed inservice training; a per-instance CMP of $3,050; and, as a consequence of a finding of substandard quality of care, a two-year Nurse Aide Training and/or Competency Evaluation Program (NATCEP) prohibition (from May 16, 2003). ALJ Decision at 1.

Brightview filed a request for a hearing before an ALJ on July 7, 2003. It challenged the two findings of noncompliance (under 42 C.F.R. §§ 483.25(h)(2) and 483.15(g)), the immediate jeopardy determination, the substandard quality of care finding, the two-year NATCEP prohibition, and the CMP.

As noted above, the parties submitted a joint stipulation of facts (SOF) and 26 joint exhibits in support of the SOF (Jt. Exs.

[2] The information in this section is drawn from the ALJ Decision and the record before the ALJ, 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 and conclusions of law (FFCLs).

1-26) to the ALJ.[3] They also submitted briefs and a small number of supplemental exhibits.[4] CMS moved for summary affirmance. Brightview opposed summary affirmance and moved for summary reversal. CMS opposed summary reversal. Both parties' oppositions to summary disposition were based on competing views that the stipulated facts, as properly viewed, and the law, as properly applied to those facts, did not compel a conclusion that the opposing party must prevail. Neither party took the position that there was a genuine dispute as to one or more material facts.

Below, we summarize the facts (from the stipulation of facts) on which the ALJ relied in upholding CMS's finding that Brightview was not in compliance with 42 C.F.R. § 483.25(h)(2). See ALJ Decision at 5-15.

Resident #2, who eloped from Brightview on April 19, 2003, had undergone heart surgery in January or early February 2003, and was readmitted to Brightview following the surgery. ALJ Decision at 5, 6; SOF 16, 24-28.[5] At that time, he was 71 years old, and suffered from organic brain syndrome, hypothyroidism, hypertension, osteoporosis, dementia, bipolar disorder with psychotic features, chronic obstructive pulmonary disease, disorientation, and confusion. ALJ Decision at 6; SOF 14. His minimum data set (MDS) assessment, updated upon his readmission to Brightview February 14th after the heart surgery, indicated that he suffered from short- and long-term memory problems, had "moderately impaired" cognitive skills (meaning he had poor decisional abilities and required cues or supervision); had "indicators of delirium and periodic disordered thinking [and] awareness"; and had periods of altered perception or awareness of surroundings, episodes of disorganized speech, periods of restlessness, lethargy, and varying mental functioning

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[3] According to the parties, the joint exhibits were submitted to clarify and elaborate upon the stipulated facts. Respondent's Memorandum of Law in Support of Its Motion for Summary Affirmance at 17, n.5. However, the parties noted that they had not stipulated to any opinions or standards of law or conduct in any exhibit, or to any fact in an exhibit that would conflict with a stipulated fact. Id.

[4] The ALJ did not refer to or rely on any of the supplemental exhibits; we do not do so either.

[5] For reasons of privacy, we refer to the resident by the number assigned by the state surveyors.

over the course of the day. ALJ Decision at 6; SOF 17. At the time of the February 14th MDS assessment, his psychotropic medications were Lithium Carbonate and Zyprexa, and he was assessed as "at risk for falls secondary to psychotropics." ALJ Decision at 6; SOF 17, 18.

On February 27, 2003, Brightview assessed Resident #2 as an elopement risk under Brightview's Elopement Risk Assessment Protocol (ERAP). ALJ Decision at 6; SOF 19. At that time, however, he was also assessed as not having the physical capacity to leave the building, because the effects of his recent heart surgery left him dependent on staff members for moving within the building. ALJ Decision at 6; SOF 19, 20.

According to the facility's elopement prevention program, elopement risk residents such as Resident #2 were not supposed to leave the building unescorted. ALJ Decision at 8; SOF 30. Pursuant to the written guidelines of Brightview's elopement prevention and wandering programs, photographs of the residents at risk for elopement were shared with staff members and placed at the receptionist's desk by the front door. Id. Brightview's elopement prevention program guidelines further required that the "[r]eception[ist] maintains vigilance to make sure that the resident does not leave the building and notifies the nursing department if resident behavior regarding leaving the building escalates." Id.

On April 12, 2003, Brightview staff members began a new MDS assessment for Resident #2, because there had been improvement in his cognitive skill, activities of daily living, and mobility, as a result of his ongoing recovery from the heart surgery. ALJ Decision at 6; SOF 21. Resident #2 no longer had periods of altered perception or awareness of surroundings, and no longer had episodes of disorganized speech. Id. However, he was still "easily distracted" and his mental functioning varied over the course of a day. ALJ Decision at 6-7; SOF 21. His cognitive status was still assessed as "moderately impaired;" his only psychotropic medication at that time was Risperdal. ALJ Decision at 7; SOF 21. By April 14, 2003, Resident #2 was able to walk on his own within the building, with supervision, and by April 19 he could locate his room and go to the dining room and smoking room without assistance or direction. ALJ Decision at 7; SOF 22, 23.

On April 19, 2003, at approximately 9:25 p.m., Resident #2 went outside on Brightview's front porch. The receptionist's report describes what happened:

> [Resident #2] told me that he wanted to go out to the front porch to take some fresh air. I knew he was on Elopement Risk, but I let him go out because he promised me that he would stay on the front porch with another resident who was also out there. He was under my supervision; I could clearly see him by looking out the window. I received a phone call at this time and within 10 minutes he was not on the porch. I reported this to the supervisor - Malou.

ALJ Decision at 7; SOF 24.

Brightview then implemented its procedure on missing residents, and searched in and outside the building and in the immediate neighborhood. ALJ Decision at 7; SOF 26. Resident #2 was not found, and the facility notified the Chicago police at 9:45 p.m. that Resident #2 was missing. ALJ Decision at 7; SOF 27. The police found Resident #2 at an unknown hour, and took him to the hospital at approximately 4:30 a.m. ALJ Decision at 7-8; SOF 28. Resident #2 was returned to Brightview, unharmed, at 11 a.m. on April 20, 2003. ALJ Decision at 7-8; SOF 29.

Following Resident #2's elopement, Brightview took a number of corrective actions, including analyzing the April 19 incident, warning and counseling the receptionist,[6] implementing a new system using WanderGuard monitoring equipment, various inservice trainings for staff, and QA committee meetings and activities. ALJ Decision at 8; SOF 31. Resident #2 received an updated care plan and an assessment of risk for elopement (pursuant to Brightview's newly revised ERAP). ALJ Decision at 8; SOF 33, 39.[7] He was placed on modified elopement precautions, which included the use of a WanderGuard device. ALJ Decision at 9; SOF 39.

ALJ Decision

The ALJ determined that CMS was entitled to judgment as a matter of law because the stipulated facts established that Brightview

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[6] The Brightview receptionist was given a written "Employee Report" noting that she was warned and counseled "for not following the proper procedures regarding residents on elopement precautions." SOF 31.

[7] Following his elopement and return, elopement precautions were included in Resident #2's plan of care for the first time. SOF 33.

did not ensure that each resident received adequate supervision and assistance devices to prevent accidents, as required by 42 C.F.R. § 483.25(h)(2). ALJ Decision at 9-15.[8] The ALJ reasoned, inter alia, that Resident #2 was a known elopement risk and that the Brightview receptionist permitted him to leave the building contrary to her responsibilities under facility policy. Id. at 11-15. The ALJ further held that CMS's determination that Brightview's noncompliance was at the immediate jeopardy level was not clearly erroneous (id. at 15-16), and that the $3,050 per instance CMP assessed against Brightview was reasonable (id. at 17-18).

Brightview disagreed with and appealed all of the FFCLs in the ALJ's Decision. P.R.R. at 1.

Applicable law

Long-term care facilities participating in the Medicare and Medicaid programs are subject to the survey and enforcement procedures set out in 42 C.F.R. Part 488, subpart E, to determine if they are in substantial compliance with applicable program requirements at 42 C.F.R. Part 483, subpart B. "Substantial compliance" means a level of compliance with the requirements of participation such that "any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. "Noncompliance," in turn, is defined as "any deficiency that causes a facility to not be in substantial compliance." Id.

A long-term care facility found not to be in substantial compliance is subject to various enforcement remedies, including a per-instance or per-day CMP. 42 C.F.R. §§ 488.402(c), 488.406, 488.408, 488.430. When civil money penalties are imposed for an instance of noncompliance, the penalties will be in the range of $1,000 to $10,000 per instance. 42 C.F.R. § 488.438(a)(2). The regulations set out a number of factors that CMS considers in determining the amount of a CMP. 42 C.F.R. § 488.438(f); § 488.404.

[8] The ALJ did not adjudicate the validity of the CMS finding of noncompliance with 42 C.F.R. § 483.15(g) (medically-related social services). She found instead that Brightview's noncompliance with 42 C.F.R. § 483.25(h)(2) at an immediate jeopardy level supported the remedies imposed. ALJ Decision at 5.

"Immediate jeopardy" is defined as "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination that a deficiency constitutes immediate jeopardy must be upheld unless it is clearly erroneous. Woodstock Care Center, DAB No. 1726, at 39 (2000) (citing 42 C.F.R. § 498.60(c)), aff'd, Woodstock Care Ctr. v. U.S. Dept. of Health and Human Servs., 363 F.3d 583 (6th Cir. 2003).

The participation requirement at issue here — that a facility ensure adequate supervision to prevent accidents — falls under the "quality of care" requirements, which share the same regulatory objective 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." 42 C.F.R. § 483.25. Section 483.25(h) provides in relevant part:

> *Accidents.* The facility must ensure that -
>
> * * *
>
> (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

Standard of Review

Our standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. Our standard of review on a disputed finding of fact is whether the ALJ decision is supported by substantial evidence in the record as a whole. Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs (Guidelines), http://www.hhs.gov/dab/guidelines/prov.html; Batavia Nursing and Convalescent Inn, DAB No. 1911, at 7 (2004), aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson, 143 F. App'x 664 (6th Cir. 2005); Hillman Rehabilitation Center, DAB No. 1611, at 6 (1997), aff'd, Hillman Rehabilitation Ctr. v. U.S. Dep't of Health and Human Servs., No. 98-3789 (GEB) (D.N.J. May 13, 1999).

We review de novo the legal issue of whether the ALJ's grant of summary disposition was appropriate. Lebanon Nursing and Rehabilitation Center, DAB No. 1918, at 4 (2004).

Analysis

I. The ALJ correctly granted summary judgment to CMS.

In its briefs on appeal, Brightview argues that the ALJ erred in her application of the summary judgment standard to resolve CMS's motion for summary disposition. P.R.R. at 3-4; Pet. Reply at 2-5. Brightview contends that the ALJ failed to view the evidence in the light most favorable to Brightview and failed to draw reasonable inferences for Brightview which together would have established that CMS was not entitled to judgment as a matter of law. P.R.R. at 3-4, 6-10; Pet. Reply at 2-5.

While the ALJ did not fully state the standard for summary judgment, or summary disposition, in her decision, her discussion suffices to establish that no inferences could reasonably have been drawn sufficient to deny CMS judgment as a matter of law. See ALJ Decision at 4-5. The ALJ stated that CMS was entitled to summary judgment if it had made a prima facie showing that Brightview was not in substantial compliance with a participation requirement, and had demonstrated that there was no dispute about any material fact supporting its case and that it was otherwise entitled to judgment as a matter of law. Id. On the other hand, the ALJ said, CMS was not entitled to summary judgment if Brightview had proffered evidence "that would permit the ALJ to conclude that it was in substantial compliance with Medicare participation requirements during the relevant time." Id., quoting Livingston Care Center, DAB No. 1871, at 6 (2003).

The ALJ's formulation was correct in part, but incomplete. The ALJ omitted to state that a contested summary judgment or summary disposition motion can only be granted once the ALJ has viewed the evidence in the light most favorable to the non-moving party, and has drawn all reasonable inferences from the evidence in that same party's favor. Once that is done, if the ALJ finds the moving party entitled to judgment as a matter of law, then summary disposition may be entered. These prerequisites are well-established elements of summary disposition law under Departmental Appeals Board practice. See Madison Health Care, Inc., DAB No. 1927, at 5-7 (2004) and cases cited therein. They are also well-established parts of federal courts' summary judgment practice under Rule 56 of the Federal Rules of Civil Procedure (see, e.g., Matsushita Elec. Industrial Co. v. Zenith Radio, 475 U.S. 574, 587 (1986)), which the Board refers to as a source of guidance (see, e.g., Alden-Princeton Rehabilitation and Health Care Center, DAB No. 1978, at 5, n.1 (2005)).

In the present case, the material facts were not in dispute in light of the stipulations, but the parties disputed how those facts should be viewed and what inferences should be drawn from them, in addition to how the relevant legal requirements should be applied to the facts. The ALJ did not make explicit her rejection of the views and inferences proposed by Brightview as unreasonable. Nevertheless, her decision as a whole makes clear that she did not in fact find them reasonable. No prejudice could inure to Brightview from any lack of clarity about this since we find de novo that the inferences and views propounded by Brightview are not reasonable and could not as a matter of law serve to alter the outcome.[9] See, e.g., Carmel Convalescent Hospital, DAB No. 1584, at 19 (1996) (harmless error standard).

For the reasons discussed in the next section, we conclude that the record established before the ALJ supports summary disposition for CMS in this case under a correct application of the summary disposition standard and the rules governing long-term care facilities.

II. CMS is entitled to judgment as a matter of law, based on the stipulated facts and joint exhibits, even drawing all reasonable inferences in Brightview's favor and viewing the facts in the light most favorable to Brightview.

As noted above, the regulations require each long-term care facility to "ensure that . . . [e]ach resident receives adequate supervision and assistance devices to prevent accidents." Section 483.25(h)(2). In a series of cases the Board has applied the requirements of this provision. In Woodstock Care Center, DAB No. 1726 (2000), aff'd, Woodstock Care Ctr. v. U.S. Dept. of Health and Human Servs., 363 F.3d 583 (6th Cir. 2003), the Board held that the regulation imposes an affirmative duty on a facility to provide supervision and devices to prevent accidents to the highest degree practicable. DAB No. 1726, at 25-35. On appeal, the Court of Appeals for the Sixth Circuit affirmed, reiterating that long-term care facilities must take "all reasonable precautions against residents' accidents." 363 F.3d at 589. In the years since that ruling the Board has reiterated and applied the Woodstock requirement numerous times. See, e.g., Eastwood Convalescent Center, DAB No. 2088, at 4, 12 (2007); and

[9] Brightview recognizes that we review grants of summary disposition on a de novo basis, since they present an issue of law. P.R.R. at 17.

Golden Age Skilled Nursing & Rehabilitation Center, DAB No. 2026, at 11 (2006).

A. Brightview breached its own elopement prevention programs.

Our analysis begins with a review of Brightview's own elopement prevention programs, and whether or not they were followed in this instance. This is not to say that the Brightview programs were necessarily adequate in all instances to ensure the facility's compliance with 42 C.F.R. § 483.25(h)(2). Rather, Brightview's own programs provide a starting point for our review because they are the policies the facility itself has designed to ensure that its residents have adequate supervision (and assistance devices) to prevent accidents. The Board has previously observed that summary judgment may be appropriate in cases arising under section 483.25(h)(2) "[i]f a facility concedes that it identified a risk in the resident assessment and that it either failed to plan for the risk or failed to follow its own plan . . . ." St. Catherine's Care Center of Findlay, Inc., DAB No. 1964, at 13, n.9 (2005).

At the time of the elopement incident, Brightview had two written policy statements, one for preventing elopement and one for addressing wandering (including wandering that might involve elopement). The elopement prevention program guidelines, dated "Rev. 11/02," provided for:

- each resident to be assessed by a nurse for risk of elopement;
- the nurse to notify her supervisor and director of nursing if the assessment indicates a risk of elopement;
- one of them to take a photograph of the resident;
- the supervisor or nurse in charge of house to show the photograph of the resident (and mention his or her elopement risk) to all members of the interdisciplinary team;
- the supervisor to notify the receptionist of this resident's elopement risk, and post the photo at the reception desk;
- the receptionist to "maintain vigilance to make sure that the resident does not leave the building and

> [to] notif[y] [the] nursing department if resident behavior regarding leaving the building escalates;"
>
> - the nurse to document the methods of elopement prevention initiated and the resident's response;
> - the nurse to place the information in the 24-hour report and the supervisor to place it in his or her report;
> - the director of nursing or supervisor to notify the interdisciplinary team at the morning report;
> - the nursing supervisor to notify the weekend social worker; and
> - the residents to be reassessed for elopement risk as defined in the guidelines.

SOF 30; Jt. Ex. 17, at 10. To summarize, the Brightview elopement prevention program included assessing each resident for elopement risk, informing all members of the staff of the identities and physical appearances of those residents who were at risk of eloping, reminding staff members of this information, and having the receptionist maintain vigilance to make sure the resident did not leave the building.

The other Brightview policy statement in effect at the time of Resident #2's elopement, the "wandering program" statement dated 7/21/98, overlapped the elopement prevention program described above. The wandering program policy statement provided for the names and pictures of those residents identified as "elopement risk wanderers" to be posted at the front desk, and for those residents not to leave the facility unescorted. Jt. Ex. 19, at 1. The statement also explained that if a resident identified as an elopement risk was trying to leave the facility unescorted, it was the responsibility of every staff member to prevent the wanderer from leaving and to escort the resident to the front desk, notify the front desk, and have the front desk notify the charge nurse on the resident's floor to send down a staff member to escort the resident back up to his or her floor. Id. The policy also required the charge nurse to document the incident, and other staff members to do appropriate follow-up, such as notifying the family and adding any additional documentation to the chart. Id. This policy, similar to the elopement prevention policy, relied on identifying residents who were at risk for eloping, making their identities and personal appearances known to staff members, and, in the event a resident started to elope,

having a staff member stop the resident, and having the receptionist at the front desk notify a charge nurse to arrange an escort for the resident back to his or her floor. Id.

The stipulated facts show that Brightview assessed Resident #2 as an elopement risk and followed some of the steps in its elopement prevention policies (such as taking his photograph and posting it at the reception desk). However, it is also undisputed that on April 19, 2003, a Brightview receptionist permitted Resident #2 to go out on the front porch unescorted. SOF 24.

In so doing, she actually breached two provisions in Brightview's policies. She not only allowed him to leave the building unescorted, but she also failed to maintain vigilance to make sure that he did not leave the building. Further, she allowed her attention to wander sufficiently to permit him to leave the front porch and elope from the premises entirely. Once he had eloped, then he was entirely without supervision or support from the facility for his personal safety. See Woodstock Care Ctr. v. Thompson, 363 F.3d at 589 ("More significantly, a resident who has eloped and wanders an environment dangerous to him or her is completely without *any* supervision.").

Brightview acknowledges, in fact, that "[t]here is no dispute that permitting [Resident #2] to go to the front porch area was contrary to his elopement precautions, and the receptionist should not have permitted it . . . ." Pet. Motion for Summary Reversal and Opposition to Summary Affirmance at 24. Brightview also concedes that "there is no question that the sole cause of [Resident #2's] unauthorized departure from Brightview on April 19 was the failure of the receptionist to follow the elopement prevention procedures on which she had been instructed . . . ." Id. at 25.

Brightview's elopement prevention policies on their face gave the receptionist a key role in preventing residents at risk of eloping from going out the front door. Brightview asks us to infer that its receptionist was only a receptionist and not a "front door monitor," and that its overall policy and procedures for its receptionist were not a "primary means of supervising the resident" and preventing his elopement. Pet. Reply at 4. However, we cannot reasonably infer from the existence of other precautions in its elopement prevention policies and procedures that Brightview did not place considerable reliance on the front desk staff to prevent elopements. The other precautions in Brightview's policies, quoted above, were limited in their number and impact. Basically, the policies required all staff members to monitor "elopement risk" residents and stop them from leaving

the facility unescorted. The policies assume that all staff members will do this in addition to their other responsibilities. The receptionist alone was assigned the duty to "maintain vigilance to make sure that the resident does not leave the building." SOF 30; Jt. Ex. 17, at 10.

Certainly, at a minimum, the Brightview staff were not to facilitate elopements by letting residents at risk go outside to an insecure area without an escort. Unfortunately, the receptionist here not only failed to stop Resident #2 from going out the front door without an escort, she affirmatively told him, in response to his request, that he could do so. SOF 24. This was a serious breach of both the elopement and the wandering policies, and resulted in exactly the kind of problem the policies were intended to prevent. The ALJ correctly concluded that Brightview did not take reasonable steps to prevent accidents, as required by section 483.25(h)(2), because it failed to take the steps it planned itself to address the risk it had identified.[10]

B. *Brightview's argument that it is not responsible because Resident #2 "tricked" the receptionist and eloped "deliberately" is without merit.*

Brightview argues that "viewing the evidence in the light most favorable to Brightview" and drawing "all reasonable inferences in Brightview's favor" would establish that Resident #2 did not "wander" away from the facility as suggested by the ALJ (ALJ Decision at 13), "but instead deliberately violated the limitations imposed on him and left Brightview by tricking the receptionist into letting him go onto the porch . . . ." P.R.R. at 9-10. Brightview argues that "the risk that [Resident #2] would attempt to leave the facility in that manner was not reasonably foreseeable," and therefore Brightview should not be held responsible for his elopement. Id. at 10-11.

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[10] Brightview points to several factual comments in the ALJ discussion as showing that the ALJ drew unnecessary inferences from the facts of record which were unfavorable to Brightview. Specifically, the ALJ stated that evidently Brightview residents were often allowed outside to smoke and that having multiple residents outside smoking increased the risk of elopements. ALJ Decision at 13. These comments were not necessary to the decision, are not supported by the stipulated facts or joint exhibits, and we do not accept or rely on them in reaching our conclusions.

Insofar as Brightview contends that it is not responsible for providing adequate supervision under 42 C.F.R. § 483.25(h)(2) when one of its residents has acted "intentionally" or "deliberately," the Board has rejected such contentions. Many long-term care facility residents suffer from varying degrees of dementia, and other cognitive and psychological problems. Long-term care facilities cannot avoid responsibility for providing supervision to prevent accidents to such residents by attributing intentionality to the residents. In Woodstock Care Center, the Board explained:

> The ALJ rejected Woodstock's contention that behaviors like attacking another resident or leaving the facility are volitional, intentional acts. ALJ Decision at 13. The ALJ found that, given the severely-demented state of the residents involved in this case and the facility's awareness of their proclivities and illnesses, the departures and altercations were more likely uncontrolled behaviors rather than willed acts. ALJ Decision at 14.
>
> We agree. As the ALJ pointed out, it is difficult to imagine a meaningful or appropriate sense in which one might consider these events intentional from the viewpoint of "actors" who are plainly described in Woodstock's records as confused, unable to function outside of a supervised setting, and displaying a range of combative and disruptive behaviors. See ALJ Decision at 13. These "actors" were known to be suffering from advanced dementia, schizophrenia, and/or organic mental disorders, as well as from the effects of various medications, all of which suggests that malice or any other intentional mental state was likely to be beyond their capacity. Id.

DAB No. 1726, at 23-24 (emphasis in original). Resident #2's limited cognition and psychological diagnoses were known to the Brightview staff, and, in fact, were themselves reasons for his assessment as an elopement risk. SOF 19.[11] These limitations

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[11] Resident #2 was deemed an elopement risk because he had a diagnosis of dementia and/or severe confusion or delirium; he was not oriented as to place and would be unable to find his way back to the facility or give its name; and he was unable to function safely in the community, and could not recognize danger (e.g., crossing streets). SOF 19 (Elopement Risk Assessment

(continued...)

also made him particularly dependent on the facility staff for monitoring to forestall all kinds of possible accidents. Once he was allowed to go out of the building and then to elope off the premises, the facility's ability to ensure that he received adequate supervision to prevent accidents was obviously compromised.

Even if Resident # 2's state of mind were legally relevant to Brightview's duty to ensure that he was adequately supervised, the stipulated facts and joint exhibits provide no foundation for Brightview's view of Resident #2 as a person capable of "deliberately" breaking the rules and "tricking" the facility's receptionist, and Brightview proffered no additional evidence to support this claim. As noted above, he had been diagnosed with major cognitive and psychiatric deficits, as well as short- and long-term memory problems. SOF 14, 17, 21. He was easily distracted and suffered from delusions. Jt. Ex 14, at 40-41.[12] Given these mental and psychological traits, it would be unreasonable to characterize Resident #2's leaving the front porch at Brightview as "intentional" in any meaningful way. See Woodstock Care Center, DAB No. 1726, at 23-24. Nor can his request to go out be reasonably characterized as part of a scheme to "trick" the receptionist into lowering her guard.[13]

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[11](...continued)
Protocol) (Feb. 27, 2003).

[12] For example, Brightview's records for the period just preceding Resident #2's elopement state: "still delusional — have ideas about going to Las Vegas to work. According to the resident he is still working and people are going to be mad if he is late for work." Jt. Ex. 14, at 41.

[13] In any event, the only factual support Brightview cites for this contention was that Resident # 2 said he would stay on the porch but "left [the outdoor porch] quickly and deliberately, as evidenced by the fact that he could not be located after a search of the area immediately surrounding the building." P.R.R. at 10. The mere fact that the resident did not comply with his "promise" when the receptionist failed to observe him cannot reasonably support the proposed inference that his departure was deliberate, given the circumstances here. His cognitive status was sufficiently unreliable that he may have simply forgotten his promise to the receptionist or become disoriented or distracted by something and wandered off.

Even assuming Resident #2 had the mental capacity to "trick" the receptionist (and the facility's own assessment of him argues against this), he left the building via the front door, in full view of the receptionist and with her consent. Plainly, this scenario is exactly the type of situation that the two Brightview policies were written to address: The names and pictures of those residents identified as "elopement risk wanderers" were to be posted at the front desk, and those residents were not to be allowed to leave the building unescorted. The receptionist in particular was to "maintain vigilance to make sure that the resident does not leave the building." The drafters of these policies clearly foresaw that residents might elope by going out the front door, and assigned the receptionist the responsibility of "maintaining vigilance" to prevent this, summoning other staff members as needed.

All the receptionist had to do to fulfill her responsibility under the facility policy when he asked her if he could go on the front porch, was to say no, and perhaps redirect him to the fully enclosed back patio, where smoking was allowed. See SOF 38. If he disagreed or persisted, she could have gotten assistance from another staff member or called for an escort for him, as the Brightview policies instructed.

In interpreting and applying section 483.25(h)(2), the Board has acknowledged that taking steps to prevent accidents does involve an element of reasonableness, and that deciding whether a facility has taken all reasonable steps involves assessing whether it could reasonably foresee that an accident might occur under the circumstances. See, e.g., Eastwood Convalescent Center, DAB No. 2088, at 4, 12-18 (2007) (assessing the foreseeability of accidents and risk for a resident who the facility allowed to leave a dialysis center with her husband, via wheelchair, for a number of hours without medications). However, a facility is not permitted to ignore foreseeable risks, or later disclaim responsibility, simply because the exact time, place, or manner of the risk was not predictable. See, e.g., Century Care of Crystal Coast, DAB No. 2076 (2007) (finding it foreseeable that the facility's failure to enforce its smoking policy would lead to a resident burning himself); Lutheran Home at Trinity Oaks, DAB No. 2111 (2007) (circumstances apparent to facility determine if harm should have been anticipated); Josephine Sunset Home, DAB No. 1908, at 13-16 (2004) (an accident may be foreseeable even if it has not previously occurred to the same person in the same way).

In the instant case, the facility recognized that Resident #2's elopement was foreseeable when it assessed him as at risk for

elopement. Here, the elopement was not only foreseeable, but actually occurred with the active assistance of the Brightview staff receptionist. The facility should have realized that if Resident #2, or any other resident at risk for elopement, was left unattended on the unsecured front porch, he might easily walk off. This was not a novel or unique way to elope.

C. The Board's decision in Alden-Princeton does not support Brightview's position.

Brightview relies on a Board decision in a prior nursing home case reversing summary judgment to support its arguments for reversal here. Pet. Reply at 3-7, citing Alden- Princeton Rehabilitation and Health Care Center, DAB No. 1978 (2005). In Alden-Princeton, the Board reversed the ALJ's conclusion that placing photos of potential elopers at a receptionist desk near the front doors of a building with a locked third floor dementia ward necessarily implied that the receptionist was intended to monitor for elopers. Alden-Princeton, DAB No. 1978, at 9. The ALJ reasoned that the failure to have a receptionist continuously monitoring for elopers must therefore constitute a failure as a matter of law to provide adequate supervision. Id. The Board found that Alden-Princeton raised a genuine dispute of material fact about whether its anti-elopement procedures included continuous monitoring by the receptionist. Id. at 10-11. Instead, the Board found that viewing the evidence proffered before the ALJ in the light most favorable to Alden-Princeton could reasonably support a contrary inference that the receptionist's desk was not intended as a primary measure against elopement, given that continuous monitoring was not required by the facility's elopement policy and numerous other measures were in place (including a coded elevator keypad and operational door alarms on the locked third floor ward). Id. at 13. Therefore, the Board remanded to the ALJ to provide further proceedings.

Brightview contends that the ALJ here similarly erred by relying on her prior decision to hold that Brightview failed as a matter of law by not keeping its receptionist free of other duties so as to watch for possible elopers. P.R.R. at 7-8; cf. ALJ Decision at 10-15. The critical distinction which Brightview ignores is that Brightview's policy expressly called on the receptionist to "maintain vigilance" as an integral part of its anti-elopement measures. The nature of the receptionist's intended role in the present case, unlike in Alden-Princeton, was a matter of record, not a matter for inference alone. Although Brightview suggests that vigilance by the receptionist was only one of a number of other measures listed in its policy, Brightview points to nothing analogous to the redundant technological systems in place in

Alden-Princeton that could support an inference that Brightview did not intend human monitoring to be a primary means of preventing elopements.

The situation in Brightview is more like that in another case in which a facility placed a receptionist in the position of serving as a primary line of defense against elopement, Liberty Nursing and Rehabilitation Center – Mecklenberg County, DAB No. 2095, at 15-20 (2007). The Board there upheld an ALJ holding that a receptionist who was distracted by performing other duties could not be considered to be providing effective "24-hour monitoring" of two front exits.

Brightview's elopement prevention and wandering programs specifically assign responsibility to the receptionist to ensure that residents assessed as at risk for elopement do not leave the building unescorted. Jt. Ex. 17, at 10; Jt. Ex. 19, at 1. In this case, the receptionist failed to fulfill her elopement prevention responsibilities on April 19, 2003, and that lapse enabled Resident #2 to elope. No other inference can reasonably be drawn.[14]

III. The ALJ did not err in finding that CMS's immediate jeopardy determination was not clearly erroneous.

Brightview contends that the ALJ erred in finding that CMS's immediate jeopardy determination was not clearly erroneous. However, we conclude that the ALJ was correct. For immediate jeopardy to exist, the resident need not suffer actual harm. If the facility's violation of the condition of participation is likely to cause harm or serious injury, that provides an adequate basis for finding immediate jeopardy. 42 C.F.R. § 488.301; see, e.g., Southridge Nursing and Rehabilitation Center, DAB No. 1778, at 10-12 (2001) (resident was likely to suffer harm from exposure

[14] In its appeal, Brightview objects to the ALJ's including statements from its quality assurance committee summary in her decision, arguing that this contravenes 42 C.F.R. § 483.75(o)(4). We need not reach this contention, however, since the ALJ expressly stated that she would reach the same conclusions on the record before her even if the quality assurance summary were excluded. After reviewing the ALJ's Decision and the full record in this matter, we conclude that the ALJ's decision was sufficiently supported by the stipulated facts and joint exhibits we have cited here, and the statements from the quality assurance committee summary were not necessary to the outcome in this case.

to the elements when his wheelchair rolled down a steep hill outside the facility and he had to spend the night outside on the ground because he was unable to get help).

In the instant case, the ALJ found, and we agree, that the elopement was likely to cause Resident #2 serious injury, harm, impairment, or death. ALJ Decision at 16. He was unsupervised in an urban area for up to six and one-half hours, with problems of dementia, delusions, disorientation, confusion, and frailty. Id. He was assessed at risk for falls, which could only increase with him unobserved in unfamiliar terrain. ALJ Decision at 6-8, 16; SOF 18. He had been assessed as unable to function safely in the community, due to his inability to recognize dangers, such as crossing streets. ALJ Decision at 6, 16; SOF 19. Brightview is in Chicago, in a very busy traffic area with fast moving and heavy traffic to the north, south and west streets adjacent to it. ALJ Decision at 16; Jt. Ex. 1, at 4.

It is also relevant that the elopement of Resident #2 exposed a more general flaw in Brightview's anti-elopement policy. If the receptionist's other duties and distractions interfered with the kind of vigilance necessary to prevent Resident #2 from eloping, the problem also placed at risk the other residents who had the potential to elope. Until an effective system was in place, it was likely that other vulnerable residents might also leave the premises by similar means.

Based on these factors, we do not find CMS's immediate jeopardy finding to be clearly erroneous. Accordingly we sustain the ALJ's upholding of CMS's finding of immediate jeopardy.[15]

IV. The ALJ did not err in finding that the amount of the per-instance CMP was reasonable.

The ALJ concluded that the CMP assessed by CMS, a per-instance penalty of $3,050, was reasonable. ALJ Decision at 17-18. Brightview took exception to this conclusion on the grounds that: "[Brightview's] prior history of noncompliance in general is good, and there is no history of noncompliance of the type alleged to exist in this case;" "[t]here was no actual harm in

[15] We have upheld a deficiency under section 483.25 at the immediate jeopardy level, which constitutes substandard quality of care as defined at 42 C.F.R. § 488.301. Therefore, Brightview was correctly subject to a two-year prohibition on approval for its NATCEP program pursuant to 42 C.F.R. §§ 483.151(b)(2)(iii) and 488.310(c).

this case, . . . [and] the potential for harm . . . was minimal;" "[a]ny deficient practice reflected in the record is indisputably isolated;" and Brightview's "degree of culpability is relatively low . . . ." P.R.R. at 16.

Our starting point in this analysis is the range of per-instance CMPs allowed: $1,000 to $10,000. 42 C.F.R. § 488.438(a)(2). An ALJ reviewing the imposition of a CMP must consider four factors identified in section 488.438(f). The first factor is the facility's history of noncompliance. Although Brightview says its record of compliance "in general is good," and that it had no prior citation under section 483.25(h)(2) (P.R.R. at 16), Brightview does have a history of noncompliance, with citations in the years 1998 to 2000.[16] The second factor is the facility's financial condition. Brightview reported a net profit of $273,647, as defined in paragraph 19, line 43, of its Illinois Public Aid Medicaid cost report, for the period January 1, 2002 to December 31, 2002. ALJ Decision at 17; SOF 40. Its total adjusted net profit, as defined in the same report, for the same period, was $662,622. Id. The ALJ did not err in weighing this second factor and concluding that the evidence shows that Brightview could pay a CMP of $3,050. ALJ Decision at 17. The third factor includes the points specified in section 488.404, the scope and severity of the deficiency and the facility's prior history with respect to the cited deficiency. Here, the ALJ noted that, although the deficiency was an isolated incident, the noncompliance was at the immediate jeopardy level. ALJ Decision at 17. The fourth factor is the facility's degree of culpability, including but not limited to neglect, indifference, or disregard for resident care, comfort or safety. Section 488.438(f)(4). The ALJ did not rely on any finding of culpability to increase the CMP. Id.

The ALJ also noted that the per-instance amount imposed here was the same as the minimum amount that could be imposed for a single day of immediate jeopardy had a per-day CMP been imposed. ALJ

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[16] Specifically, D and E level deficiencies were noted in a 1997 survey (no remedies imposed). SOF 41. Allegations of a G level deficiency were noted in July 1998 and another G level deficiency was noted in August 1998. Two D level deficiencies were also alleged in the same survey cycle that concluded in December 1998 (a $4,900 CMP was imposed). Id. Between October 29, 1999 and January 20, 2000 surveyors documented an E and a G level violation, remedies were imposed, Petitioner appealed, and a decision had not yet been issued at the time of briefing in 2003-04. Id.; ALJ Decision at 17.

Decision at 18. By analogy, the ALJ concluded that $3,500, which was in the lower half of the per-instance CMP range, was not an unreasonable amount in these circumstances. Id.

We find no error in the ALJ's analysis in determining that a per-instance CMP of $3,050 was reasonable.

Conclusion

For the reasons stated above, we conclude that summary disposition was appropriate. We sustain the ALJ's conclusion that Brightview was not in substantial compliance with 42 C.F.R. § 483.25(h)(2), and conclude that the ALJ did not err in finding that CMS's immediate jeopardy level finding was not clearly erroneous and that the amount of the per-instance CMP was reasonable.

/s/
Judith A. Ballard

/s/
Sheila Ann Hegy

/s/
Leslie A. Sussan
Presiding Board Member