Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: May 7, 2008
Harlan Nursing Home,	
Petitioner,	Civil Remedies CR1644 App. Div. Docket No. A-08-22
- v. -	Decision No. 2174
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Harlan Nursing Home (Harlan) requested review of the decision of Administrative Law Judge (ALJ) Jose A. Anglada in Harlan Nursing Home, DAB CR1644 (2007)(ALJ Decision). The ALJ Decision upheld the determination by the Centers for Medicare & Medicaid Services (CMS) to impose on Harlan a civil money penalty (CMP) of $8,050 per day for the period August 9 through 17, 2005 and a CMP of $100 per day for the period August 18 through 25, 2005. CMS found, and the ALJ agreed, that Harlan was not in substantial compliance with the federal participation requirements at 42 C.F.R. § 483.25(h)(2) (requiring a facility to provide adequate supervision and assistance devices to prevent accidents) and § 483.75 (requiring a facility to administer its resources effectively and efficiently so as to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident). The ALJ also upheld as not clearly erroneous CMS's determination that Harlan's noncompliance was at the immediate jeopardy level from August 9 through 17, 2005.

On appeal, Harlan argues that it was in substantial compliance with sections 483.25(h)(2) and 483.75. Harlan also takes the

position that, even if it was not in substantial compliance, either there was no immediate jeopardy or the immediate jeopardy was removed on August 9 or 10. As explained below, we conclude that the ALJ Decision is free of legal and procedural error and supported by substantial evidence in the record as a whole. Accordingly, we affirm the ALJ Decision.[1]

Applicable Legal Provisions

The ALJ Decision sets out the applicable laws and regulations (ALJ Decision at 3-4), so we do not repeat them here.

Case Background

CMS's determination to impose remedies was based on State survey agency findings following a complaint survey completed on August 12, 2005 and a revisit survey completed on August 23, 2005. In support of the noncompliance cited under section 483.25(h)(2), the Statement of Deficiencies states in part:

> [T]he facility failed to provide adequate supervision to prevent accidents for 6 of 6 residents. The facility's system for monitoring the whereabouts of 6 residents who were identified to be at risk for elopement included the use of alarms on the exit doors. The facility staff knowingly disarmed the exit door alarm system on the West unit to allow for supply deliveries without implementing protective measures to monitor the residents who were at risk for elopement. In addition, direct care staff members were not trained regarding use of the alarm system and were not made aware when the alarm system was disengaged to assure continued supervision of the residents. Resident Number 1 exited the facility on August 9, 2005, and left the grounds without staff knowledge. The facility staff was not aware of the elopement for at least one hour after the resident was last observed by the staff to be in the facility . . . . [T]he resident was found to be deceased in an open field behind the facility.

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[1] Harlan does not specifically dispute the non-immediate jeopardy CMP imposed for the period August 18 through 25. In any event, we sustain the ALJ's decision to uphold its imposition since Harlan does not point to any basis for finding that substantial compliance was achieved before August 26 or that a $100 per day CMP was unreasonable.

CMS Ex. 1, at 4-5 (quoted in ALJ Decision at 13).

In support of the noncompliance cited under section 483.75, the survey report repeats some of the same findings and further states: "The administration failed to ensure that residents with known elopement risks (Residents 1, 2, 3, 4, 5 and 6) were supervised to assure that they did not elope from the facility through unmonitored exit doors." CMS Ex. 1, at 13 (quoted in ALJ Decision at 13).

Standard of Review

We review a disputed finding of fact to determine whether the finding is supported by substantial evidence, and a disputed conclusion of law to determine whether it is erroneous. Departmental Appeals Board, *Guidelines for Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs,* http://www.hhs.gov/dab/guidelines/prov.html; Batavia Nursing & Convalescent Inn, DAB No. 1911, at 7 (2004), aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson, 143 Fed.Appx. 664 (6th Cir. 2005).

Analysis[2]

Substantial evidence in the record supports the ALJ's conclusion that Harlan failed to substantially comply with sections 483.25(h)(2) and 483.75.

Below, we explain why we reject Harlan's arguments that some of the findings of fact on which the ALJ based his conclusion that Harlan failed to substantially comply with sections 483.25(h)(2) and 483.75 are not supported by substantial evidence.

Harlan takes exception to the ALJ's finding that Harlan "failed to provide six residents who were at risk for elopement . . . with adequate supervision" (ALJ Decision at 5), arguing that "there is not one single example, much less substantial evidence in the record, to support the finding that at-risk residents were not monitored." P. Br. at 2. According to Harlan, the "only evidence of an elopement was the incident with Resident #1 in August 2005" and "there was never even a single incident prior to

[2] We have fully considered all of Harlan's arguments on appeal, regardless of whether we have specifically addressed particular assertions or documents.

the one at issue where he or any other person left the building without the alarm sounding and the staff immediately responding and redirecting the resident safely back inside." Id. In essence, Harlan takes the position that Resident 1's elopement was not a basis for finding that Harlan failed to adequately supervise its residents since the elopement was unforeseeable.

Contrary to what Harlan's argument suggests, the ALJ relied on evidence in addition to Resident 1's elopement in concluding that Harlan failed to adequately supervise its residents. The ALJ Decision discusses at length evidence in the record showing that Harlan had a practice of disarming the door alarms and that staff were ignorant "as to the manner of operation of the alarm system[.]" See ALJ Decision at 8-12. The ALJ found it particularly significant that some staff were unaware that the door alarms were designed to be armed and disarmed by flipping a switch on alarm panels that controlled the doors in each wing of the building and that it was thus possible for a door alarm to be disarmed even though a light indicated that the alarm system was armed. Id. at 10 and n.5.

Harlan does not dispute that it had a practice of disarming the door alarms, or that some staff were ignorant as to the proper operation of the alarm system. Harlan takes issue with the ALJ's reliance on a statement in Ms. Burton-Brock's testimony that "when I started . . . questioning people what the switches were for, nobody could tell me that information." Tr. at 79, cited in P. Br. at 7. However, the ALJ Decision does not cite the transcript page at which that statement appears. Rather, he cites evidence showing that a number of employees when questioned by the surveyors made responses indicating that they did not understand the function of the switches. See ALJ Decision at 10-11 (citing testimony and/or notes of Surveyors Burton-Brock and Estes[3] regarding their interviews on August 10 with seven staff members–Nurse Aides Rigney, Birchfield, and Boggs, Nurse Supervisor Mefford, and the Administrator, Director of Nursing (DON), and Social Services Director).

Furthermore, Harlan's reliance on the fact that no resident had eloped before Resident 1 eloped on August 9 reflects a fundamental misunderstanding of the requirement at section 483.25(h)(2) that a facility ensure that each resident receives

[3] The ALJ states that the interviews were conducted by Surveyor Burton-Brock but cites to testimony and notes of Surveyor Estes as well as Surveyor Burton-Brock.

adequate supervision to prevent accidents. The Board has repeatedly explained that this requirement–

> obligates the facility to provide supervision and assistance devices designed to meet the resident's assessed needs and to mitigate foreseeable risks of harm from accidents. In addition, the Board has indicated that a facility must provide supervision and assistance devices that reduce known or foreseeable accidents 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) (citations omitted). Thus, the regulation focuses on the need to prevent accident risks (such as elopements), not on whether an accident occurs. The fact that Resident 1 had repeatedly tried to elope in the past, only to be stopped when the alarm sounded and staff who responded to the alarm redirected him, made it entirely foreseeable that Resident 1 could successfully elope when the alarm was disarmed, as it was on August 9. Accordingly, in disarming the alarm without making other arrangements to supervise its residents, Harlan failed to provide supervision to reduce a foreseeable accident risk in violation of the regulation.

Harlan's appeal also raises a question as to what type of supervision of Resident 1 would constitute adequate supervision within the meaning of section 483.25(h)(2). The ALJ found that the facility itself had assessed Resident 1, whose diagnoses included dementia, a history of schizophrenia, and chronic obstructive pulmonary disease, as needing supervision at all times due to a history of elopement from his prior facility. ALJ Decision at 6, citing CMS Ex. 11, at 1, 5; see also id., citing CMS Ex. 4, at 24 (Surveyor Burton-Brock's notes of interview with Harlan's Minimum Data Set Coordinator). Harlan does not dispute this but argues that section 483.25(h)(2) does "not require one-on-one uninterrupted supervision, even with residents at high risk for elopement." P. Br. at 5. Harlan appears to misapprehend what constitutes adequate supervision within the meaning of the regulation. As the Board has repeatedly stated, the regulation gives facilities "the 'flexibility to choose the methods of supervision' to prevent accidents as long as the methods chosen are consistent with the resident's needs and ability to protect himself/herself from harm." Liberty Commons Nursing and Rehab - Alamance, DAB No. 2070, at 3 (2007), citing Golden Age Skilled Nursing & Rehabilitation Center, DAB No. 2026 (2006) and Woodstock Care Ctr. v. Thompson, 363 F.3d 583 (6th Cir. 2003). We find Harlan's own assessment of Resident 1's need

for supervision at all times to be persuasive evidence of the supervision that was necessary. See Golden Age Skilled Nursing & Rehabilitation Center at 12 (relying on SNF's care plan assessment that resident's impaired vision put her at high risk for falls). Moreover, even if Harlan did not intend by its assessment to require that staff know Resident 1's whereabouts at all times when the alarm system was armed, this resident clearly required this degree of supervision when the alarm system was disarmed in light of his diagnoses and his history of eloping.[4]

Harlan also disputes the ALJ's finding that proper training on the operation of the alarm system was absent or inadequate.[5] P. Br. at 3-4. According to Harlan, "[i]t is unrefuted in the record that staff members were trained on the alarm system in orientation and on a one-to-one basis before being responsible for the supervision of residents on the floor." P. Br. at 3. As discussed below, we conclude that there is substantial evidence in the record that Harlan's new employee orientation did not include training on the operation of the alarm system. We further conclude that any one-to-one training on the operation of the alarm system provided "on the floor" for new staff was inadequate.

The ALJ Decision cites to several pieces of evidence showing that Harlan's new employee orientation did not include training on the operation of the alarm system. That evidence includes the affidavit of Ms. Ford, Harlan's corporate quality assurance nurse consultant, that four nurse aides (Ms. Birchfield, Ms. Boggs, Ms.

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[4] Harlan also disputes the survey finding that facility staff were not aware of Resident 1's elopement for at least one hour after the resident was last observed to be in the facility. P. Br. at 4 (alleging that at most 20 minutes elapsed). In fact, the ALJ noted that several different times were reported by different people. ALJ Decision at 8. Moreover, the ALJ found, and we agree, that it was unnecessary for him to reconcile these time differences in order to determine whether the facility failed to provide residents at risk for elopement with adequate supervision and assistance devices to prevent accidents. Id.

[5] We assume that Harlan is disputing this finding (at page 10 of the ALJ Decision) although its brief refers only to the finding in the Statement of Deficiencies that "direct care staff members were not trained on the use of the alarm system[.]"

Blas, Ms. Ramsey) received instruction on the alarm system only when they attended Harlan's nurse aide training program (for employees not already certified as nurse aides who were seeking certification) or "in orientation on the floor[.]"[6] P. Ex. 6, at 2-4. The affidavit also indicates that a fifth employee who was already certified as a nurse aide when she was hired by Harlan (Ms. Curtis) received instruction on the alarm system only in "the orientation on the floor." Id. at 4. The ALJ found that Ms. Ford's affidavit constituted "an implied admission" that these individuals did not receive training on the alarm system during the new employee orientation. ALJ Decision at 11. The affidavit also identifies four other employees interviewed by Ms. Ford (LPN Engle, Nurse Aide Newsome, Nurse Aide Amburgy, and Nurse Supervisor Morgan) without indicating that they received any instruction whatsoever on the alarm system. P. Ex. 6, at 2-3. This could be viewed as further support for the ALJ's finding. The ALJ also cited Harlan's New Employee Orientation Checklist, which does not list training on the alarm system as a topic to be covered. ALJ Decision at 11, citing P. Ex. 4. In addition, the ALJ cited to Surveyor Burton-Brock's testimony regarding her interview with Ms. Lester, who was responsible for conducting Harlan's new employee orientation. Id. Ms. Burton-Brock testified that Ms. Lester told her that she did "absolutely no teaching or training on . . . the exit doors and the alarm panel" but only on the Wander-Guard system.[7] Tr. at 61-62. According to Ms. Burton-Brock's notes of her interview with Ms. Lester, moreover, Ms. Lester stated that she did not go over arming the alarm system in orientation but that instead each "orientee" was assigned to a nurse or nurse aide whom she assumed "will teach them[.]" CMS Ex. 4, at 27.

The ALJ Decision does note that, contrary to the evidence described above, Ms. Ford testified during the hearing that training on the operation of the alarm system was included in part of Harlan's initial orientation for new staff members. ALJ Decision at 11, citing Tr. at 183-85. As the ALJ found, however, this testimony was inconsistent with Ms. Ford's own affidavit. ALJ Decision at 11. Harlan does not cite to any evidence that corroborates Ms. Ford's testimony. Accordingly, the ALJ properly

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[6] As evidenced by Harlan's New Employee Orientation Checklist (Petitioner Exhibit 4), the so-called "orientation on the floor" was not part of the new employee orientation.

[7] The Wander-Guard alarm system was used for the front door only and is not at issue here. Tr. at 61-62.

found that Ms. Ford's testimony is "not supported by the credible evidence of record." Id.

Moreover, the ALJ could reasonably have discounted the importance of the evidence that some new employees had received training on the operation of the alarm system when working with assigned staff "on the floor." As discussed above, it is undisputed that a significant number of staff were ignorant of the proper operation of the alarm system. Thus, any training new employees received "on the floor" on the operation of the alarm system was likely inadequate. Furthermore, even if some employees may have received training on the operation of the alarm system as part of their nurse aide training at Harlan, such evidence is of little consequence since it does not show that Harlan had systems in place - such as training all staff during new employee orientation with follow-up training as needed - to ensure that all staff knew how to properly operate the alarm system.

Harlan further argues that the ALJ should have inferred that staff were trained on the alarm system because 1) staff were able to disarm and re-arm the alarm system for weekly deliveries and 2) except in the case of Resident 1's August elopement, the alarm sounded on the frequent occasions when Resident 1 attempted to exit the facility after having been reset each time. P. Br. at 3. The facts alleged by Harlan as the basis for this inference are not supported by substantial evidence in the record. First, not all staff were able to disarm and re-arm the alarm system when deliveries were made. The ALJ found, and Harlan does not dispute, that Ms. Birchfield, who was instructed to reset the alarm after the vendor left on the date of Resident 1's elopement, did not know that it was necessary to change the position of the switch to reset the alarm and in fact failed to reset the alarm at that time.[8] See ALJ Decision at 11-12, citing Tr. at 116-17, CMS Ex. 6, at 6, and P. Ex. 9, at 4. In addition, even assuming that someone successfully reset the alarm on prior occasions when Resident 1 exited the facility, it does not necessarily follow that all staff had received training on the alarm system. Moreover, as discussed above, even if all staff

[8] Harlan misreads the ALJ Decision as stating that another staff member successfully re-armed the alarm system later that day by pushing buttons rather than using a switch. P. Br. at 8. In fact, the ALJ was referring to the manner in which Ms. Birchfield allegedly re-armed the door alarm and was making the point that staff erroneously believed that it could be re-armed in this manner. ALJ Decision at 11.

received training on the operation of the alarm system, that training was clearly inadequate.

In connection with the ALJ's conclusion that Harlan failed to substantially comply with the requirement at section 483.75 that a facility administer its resources effectively and efficiently, Harlan disputes what it describes as the ALJ's finding "that staff was not aware of the wanderers in the building[.]" P. Br. at 2. The ALJ based this finding on evidence that, although Resident 1's Care Plan indicated he was to be monitored frequently, it contained no specific monitoring schedule, despite facility assessments that the resident needed constant supervision. See ALJ Decision at 13 and record citations therein. The ALJ also relied on evidence showing that "staff members had never seen a wandering resident list, and did not know that such a list existed." Id., citing CMS Ex. 4, at 3, 15 (Surveyor Burton-Brock's notes on interviews with facility staff); CMS Ex. 5, at 8 (Surveyor Estes' notes on interviews with facility staff); Tr. at 59, 164 (testimony of Surveyors Burton-Brock and Estes). According to Harlan, the ALJ's finding is contradicted by other testimony of Ms. Burton-Brock that all staff knew Resident 1 was always trying to escape and that staff checked the Wander-Guard bracelets that the wandering residents were wearing. P. Br. at 3, citing Tr. at 60, 138-39. Harlan also asserts that its staff "were aware of wanderers by being told orally and from caregiving on a daily basis." P. Reply Br. at 3. That assertion is consistent with the interview notes and testimony of Ms. Burton-Brock (CMS Exhibit 4, at 15, and Transcript at 59). However, while this evidence indicates that Harlan's staff may have known the identity of the residents who were considered to be wanderers through other means, it does not undercut the ALJ's finding that Harlan failed to make a list of wanderers available to its staff. Neither does it undercut the significance of that finding. To administer its resources effectively and efficiently in this instance, Harlan needed to have a system for ensuring that all staff were aware of the identify of residents who were at risk of elopement and who therefore required supervision to mitigate this risk. Instead, Harlan left staff to learn the identity of such residents on an ad hoc basis, such as through "being told orally" and "caregiving on a daily basis."

The ALJ did not err in concluding that CMS's findings that Harlan's noncompliance posed immediate jeopardy and that the immediate jeopardy continued from August 9 through August 17, 2005, were not clearly erroneous.

CMS's determination that a deficiency constitutes immediate jeopardy must be upheld unless it is clearly erroneous. 42 C.F.R. § 498.60(c). See also Beverly Health Care Lumberton, DAB No. 2156, at 4 (2008), citing Woodstock Care Center, DAB No. 1726, at 39 (2000), aff'd, Woodstock Care Ctr. v. Thompson. The Board has held that section 498.60(c) "places the burden on the SNF [skilled nursing facility] – a heavy burden, in fact – to upset CMS's finding regarding the level of noncompliance." Liberty Commons Nursing & Rehab Center v. Johnston, DAB No. 2031, at 18 (2006), aff'd, Liberty Commons Nursing and Rehab Center – Johnston v. Leavitt, 241 Fed.Appx. 76 (4th Cir. 2007), quoting (with emphasis in original) Barbourville Nursing Home, DAB No. 1962 (2005), aff'd, Barbourville Nursing Home v. U.S. Dep't of Health & Human Servs., No. 05-3241 (6th Cir. April 6, 2006).

The ALJ concluded that Harlan had not met this burden and upheld CMS's finding that immediate jeopardy existed from August 9 (the first day of noncompliance) through August 17, 2005. ALJ Decision at 15-16, 18-19. Harlan takes the position that there was no immediate jeopardy, relying on the same arguments it used to challenge the ALJ's ultimate conclusion that Harlan failed to substantially comply with the requirements of sections 483.25(h)(2) and 483.75. P. Br. at 5-6. Since we concluded above that the ALJ did not err in reaching that ultimate conclusion, we conclude here without further discussion that the ALJ correctly concluded that CMS's finding of immediate jeopardy was not clearly erroneous.

Harlan argues in addition that even if immediate jeopardy existed, it was removed on either August 9 or 10, 2005 (leaving only one or two days of immediate jeopardy, respectively). As we have stated, CMS's determination of immediate jeopardy can be overturned only if the provider shows that it is clearly erroneous. A noncompliant facility, furthermore, bears the burden of proving that it achieved substantial compliance earlier that the date determined by CMS. Sunbridge Care and Rehabilitation for Pembroke, DAB No. 2170, at 36 (2008), citing 42 C.F.R. § 488.454(e)(1). Here, Harlan failed to demonstrate that it abated the immediate jeopardy at any point prior to August 18, 2005, or that CMS's determination of the duration of immediate jeopardy was wrong, much less clearly erroneous. Also, Harlan has not shown that it achieved substantial compliance with all requirements earlier than August 26, 2005.

The ALJ found, and Harlan does not dispute, that inservice training on evaluation of wanderers, which Harlan deemed necessary, was not completed until August 18, 2005. ALJ Decision at 19, citing CMS Ex. 13, at 10. The ALJ also noted that the

Credible Allegation of Removal of Immediate Jeopardy (hereafter referred to as "credible allegation") submitted by Harlan is dated August 18, 2005. Id., citing Tr. at 205 and CMS Ex. 12. This credible allegation identifies the "Date of Completion" as August 18, 2005 (CMS Ex. 12, at 6) and is the credible allegation that CMS verified on the August 23, 2005 revisit. Since Harlan's credible allegation alleged that the immediate jeopardy was abated on August 18, 2005, CMS had no basis for considering whether Harlan had abated the immediate jeopardy as of August 9 or 10, 2005. Clearly, Harlan did not think that it had removed the immediate jeopardy on August 9 or 10, 2005, or it would have so stated in the August 18, 2005 credible allegation.[9] Thus, the ALJ did not err in concluding that CMS's finding that the immediate jeopardy continued from August 9 through August 17, 2005, was not clearly erroneous.

Even disregarding the August 18, 2005 completion date in Harlan's credible allegation, Harlan's arguments that the immediate jeopardy was removed on August 9 or 10, 2005, are not persuasive. Before the ALJ, Harlan argued that the immediate jeopardy was removed on August 9 because "beginning August 9, 2005, all facility staff were inserviced regarding the policy of not disarming the alarm doors, and no one was allowed on the floor until they received training." ALJ Decision at 18. The ALJ rejected that argument, finding that "several staff members that were on duty on August 10, 2005, admitted to the surveyors never having received such training. . . ." Id. Harlan now asserts that the surveyors questioned the staff members about what inservice training had been provided on the alarm system prior to August 9, 2005, not about whether they had received such training on the evening of August 9 (following the elopement that day). P. Br. at 7, citing Tr. at 95 (Ms. Burton-Brock), 152 (Ms. Estes). Harlan appears to be correct on this point. However,

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[9] Harlan also submitted a credible allegation on August 15, 2005 (ALJ Exhibit 1), which the State survey agency returned to Harlan for further clarification, resulting in submission of the August 18, 2005 credible allegation. Even in its unaccepted August 15, 2005 credible allegation, Harlan alleged only that the immediate jeopardy was removed as of August 12, 2005.

CMS objects to the ALJ's admission of the last 50 pages of ALJ Exhibit 1. CMS Br. at 29, n.9. Since CMS was not adversely affected by the admission of those pages, however, we see no need to determine whether the ALJ erred in admitting them.

even if all staff on duty on August 10 had received inservice training on the alarm system on August 9, that is not a basis for finding that the immediate jeopardy was removed on August 9. As discussed above, it is undisputed that a significant number of staff on duty on August 10 were ignorant of the proper operation of the alarm system notwithstanding any training they had received. It is not surprising that staff who had received the inservice training on August 9 would still be unaware of the proper operation of the alarm system since the ALJ found, and Harlan does not dispute, that the training was "hastily put together," lasted only 20 to 30 minutes although it covered several other topics, and was conducted by an individual who was "still ignorant as to the operation of the alarm system" at the time of the hearing. ALJ Decision at 18. Thus, any error made by the ALJ with respect to who received the August 9 inservicing was harmless.

Harlan also argues that any immediate jeopardy was removed on August 9 because the facility ended its practice of disarming the door alarms for deliveries on that date. P. Br. at 9. This argument assumes that the ALJ upheld CMS's determination of immediate jeopardy based only on this practice. As Harlan's other arguments recognize, however, the ALJ relied both on this practice and on "the ignorance of the staff as to the manner of operation of the alarm system." ALJ Decision at 9.

Harlan argues further that the ALJ should have found that the immediate jeopardy was removed on August 10 because, as of that date, in addition to having discontinued its practice of disarming the alarms for deliveries, Harlan had installed plexiglass covers over the switches that turned the alarm on and off and had monitors checking the doors and the location of wandering residents "around the clock." P. Br. at 9, citing Tr. at 80-88 and CMS Ex. 10. This argument is not persuasive. The ALJ found that, even after the covers were added, there was confusion as to whether and how access to the control panel (where the critical switches were located) would be secured. ALJ Decision at 12, n.7 (citing contradictory testimony by Ms. Ford and Harlan's maintenance supervisor, Mr. Gooden). Moreover, the exhibit Harlan cites shows that residents were monitored on an hourly basis for only four hours on August 10 (the day after the elopement), not "around the clock" that day as Harlan contends. CMS Ex. 10, at 4 ("[a]ll residents on census" found "present & accounted for" at 2 p.m., 3 p.m., 4 p.m. and 5 p.m.). In addition, Ms. Burton-Brock testified that she did not recall "seeing staff continuously at each door" during the survey on August 10-12, 2005 (Tr. at 63), calling into question whether the doors were being monitored as Harlan asserts.

Finally, Harlan argues that the ALJ should have found that the immediate jeopardy was removed on August 10 because Surveyor Burton-Brock testified that she thought when she left the facility on that date that the residents were safe. P. Br. at 10. However, Ms. Burton-Brock made it clear that this was her thinking only "[a]t that time" and that she changed her mind by August 12, when she participated in making the immediate jeopardy determination. Tr. at 84, 86-88. Moreover, her opinion as to whether and when the residents became safe is not dispositive since, even in the absence of an immediate jeopardy determination by a state survey agency, CMS may make a determination of immediate jeopardy based on the survey findings. See Lake Mary Health Care, DAB No. 2081, at 7 (2007), citing section 1919(h)(5) of the Social Security Act (providing that where either CMS or the state finds immediate jeopardy, the entity finding immediate jeopardy shall notify the other and apply the legal remedies available in immediate jeopardy situations).

The ALJ did not err in determining that the $8,050 per day CMP imposed for the period of immediate jeopardy was reasonable.

Harlan argues that the CMP was not reasonable in amount because the "facility reacted at lightening [sic] speed to address the incident." P. Br. at 10.[10] Even if this were true, a facility's corrective action, or the speed with which the facility takes that action, are not factors that CMS may consider in determining the amount of the CMP. See 42 C.F.R. § 488.438(e) and (f). Moreover, Harlan does not point to any error in the ALJ's conclusion that a $8,050 per day CMP was reasonable in light of the scope and severity of the deficiency and the facility's degree of culpability, two of the regulatory factors that an ALJ may properly consider. See ALJ Decision at 17.

[10] In the conclusion of its reply brief, Harlan asserts for the first time that the appropriate remedy for its immediate jeopardy noncompliance, assuming it existed, would have been a $10,000 per instance CMP. "The Board will not consider issues not raised in the request for review, nor issues which could have been presented to the ALJ but were not." Board Guidelines; Ross Healthcare Center, DAB No. 1896, at 11 (2003). Accordingly, we do not address this issue.

Conclusion

For the reasons stated above, we affirm the ALJ Decision.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Sheila Ann Hegy
Presiding Board Member