

Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD

Appellate Division

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In the Case of:)	
)	
Pinehurst Healthcare &)	DATE: April 30, 2009
Rehabilitation Center,)	
)	
Petitioner,)	Civil Remedies CR1854
)	App. Div. Docket No. A-09-27
- v.-)	
)	Decision No. 2246
Centers for Medicare &)	
Medicaid Services.)	
_____)	

FINAL DECISION ON REVIEW OF
ADMINISTRATIVE LAW JUDGE DECISION

Pinehurst Healthcare & Rehabilitation Center (Pinehurst), a North Carolina skilled nursing facility, appeals the October 8, 2008 decision of Administrative Law Judge (ALJ) Alfonso J. Montaña, Pinehurst Healthcare & Rehabilitation Center, DAB CR1854 (2008) (ALJ Decision). At issue before the ALJ was Pinehurst's challenge to enforcement remedies imposed by the Centers for Medicare & Medicaid Services (CMS) for Pinehurst's alleged noncompliance with Medicare participation requirements. The remedies imposed by CMS included: a civil money penalty (CMP) of \$3,050 per day for alleged noncompliance that CMS found to be at the level of "immediate jeopardy" from April 6, 2004 through July 25, 2004; a \$100 per-day CMP for alleged noncompliance of lesser seriousness from July 26, 2004 through August 24, 2004; and a denial of payment for new admissions (DPNA) that ran from July 23, 2004 through August 24, 2004. CMS also informed Pinehurst that its alleged noncompliance precluded approval of its nurse aide training and competency evaluation program (NATCEP).

After an evidentiary hearing and post-hearing briefing, the ALJ concluded that Pinehurst was not in substantial compliance with

various Medicare participation requirements from April 6, 2004 through August 24, 2004; that CMS's determination of immediate jeopardy was not clearly erroneous; that the CMP amounts were reasonable; that CMS had an adequate basis for imposing the DPNA; and that loss of Pinehurst's NATCEP was mandated by operation of law. Based on these conclusions, the ALJ sustained the enforcement remedies imposed upon Pinehurst.

For the reasons discussed, we affirm the ALJ Decision with only minor, technical changes.

Legal Background

The participation requirements for skilled nursing facilities (SNFs) and other long-term care facilities that participate in Medicare and Medicaid are set forth at 42 C.F.R. Part 483, subpart B. State agencies under contract with CMS perform surveys to verify that SNFs comply with these requirements. A state survey agency reports any "deficiencies" (failures to comply with participation requirements) on a standard form called a "Statement of Deficiencies" (SOD). The SOD identifies each deficiency with a unique survey "tag" number that corresponds to the participation requirement allegedly violated.

CMS may impose enforcement remedies, including CMPs, when it finds that a SNF is not in "substantial compliance" with one or more participation requirements. See 42 C.F.R. §§ 488.400 et seq. "Substantial compliance" means a level of compliance such that "any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." Id. § 488.301. CMS's regulations (and we) use the term "noncompliance" to refer to "any deficiency that causes a facility to not be in substantial compliance." Id.

CMS sets the amount of a CMP based in part on its determination of the "seriousness" – that is, the scope and severity – of the noncompliance. See 42 C.F.R. § 488.404. The most serious deficiency is one that creates "immediate jeopardy," which the regulations define 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." Id. § 488.301.

A SNF may request an ALJ hearing to contest a finding of noncompliance that has resulted in the imposition of a CMP or other enforcement remedy. 42 C.F.R. §§ 488.408(g)(1), 498.3(b)(13). In an ALJ proceeding, "CMS has the burden of coming forward with evidence related to disputed findings that is

sufficient (together with any undisputed findings and relevant legal authority) to establish a prima facie case of noncompliance with a regulatory requirement." Evergreene Nursing Care Center, DAB No. 2069, at 4 (2007); Batavia Nursing and Convalescent Center, DAB No 1904 (2004), aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson, 129 F. App'x 181 (6th Cir. 2005). "If CMS makes this prima facie showing, then the SNF must carry its ultimate burden of persuasion by showing, by a preponderance of the evidence, on the record as a whole, that it was in substantial compliance during the relevant period." Evergreene Nursing Care Center at 4.

Case Background

In this case the challenged enforcement remedies stem from three surveys of Pinehurst: a complaint survey completed on July 15, 2004; a complaint survey completed on July 21, 2004; and a revisit survey completed on August 3, 2004. Our decision refers to these surveys as the July 15 survey, the July 21 survey, and the August 3 survey.

The July 15 survey: This survey focused on an April 6, 2004 incident involving Resident 4 (a female resident) and Resident 3 (a male resident). Based on its investigation of that incident, the state survey agency concluded that Pinehurst had failed to protect Resident 4 from sexual abuse by Resident 3. For that alleged failure, the state survey agency cited Pinehurst for noncompliance with sections 483.13(b), 483.13(c), and 483.75 under tags F223, F226, and F490. CMS Ex. 1, at 1, 20, 42. Based on other, unrelated circumstances, the state survey agency also cited Pinehurst under tag F497 for noncompliance with section 483.75(e)(8). Id. at 50. In addition, the state survey agency determined that the noncompliance cited under tags F223, F226, and F490 had created a situation of immediate jeopardy as of April 6, 2004, and that this immediate jeopardy situation remained unabated during the July 15 survey. Id. at 1, 20, 42.

The July 21 survey: As a result of the July 21 survey, the state survey agency cited Pinehurst under tag F324 for noncompliance with section 483.25(h)(2), alleging that Pinehurst had failed to secure certain exit doors and take other measures to prevent cognitively impaired residents from leaving the facility without adequate supervision. CMS Ex. 35, at 3-12. The state survey agency also determined that this noncompliance was at the immediate jeopardy level from May 28, 2004 through July 21, 2004 then continued at a lower level of seriousness after July 21, 2004. Id. at 3. Based on other, unrelated circumstances, the

state survey agency also cited Pinehurst under tag F278 for noncompliance with section 483.20(g). Id. at 1.

The August 3 survey: As a result of the August 3 survey, the state survey agency cited Pinehurst under tags F225 and F226 for noncompliance with provisions in section 483.13 that require SNFs to report and investigate allegations of mistreatment, abuse, neglect, and misappropriation of property. CMS Ex. 45, at 1-18. In addition, the state survey agency cited Pinehurst under tag F469 for noncompliance with section 483.70(h)(4), which requires SNFs to maintain an effective pest control program. Id. at 19. The state survey agency also determined that Pinehurst had removed the immediate jeopardy identified during the July 15 survey as of July 26, 2004, and that Pinehurst had fully removed the noncompliance identified during the July 15 and July 21 surveys by August 3, 2004. See P. Ex. 5, at 2, 5-6.

During a September 29, 2004 revisit survey, the state survey agency determined that Pinehurst was back in substantial compliance with all Medicare participation requirements as of August 25, 2004. CMS Ex. 54.

CMS concurred with all of the survey findings and based on them imposed the following remedies:

- a \$3,050 per-day CMP from April 6, 2004 through July 25, 2004;
- a \$100 per-day CMP from July 26, 2004 through August 24, 2004; and
- a DPNA from July 23 through August 24, 2004.

See CMS Exs. 51-54. Pinehurst then requested and received an evidentiary hearing before the ALJ.

The ALJ sustained all of the survey findings except for the deficiency citation under tag F278 from the July 21 survey. The ALJ also concluded that the remedies imposed by CMS were lawful and, in the case of the CMPs, reasonable. The ALJ stated his broad legal conclusions in numbered "Findings" that preface the analyses supporting those conclusions. See section II.C of the ALJ Decision at 6, 16, 19, 20, 23-26.

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 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*, <http://www.hhs.gov/dab/guidelines/prov.html>.

"Substantial evidence" is "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). Under the substantial evidence standard, "our role is not to re-weigh the evidence or to substitute our own evaluation of the evidence for that of the ALJ." Life Care Center at Bardstown, DAB No. 2233, at 10 (2009) (citing cases). Thus, we must not displace a "choice between two fairly conflicting views," even though a different choice could justifiably have been made if the matter had been before us de novo. Universal Camera Corp. v. NLRB, 340 U.S. 474, 488 (1951). We must, however, set aside the initial conclusions if we "cannot conscientiously find that the evidence supporting that decision is substantial, when viewed in the light that the record in its entirety furnishes, including the body of evidence opposed to the [ALJ's] view." Id. Moreover, "as an appellate body, we do not disturb an ALJ's assessment about the relative credibility of testimony by witnesses who appear in person at the hearing absent a compelling reason to do so." Koester Pavilion, DAB No. 1750, at 15 (2000).

Discussion

In its request for review, Pinehurst states that it disagrees with all of the Findings made by the ALJ in CMS's favor. See Request for Review (RR) at 3 (§ 15). Before discussing the specific points of disagreement, we note that Pinehurst's arguments generally fail to acknowledge or account for the Board's standard of review. In most instances, Pinehurst argues that a "preponderance of evidence" shows that it was in substantial compliance with the relevant participation requirement. As an appellate body, however, the Board reviews the ALJ's findings of fact to determine whether they are supported by "substantial evidence" in the record as a whole. Under that standard of review, the Board does not – as Pinehurst seems to be asking us to do – re-weigh the evidence to find that the facility met its burden of proof. Community Skilled Nursing Centre, DAB No. 1987, at 3 (2005) (citing and quoting cases). Furthermore, under the substantial evidence standard, we cannot "displace a choice between two fairly conflicting views" of the record, "even though a different choice could justifiably have been made if the matter had been before the reviewer de novo."

Id.

Applying the appropriate standard of review, we now consider - but reject - Pinehurst's specific exceptions to the ALJ Decision.

1. **Tag F223, July 15 survey**

- a. *The ALJ's conclusion that Pinehurst was not in substantial compliance with 42 C.F.R. § 483.13(b) as of April 6, 2004 is supported by substantial evidence and free of legal error.*

Under tag F223, the state survey agency found, and CMS concurred, that Pinehurst was not in substantial compliance with section 483.13(b) as of April 6, 2004. CMS Ex. 1, at 1; P. Ex. 2. Section 483.13(b) provides:

Abuse. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

The Board has held that "[p]rotecting and promoting a resident's right to be free from abuse necessarily obligates the facility to take reasonable steps to prevent abusive acts, regardless of their source." Western Care Management Corp., DAB No. 1921, at 12 (2004).

As noted, the survey finding under tag F223 stemmed from an April 6, 2004 incident involving Residents 3 and 4, about which the ALJ found the following undisputed facts. See ALJ Decision at 6-7. Resident 3 was 70 years old at the time of the incident. Although he was almost completely blind, he was alert and oriented, able to get around his room without assistance, and mentally competent to handle his own affairs. Prior to April 6, 2004, Resident 3 "occasionally asked female facility staff for dates, 'pat[ted]' them on their bottoms, or asked them for kisses." ALJ Decision at 6 (citing Tr. at 656-57).

Resident 4 had dementia, poor decision-making skills, and a tendency to wander.¹ She was known for being flirtatious and affectionate. In October 2003, Resident 3 reported that Resident

¹ In the nursing home context, wandering behavior means moving with no rational purpose, seemingly oblivious to needs or safety. CMS Ex. 5, at 24. Prior to April 6, 2004, Pinehurst assessed Resident 4 as wandering daily. Id. at 24, 26.

4 entered his room and hit him in the nose, after which a nurse noted a scratch on his nose. There is no evidence that the facility investigated this incident.

On the morning of April 6, 2004, Resident 4 was walking down the hall outside Resident 3's room. A registered nurse assistant heard Resident 3 say to Resident 4 "come here." Shortly thereafter, two certified nursing assistants (CNAs) heard Residents 3 and 4 talking in Resident 3's room. The CNAs entered the room to investigate and found Resident 4 in Resident 3's bathroom bent over with her diaper down. Resident 3 was observed standing behind Resident 4 with his pants down. The CNAs separated the residents and notified their supervisors.

Based on written statements by these two CNAs, the ALJ noted:

The interpretation of what each CNA reportedly saw differs. CNA Sheila Smith's written account indicates that "[Resident 3] was having sex with her [Resident 4] from behind." When interviewed by a surveyor during the July 15, 2004 survey, CNA Tim Martin was not as certain, as he said: "[I]t looked like his [Resident 3's] privates were between her [Resident 4's] legs from behind." He was not certain that Resident 3 had penetrated Resident 4.

ALJ Decision at 7 (citations omitted).

The ALJ found the evidence "inconclusive" about whether actual sexual contact had occurred on April 6, 2004 but found that Resident 3 had attempted to have sexual contact with Resident 4 without her consent on that day. ALJ Decision at 12. "What is clear," said the ALJ, "is that a cognitively-intact resident called a cognitively-impaired, non-communicative resident incapable of consenting into his room and they were found engaged in a position suggestive of actual or imminent sexual contact." Id.

At the hearing, CMS presented the testimony of Ann Burgess, Ph.D., whom the ALJ accepted as an expert on the identification, prevention, and treatment of elder abuse. Tr. at 234, 244. Dr. Burgess testified that prior to April 6, 2004, Resident 3 had used "sexualized" language and behavior (asking female staff for kisses and patting female staff on their bottoms). Tr. at 247. In her opinion, the nursing staff failed to respond effectively to this language and behavior, and the staff's inadequate response likely encouraged Resident 3 to "try to do more and more because he is getting away with it." Tr. at 248. Dr. Burgess

testified that Pinehurst's staff should have counseled Resident 3 that such language and behavior would not be tolerated, and that staff should have been polled to determine whether Resident 3 had exhibited a pattern of sexually inappropriate behavior or directed that behavior to fellow residents. Tr. at 247-49. Dr. Burgess also testified that, based upon her review of witness statements and other evidence, Resident 3 "sexually assaulted" or attempted to sexually assault Resident 4 on April 6, 2004. Tr. at 250-51.

Based on Dr. Burgess's testimony and on other facts and evidence, the ALJ found that Pinehurst had "failed to take reasonable steps to protect Resident 4 from potential abuse" by Resident 3. ALJ Decision at 8. In particular, said the ALJ, Pinehurst "failed to demonstrate that it took reasonable steps to effectively address Resident 3's 'sexualized behavior'" and to supervise or restrict his contact with Resident 4 and other vulnerable female residents. Id. at 8-10. Summarizing his reasoning, the ALJ stated:

Petitioner was well aware that on April 6, 2004 Resident 4: (1) was cognitively impaired; (2) wandered constantly; (3) had poor decision-making skills; (4) could not appreciate potential dangers; (5) had unsteady gait and a risk for falls; (6) could not communicate meaningfully; and (7) frequently wandered the facility seemingly without regard for her own safety. She had both short- and long-term memory problems and, therefore, could not recall the location of her own room or the names of staff, and was not oriented to date, time, and place. She had poor judgment and, thus, required frequent re-direction and cuing. She was known for being flirtatious and affectionate. Despite knowledge of such risks, Petitioner allowed Resident 4 to regularly wander about the facility without supervision or adequate intervention. She was extraordinarily vulnerable to possible abuse given her diminished cognitive ability, poor judgment, and inability to communicate effectively. The potential perils she faced are obvious and the likelihood of serious injury, harm, or death resulting from failure to prevent her constant wandering, too, are apparent.

ALJ Decision at 8 (citations omitted).

In response to the ALJ's reasoning, Pinehurst contends that the evidence failed to prove that its nursing staff knew or should

have known that Resident 3 posed a risk to Resident 4 prior to the April 6, 2004 incident. "The fact that [Resident 4] wandered and was demented," says Pinehurst, "did not put the facility on notice that she was in danger of engaging in sexual behavior with another resident." RR at 5. In addition, says Pinehurst, "while there was some evidence that Resident #3 would try to pat staff members' bottoms and would ask for kisses, there is no evidence that Resident #3 ever tried to pat female residents' bottoms or ask them for kisses or that he focused any attention on incompetent residents." Id. at 5-6 (emphasis in original). Pinehurst also asserts that "[w]hile Resident #4 was friendly and affectionate, the record also showed that she could become aggressive and take care of herself if she felt threatened or someone was in her space." Id. at 5.

In support of this argument, Pinehurst relies heavily on the testimony of Susan Davidson, a social worker who worked at the facility during the period at issue and had over 20 years of experience in the nursing home industry. See RR at 6. Ms. Davidson testified that it was common for residents to want to hold hands or "ask for a kiss" and that her training as a social worker encouraged her to show affection to residents. Tr. at 624-25. She testified that prior to April 6, 2004, Resident 3 "had not shown any tendencies of being a sexual predator or anything like that." Tr. at 763-64.

Dr. Burgess and Ms. Davidson differed in their evaluations of whether Resident 3's pre-April 6, 2004 behavior revealed that he posed a potential or actual risk of sexual abuse to Resident 4 and other vulnerable residents. However, the ALJ - after observing the demeanor of these witnesses, assessing their levels of expertise in the area of elder sexual abuse, and considering the substance of their testimony in light of the totality of the circumstances known to facility staff prior to April 6, 2004 - expressly found Dr. Burgess "more persuasive" than Ms. Davidson on that issue. ALJ Decision at 10. As indicated, the Board generally defers to an ALJ's determination about the relative credibility of witness testimony unless there is a compelling reason not to do so.

Pinehurst has not shown any compelling reason to overturn the ALJ's credibility determination. Pinehurst contends that Dr. Burgess had "very little experience" in the nursing home industry. RR at 6. We disagree. Although Dr. Burgess had not recently worked in a nursing home, she testified that she consulted for "maybe a dozen" nursing homes and helped those clients write their protocols on resident abuse. Tr. at 227, 229. We cannot say that this consulting work was insubstantial

or that it failed to afford her adequate knowledge of a nursing home environment and relevant standards of care. Moreover, as the ALJ noted, Pinehurst does not challenge Dr. Burgess's expertise in the identification, prevention, and treatment of elder sexual abuse (or claim that Ms. Davidson had comparable expertise). That expertise relates directly to the population – elderly persons – primarily served by nursing homes.

Pinehurst asserts that Dr. Burgess was unfamiliar with the nursing home survey process in North Carolina. RR at 7. However, Pinehurst does not explain why this fact renders Dr. Burgess's testimony less credible or probative. In addition, Pinehurst asserts that Dr. Burgess "did not agree with CMS's definition of abuse, and had her own definition of sexual abuse on which she relied in determining if abuse did or could occur." Id. However, the testimony that Pinehurst cites in support of this assertion shows no disagreement by Dr. Burgess with CMS's definition of abuse or sexual abuse, only an acknowledgment that she did consult CMS's definition of sexual abuse before formulating her opinions. Tr. at 391.

Finally, Pinehurst contends that Dr. Burgess's opinions were "based on 'unpublished' studies, 'ongoing' investigations, an incomplete record, information the [ALJ] has determined could not be considered, and an incorrect understanding of undisputed facts." RR at 7. Pinehurst provides no argument to support this broad statement, only a string of page citations to the hearing transcript. Moreover, our review of the record indicates that throughout her testimony, Dr. Burgess made clear that her opinions regarding Pinehurst's care of Residents 3 and 4 were not based upon unpublished studies or ongoing investigations. See, e.g., Tr. at 249, 251, 256, 262, 279, 286.

Even if we found the ALJ's reliance on Dr. Burgess's testimony to be improper, which we do not, we would still uphold the ALJ's conclusion that Pinehurst was not in substantial compliance with section 483.13(b) for the following reasons. First, the ALJ's noncompliance finding was not limited to "sexual" abuse. The ALJ found that Pinehurst had failed to protect Resident 4 (and other vulnerable residents) from "abuse" without limiting that finding to any particular type or category of abuse. ALJ Decision at 8 (concluding that Pinehurst "failed to take reasonable steps to protect Resident 4 from potential abuse"). Section 483.13(b) requires a SNF to protect residents from all types of abuse – physical, mental, and sexual – and there is evidence that Pinehurst was or should have been on notice before April 6, 2004 of a potential for physical abuse involving Residents 3 and 4. Dr. Burgess testified, and the ALJ ultimately found, that the

reported October 2003 incident involving these residents, which apparently resulted in physical injury to Resident 4, should have been investigated to determine whether one or the other resident had committed an abusive act. See Tr. at 293-95; ALJ Decision at 8-9. The facility's administrator, David Culbreth, tacitly conceded that Pinehurst should have recognized the potential for physical abuse before April 6, 2004. After acknowledging that Resident 4 had been in "scrapes with people she didn't particularly like" (Tr. at 429), Administrator Culbreth testified on cross-examination that staff should not have allowed Resident 4 to enter Resident 3's room alone on April 6, 2004 (Tr. at 492-93).

Second, undisputed findings by the ALJ establish that Pinehurst failed to take adequate steps to protect Resident 4 from potential sexual and other abuse after the April 6, 2004 incident. For example, the ALJ found, and Pinehurst does not dispute, that one-on-one supervision of Resident 4 lasted only one week after the incident, after which she was allowed to wander the halls of the facility alone. ALJ Decision at 14. We find no contemporaneous documentary evidence of any plan to monitor Resident 4's movements inside the facility after this one-week period of one-on-one supervision.²

Moreover, the ALJ found, and Pinehurst does not dispute, that there were other cognitively impaired and wandering female residents in the facility who were vulnerable to abuse. ALJ Decision at 14. Yet the ALJ found no evidence, other than uncorroborated testimony by Ms. Davidson and Administrator Culbreth, that staff were instructed, or "in-serviced," to keep those vulnerable residents away from Resident 3's room and other potentially dangerous areas. ALJ Decision at 15. Pinehurst "provide[d] no evidence," the ALJ found, "to document that various 'in-services' were provided, when they were provided, who attended the 'in service,' and what specifically was discussed." Id. Our review of the record substantiates that finding.

In addition, the ALJ found that Pinehurst "has not established what specific measures it implemented after April 6, 2004 to prevent Resident 3 from behaving sexually inappropriate[ly] with other wandering female residents[.]" ALJ Decision at 15. We affirm that finding as well because we see no documentary

² Resident 4's plan of care was amended on July 7, 2004 to address the risk of her wandering outside the facility. CMS Ex. 5, at 18. Nothing in that plan indicates how her whereabouts and activities were tracked inside the facility.

evidence that Pinehurst monitored Resident 3's contacts with other residents. Moreover, we see no nursing records confirming that Resident 3's plan of care was modified to include measures to prevent a recurrence of his inappropriate behavior. This is especially troubling because, by all accounts, Resident 3 denied that his behavior on April 6, 2004 was inappropriate or that it had even occurred. Tr. at 148, 710. Dr. Burgess gave un rebutted testimony that in light of the April 6, 2004 incident, Pinehurst should have taken measures to modify Resident 3's behavior, such as determining whether he needed medication to decrease his libido and having him evaluated by a person with expertise in sexually aggressive behavior. Tr. at 283-96.

Pinehurst submits that Resident 3 was "counseled regarding his behavior, both by staff immediately after the incident and later by the Administrator and Social Worker," and that the facility's "interdisciplinary team met and discussed what interventions they would take with regard to Resident #3's sexually inappropriate behavior." RR at 8-9. Although social worker Davidson testified that Pinehurst's interdisciplinary team met to discuss Resident 3 (Tr. at 691-94), Pinehurst submitted no documentary evidence of any such meeting or of the "interventions" discussed, recommended, or ultimately implemented as a result of that meeting. Administrator David Culbreth and social worker Susan Davidson testified that they personally spoke with or counseled Resident 3 about his behavior on April 6, 2004. See Tr. at 446, 629. The ALJ could have reasonably determined that those conversations were insufficient given the nature of Resident 3's behavior, the fact that he denied wrongdoing, and Pinehurst's failure to address the behavior in Resident 3's plan of care.

Pinehurst asserts:

Short of 1:1 monitoring at all times or restraining Resident #4 in her room, the facility could not ensure that Resident #4 would not wander into another Resident's room. The first option is not realistic on a full time basis because neither Medicare nor Medicaid provide payment for 1:1 care. The second mechanism is obviously not an option for a nursing home resident.

RR at 7. These assertions are unpersuasive. Pinehurst presented no evidence that the two options it described – one-on-one monitoring and room confinement – were the only two measures available to ensure that Resident 4 was adequately supervised. Nor did Pinehurst support its assertion that one-on-one monitoring was impractical or unrealistic under the circumstances. As noted, after the April 6, 2004 incident,

Pinehurst ordered one-on-one monitoring for Resident 4 to ensure her safety. CMS Ex. 5, at 14. Why this measure was suspended after one week is neither explained nor justified in the nursing records submitted. Assuming that Resident 4 required one-on-one monitoring, we reject any claim that the facility lacked sufficient numbers of employees to provide that monitoring because a SNF must have sufficient nursing staff to meet residents' assessed needs. 42 C.F.R. § 483.30.

For the foregoing reasons, we conclude that there is substantial evidence supporting the ALJ's conclusion that Pinehurst was not in substantial compliance with section 483.13(b) as of April 6, 2004.

- b. *CMS's determination that Pinehurst's noncompliance with 42 C.F.R. § 483.13(b) placed one or more residents in immediate jeopardy as of April 6, 2004 is not clearly erroneous.*

As noted, "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" (emphasis added). CMS's determination about the level of noncompliance must be upheld unless it is clearly erroneous. 42 C.F.R. § 498.60(c). The Board has held that the clearly erroneous standard places a heavy burden on a SNF to overturn CMS's finding regarding the level of noncompliance.³ Edgemont Healthcare, DAB

³ Contrary to what the ALJ stated (ALJ Decision at 26), CMS does not have a burden to prove, prima facie, that noncompliance is at the immediate jeopardy level. The Board has held that once CMS presents evidence supporting a finding of noncompliance, CMS does not need to offer evidence to support its immediate jeopardy determination and that the burden is on the facility to show that that determination is clearly erroneous. Liberty Commons Nursing & Rehab Center - Johnston, DAB No. 2031, at 17-18 (2006), aff'd, Liberty Commons Nursing and Rehab Ctr. - Johnston v. Leavitt, 241 F. App'x 76 (4th Cir. 2007). In its Liberty Commons decision, the Board pointed out that "[t]o require CMS to make a prima facie case on the level of noncompliance would effectively and impermissibly convert what is clearly a limitation on the ALJ's scope of review under the regulations (and by extension a corresponding burden of proof on the SNF) into a burden of proof, or at least a burden of going forward, on CMS." DAB No. 2031, at 18-19.

No. 2202, at 20 (2008) (citing cases). CMS determined that an immediate jeopardy situation arose on April 6, 2004 due to the noncompliance cited under tag F223. CMS Ex. 1, at 1.

Dr. Burgess testified that, in her opinion, the noncompliance that existed on April 6, 2004 was likely to result in serious injury or harm to residents. Tr. at 324. Pinehurst cites no evidence to rebut that opinion, nor has it made a discernable argument, based on the applicable regulatory definition, that an immediate jeopardy situation did not arise on April 6, 2004 as a result of its noncompliance with section 483.13(b). Pinehurst focuses instead on measures it allegedly took on April 6 and afterward in order "to remove any alleged immediate jeopardy." RR at 7 (emphasis added). That Pinehurst took some steps to remove the immediate jeopardy does not prove that the jeopardy never existed.

Pinehurst suggests that the immediate jeopardy determination was unfounded because Resident 4 suffered no actual harm. RR at 11 (asserting that Resident 4 was not harmed in any way). This suggestion is meritless because "immediate jeopardy" is defined to include not only actual harm but a situation that is "likely to cause" serious injury, harm, impairment or death to a resident. 42 C.F.R. § 488.301.

For these reasons, we concur with the ALJ that Pinehurst did not carry its heavy burden of proving that CMS's immediate jeopardy determination was clearly erroneous.

- c. *Pinehurst did not remove the immediate jeopardy stemming from its noncompliance with 42 C.F.R. 483.13(b) until July 26, 2004.*

Pinehurst contends that it removed the immediate jeopardy stemming from its noncompliance with section 483.13(b) long before the July 15 and July 21 surveys (although it does not propose a specific end-date). See RR at 7-12. In support of this contention, Pinehurst lists several remedial actions it allegedly took on and after April 6, 2004 to (a) address potential harm suffered by Resident 4, (b) investigate and report the incident to appropriate authorities, and (c) institute measures to ensure that vulnerable residents were protected from sexually inappropriate behavior. *Id.* at 7-10. Pinehurst also asserts that surveyors found no other incidents of noncompliance with section 483.13(b) after April 6, 2004, and no evidence that any resident was harmed after that date due to noncompliance with that regulation. *Id.* at 12. "It is simply counterintuitive to argue," says Pinehurst, "that a facility could be in a state of

immediate jeopardy for 99 days and yet have no further documented incidents or findings of any injury, harm, impairment, or death." Id.

We find no merit to this argument. In a detailed discussion, the ALJ found that some of Pinehurst's corrective measures were inadequate, and that Pinehurst had failed to prove that other measures had been implemented as alleged. ALJ Decision at 12-16.

Pinehurst does not point to any evidence that the ALJ failed to consider in making those findings, nor does Pinehurst attempt to show that the findings lack evidentiary support. Pinehurst merely presents a laundry list of corrective measures allegedly taken, measures that the ALJ found inadequate or unimplemented in several instances. RR at 7-10.

Pinehurst, of course, had the burden to prove that it removed the immediate jeopardy prior to the date identified by CMS as the end of the immediate jeopardy period. Jennifer Matthew Nursing & Rehabilitation Center, DAB No. 2192, at 42 (2008); Briarwood Nursing Center, DAB No. 2115, at 17 (2007). A showing that no further incidents of abusive behavior were substantiated after April 6, 2004 is insufficient to meet that burden. There is no requirement that the duration of a remedy coincide with particular events that evidence a lack of substantial compliance. Regency Gardens Nursing Center, DAB No. 1858, at 21 (2002). The expectation is that a facility will take specific actions to correct the deficiency pursuant to an approved plan of correction that specifies the date by which each deficiency will be corrected. 45 C.F.R. § 488.401, 488.402(d). Similarly, immediate jeopardy is deemed to have been removed only when the facility has implemented necessary corrective measures so that there is no longer any likelihood of serious harm. Florence Park Care Center, DAB No. 1930, at 30 (2004) (citing cases and CMS's State Operations Manual). Pinehurst has failed to demonstrate that it implemented sufficient corrective measures prior to the date identified by CMS as the end-date of the immediate jeopardy period stemming from the noncompliance with section 483.13(c).

For the reasons discussed, we reject Pinehurst's contentions regarding the duration of this immediate jeopardy period. In addition, we modify the ALJ Decision to state that the period of immediate jeopardy for tag F223 ended on July 26, 2004, not May 28, 2004 (as the ALJ found). According to the ALJ, CMS argued in its post-hearing brief that May 28, 2004 was the end-date of that immediate jeopardy period. ALJ Decision at 12 (citing pages 14-18 of CMS's post-hearing brief). However, we see no such argument by CMS in its post-hearing brief or elsewhere in the record. Moreover, the record supports a finding that the

immediate jeopardy period for tag F223 ended on July 26, 2004. In a letter dated August 13, 2004 (as amended), the state survey agency reported results of the August 3 survey, which was performed in part to verify that immediate jeopardy identified by the July 15 survey had been removed.⁴ P. Ex. 5, at 2; P. Ex. 5, at 6. The August 13 letter states that this immediate jeopardy was removed effective July 26, 2004. P. Ex. 5, at 2. CMS confirmed its acceptance of that finding by informing Pinehurst in an August 18, 2004 letter that the \$3,050 per-day CMP that began accruing on April 6, 2004 remained in effect through July 25, 2004. P. Ex. 6, at 2.

2. **Tag F226, July 15 survey:** *The ALJ's conclusion that Pinehurst was not in substantial compliance with the requirement in 42 C.F.R. § 483.13(c) at the immediate jeopardy level as of April 6, 2004 is supported by substantial evidence and free of legal error.*

A SNF "must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property." 42 C.F.R. § 483.13(c). The ALJ concluded that Pinehurst was not in substantial compliance with this requirement as of April 6, 2004 because it failed to "properly or completely" implement its resident abuse policy in response to the incident involving Residents 3 and 4. ALJ Decision at 16-19. In particular, the ALJ found that Pinehurst had violated its resident abuse policy by: (1) taking inadequate steps to protect Resident 4 from harm after April 6, 2004; (2) failing to "impose consequences" on Resident 3 or to supervise him adequately after April 6, 2004; (3) omitting "critical factual information" from its "incident report(s)," which were prepared on April 6, 2004 (see CMS Exs. 7-11); (4) failing to report the incident on the "incident report log"; (5) omitting critical factual information on the "24-hour-report" sent to the state of North Carolina; (6) failing to provide an incident report to the residents' families or attending physician(s); (7) failing to conduct or arrange for a proper sexual assault examination of Resident 4; (8) providing inaccurate information to an Adult Protective Services (APS)

⁴ The state survey agency had previously lifted its immediate jeopardy citation stemming from the July 21 survey. The SOD for the July 21 survey states that the immediate jeopardy identified during that survey had been removed as of July 21, 2004. CMS Ex. 35, at 3.

investigator; and (9) failing to report the incident to the police until July 15, 2004. Id.

In its appeal brief, Pinehurst asserts that it "acted appropriately and in accordance" with its resident abuse policy following the April 6, 2004 incident. In particular, Pinehurst contends that it:

- conducted "routine in-services" regarding its resident abuse policy;
- responded properly to the April 6, 2004 incident by (1) immediately separating Residents 3 and 4; (2) reporting the event to supervisors, who performed an investigation and assessed the residents; (3) reporting the incident to the residents' physician, APS, the state long-term care ombudsman, and Resident 4's family.

Pinehurst does not dispute the ALJ's finding that it failed to take adequate steps to protect Resident 4 from harm after April 6, 2004 in violation of its resident abuse policy. That undisputed finding alone supports the ALJ's conclusion that Pinehurst was not in substantial compliance with section 483.13(c) as of April 6, 2004, but Pinehurst also fails to dispute the ALJ's findings that it failed to follow its resident abuse policy in other respects. For example, Pinehurst does not dispute the finding that it omitted critical factual information from its "incident reports" and the "24-hour-report" sent to the state of North Carolina. Nor does Pinehurst dispute that it failed to record the April 6, 2004 incident on the "incident report log."

In addition, Pinehurst does not deny that it failed to provide a copy of the incident report(s) to Resident 4's physician, Ward Patrick, M.D. Instead, Pinehurst suggests that Dr. Patrick was aware of the April 6, 2004 incident when he saw Resident 4 on April 9, 2004 because Resident 4's medical records at the time included information about the incident. RR at 17. However, Pinehurst cites no evidence to support that assertion, nor does it challenge Dr. Patrick's statement to surveyors that he

received no details from the staff about the incident.⁵ See ALJ Decision at 18 (citing CMS Ex. 28, at 8).

Regarding Pinehurst's contact with APS, the ALJ found that the facility's administrator, David Culbreth, provided false information to an APS investigator in April 2004 – namely, that Resident 4 had attacked Resident 3 on April 6, 2004 and that both residents had willingly participated in the encounter. ALJ Decision at 19 (citing CMS Ex. 28, at 25). Pinehurst does not dispute the ALJ's finding that Mr. Culbreth provided false information to APS, nor does Pinehurst dispute that its resident abuse policy obligated Mr. Culbreth to provide complete and accurate information. Instead, Pinehurst maintains that no staff member "interfered" with the APS investigation or prevented APS from reviewing the medical record or from interviewing residents and staff. RR at 15. Pinehurst also claims that "APS was given all the same information as CMS after the July survey" and that APS did not change its assessment of the situation based on that information. Id. at 17 (emphasis added). However, the resident abuse policy obligated Pinehurst to report to APS in April 2004, "upon receipt" of the initial incident report(s). CMS Ex. 25, at 6. The fact that APS did not change its conclusion based on information submitted three months later in July 2004 is therefore irrelevant.

Pinehurst asserts that the police "were given all the evidence that CMS had regarding the matter and found no grounds for bringing any charges against Resident #3 or removing him from the facility." RR at 17. This contention also misses the point of the ALJ's finding, which was that Pinehurst should have contacted the police immediately after the April 6, 2004 incident so that transient medical evidence would not be lost. See ALJ Decision at 19-20 (noting that a police captain had informed Pinehurst's administrator that police should have been contacted at the time of the incident). Pinehurst does not dispute that it was necessary to contact the police on April 6, 2004.

Finally, Pinehurst offers no argument to challenge CMS's determination that its noncompliance with section 483.13(c) was at the level of immediate jeopardy. For that reason, and the other reasons discussed in this section, we affirm the ALJ's

⁵ The April 2004 nursing notes for Resident 4 do not mention the April 6, 2004 incident involving Residents 3 and 4. CMS Ex. 5, at 6-9. Only the social worker's notes mention the incident. P. Ex. 14, at 1. There is no evidence that Dr. Patrick saw the social worker's notes on April 9, 2004.

conclusion that Pinehurst was not in substantial compliance with section 483.13(c) at the level of immediate jeopardy as of April 6, 2004.

3. *Tag F490, July 15 survey: The ALJ's conclusion that Pinehurst was not in substantial compliance with 42 C.F.R. § 483.75 at the immediate jeopardy level as of April 6, 2004 is supported by substantial evidence and free of legal error.*

Pinehurst's response to the April 6, 2004 incident involving Residents 3 and 4 was the basis for the survey finding of noncompliance with section 483.75. That regulation states in its prefatory paragraph that a facility "must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident."

The SOD charged that Pinehurst was not in substantial compliance with section 483.75 because its staff -

failed to implement their abuse policy related to identification, reporting, prevention/protection and training, failed to involve the interdisciplinary care plan team as described in the abuse policy, failed to involve the Medical Director, failed to notify other parties as outlined in their abuse policy and as required by law and failed to document pertinent assessment information for 1 of 2 sampled residents with cognitive impairment and wandering behaviors (Resident #4) after sexual contact by another resident (Resident #3) who was alert and oriented.

CMS Ex. 1, at 42 (emphasis added).

Based on the SOD and other evidence submitted, the ALJ concluded that CMS had made a prima facie showing of noncompliance with section 483.75 based on Pinehurst's failure to "satisfactorily implement its anti-abuse policies[.]" ALJ Decision at 20. The ALJ also concluded that Pinehurst had failed to meet its burden of proving that it was in substantial compliance with section 483.75 by a preponderance of the evidence.

The following is Pinehurst's entire exception to the ALJ's conclusions regarding tag F490:

. . . Pinehurst had in place the policies and procedures to ensure that it was administered

appropriately. There is no evidence that any action by the administration led to the incident of April 6, 2004 or that any action by the administration would have prevented it from happening. The facility appropriately responded to the incident, separating, assessing and monitoring the Residents at issue and investigating this matter. There are no grounds for a finding of a deficiency under this tag and the finding of immediate jeopardy related to administration of the facility should be removed.

RR at 18. We reject this conclusory argument because, as the evidence of record and the ALJ's well-supported findings amply demonstrate, Pinehurst did not respond appropriately to the April 6, 2004 incident. The record also demonstrates that Pinehurst's administrator - the person to whom the facility's resident abuse policy assigns principal responsibility to initiate and oversee the investigation and reporting of allegations of abuse, neglect, and other misconduct⁶ - played a significant role in the facility's failure to implement that policy in response to the April 6, 2004 incident. See, e.g., CMS Ex. 28, at 2 (indicating that the administrator told surveyors that he did not call police on April 6, 2004 to report the incident involving Residents 3 and 4 because, in his view, nothing happened); Tr. at 155-57, 178 (discussing the Pinehurst staff's belief during the survey that nothing reportable happened on April 6, 2004).

Accordingly, we affirm the ALJ's conclusion that Pinehurst was not in substantial compliance with section 483.75 at the level of immediate jeopardy as of April 6, 2004.

4. **Tag F497, July 15 survey:** *The ALJ's conclusion that Pinehurst was not in substantial compliance with 42 C.F.R. § 483.75(e)(8) during the July 15, 2004 survey is supported by substantial evidence and free of legal error.*

The SOD from the July 15 survey charged that Pinehurst was not in substantial compliance with section 483.75(e)(8), which provides

⁶ Pinehurst's resident abuse policy indicates that the administrator is responsible for initiating an investigation of an incident report and for ensuring that the results of an investigation and related decisions "are fully and appropriately documented and appropriately distributed and that required documentation is completed and filed according to laws and regulations." CMS Ex. 25, at 7-8.

that a SNF "must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews." Noting that Pinehurst had failed to dispute that allegation, the ALJ concluded that the evidence was "sufficient to establish a prima facie case of noncompliance" with section 483.75(e)(8), and that Pinehurst "did not prove by a preponderance of evidence that it was in compliance with this participation requirement." ALJ Decision at 20. Although Pinehurst indicates in its request for review that it disagrees with this conclusion, it offers no legal argument to support that position. See RR at 3 (¶ 15). Pinehurst also did not contest the deficiency citation during the ALJ proceeding. See Pinehurst's Post-Hearing Br. (dated June 22, 2007). Therefore, we summarily affirm the ALJ's conclusion regarding tag F497.

5. **Tag F324, July 21 survey**

- a. *The ALJ's conclusion that Pinehurst was not in substantial compliance with 42 C.F.R. § 483.25(h)(2) as of May 28, 2004 is supported by substantial evidence and free of legal error.*

A "facility must ensure that . . . [e]ach resident receives adequate supervision and assistance devices to prevent accidents." 42 C.F.R. § 483.25(h)(2). The requirements of this regulation have been explained in numerous Board decisions. See, e.g., Golden Age Skilled Nursing & Rehabilitation Center, DAB No. 2026 (2006); Woodstock Care Center, DAB No. 1726, at 28 (2000), aff'd, Woodstock Care Center v. Thompson, 363 F.3d 583 (6th Cir. 2003). Although section 483.25(h)(2) does not make a facility strictly liable for accidents that occur, it does require the facility to take all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents. Woodstock Care Center v. Thompson, 363 F.3d at 590 (a SNF must take "all reasonable precautions against residents' accidents"). Facilities have the "flexibility to choose the methods of supervision" to prevent accidents so long as the methods chosen are adequate in light of the resident's needs and ability to protect himself or herself from a risk. Golden Age at 11, citing Woodstock at 590.

The SOD for the July 21 survey charged that as of May 28, 2004, Pinehurst was not in substantial compliance with section 483.25(h)(2) in caring for cognitively impaired residents who tried to leave or succeeded in leaving the facility without

nursing staff supervision. CMS Ex. 35, at 3. This deficiency citation was supported in part by the following undisputed facts concerning Residents A and B.

Resident A:

- In the early morning hours of May 28, 2004, Resident A, a male resident with dementia and moderately impaired decision-making capacity, left the facility undetected by staff. CMS Ex. 35, at 4, 7. Police found him on Highway 5, a two-lane road whose speed limit was 35 miles per hour near the entrance to the facility. Id. at 4, 7-8. Resident A was returned to the facility uninjured at about 3:15 a.m. Id. at 4. There were no sidewalks beyond the boundaries of Pinehurst's property. Id. at 7.
- On May 29, 2004, a Pinehurst nurse reported that Resident A had tried to leave the facility but was "redirected" by staff. CMS Ex. 35, at 4.
- On June 17, 2004, a nurse reported that Resident A was "aware of how to disable door alarms." CMS Ex. 35, at 4.
- At 1:00 a.m. on June 23, 2004, the nursing staff reported that Resident A was "pacing [with] repeated attempts to leave the facility." CMS Ex. 35, at 4.
- On June 28, 2004, a Pinehurst social worker reported that consideration was being given to transferring Resident A to a more secure facility. CMS Ex. 35, at 4-5.
- On July 4, 2004, a nurse reported that Resident A had managed to get outside to Pinehurst's back parking lot. CMS Ex. 35, at 5. The nurse who prepared a report on this incident believed that Resident A left the facility through one of the dining room's exit doors. Tr. at 58, 60. After this incident, Pinehurst's director of nursing directed the facility's social worker to refer Resident A to a "secure facility." CMS Ex. 35, at 5.
- Resident A was transferred from Pinehurst to another SNF on July 20, 2004. CMS Ex. 35, at 5.

Resident B:

- On July 3, 2004, Resident B, a wheelchair-bound male resident with short-term memory problems and difficulty with decision-making, left the facility unsupervised and, according to facility records, "rolled up [the] hill" on a rural road outside the facility. CMS Ex. 35, at 8. A nursing assistant on lunch break spotted him and returned him to the facility. Id. When Resident B was picked up, he was in a two-lane rural street about 100 yards from the facility's front door. Id. at 10. According to a report of this incident, Resident B was "confused [and] unable to determine if he thought he was going home or going to his room." Id. at 8.
- On July 6, 2004, Pinehurst indicated on Resident B's plan of care that he was a "high risk for wandering away from the facility." CMS Ex. 35, at 8.

The ALJ found that Pinehurst knew that precautions were needed to prevent elopement by Residents A and B (and other elopement-prone residents).⁷ ALJ Decision at 22. Despite this knowledge, said the ALJ, Pinehurst failed to take "basic" and "adequate" steps to protect those residents, "such as locking and alarming the dining room doors and placing more appropriate alarms on the facility entry and exit doors." Id. The ALJ also found that Pinehurst failed to "regularly evaluate, modify, and adjust interventions as needed." Id. Based on these findings, the ALJ concluded that Pinehurst was not in substantial compliance with section 483.25(h)(2) as of May 28, 2004. Id. at 22-23.

There is substantial evidence in the record to support the ALJ's finding that Pinehurst failed to secure certain exit doors adequately. The record shows, and Pinehurst does not dispute, that during the July 21 survey, Surveyor Patrick Campbell found no alarms or locks on the exit doors in Pinehurst's dining room, despite the staff's suspicion that Resident A had left the facility through one of those doors on July 4, 2004. Tr. at 37-38, 58. Surveyor Campbell also found no alarm and a non-functioning keypad on the employee entrance behind the kitchen,

⁷ CMS presented evidence that between May and July 2004, Pinehurst cared for other residents (besides Residents A and B) who were at risk of elopement due to their mobility and cognitive impairments. Tr. at 66-67, 80; CMS Ex. 41.

which led to an unenclosed parking lot. Tr. at 38, 59. In addition, he found no lock or alarm on the activity room's exit door, which led to an unenclosed grassy area. Tr. at 38, 60.

There also was evidence that Pinehurst's front exit door was inadequately secured. Surveyor Campbell testified that during the July 21 survey, he saw that a magnetic "personal alarm" had been installed on the front exit door, an alarm that was, he said, designed to alert staff to a resident who tries to get out of bed or a wheelchair without help. Tr. at 46. Surveyor Campbell also testified that the front door alarm was not activated when he inspected it on July 21; that a personal alarm can be de-activated by throwing a switch; and that, according to facility records, Resident A knew how to disable the alarm. Tr. at 46, 49. Surveyor Campbell testified that staff had informed him that the front door was not locked during the day and that the alarm on that door was not activated until 9:00 p.m. (when the door was locked). Tr. at 45, 46.

Pinehurst does not dispute that secure and properly alarmed exit doors were necessary to prevent elopements by Residents A and B on or after May 28, 2004. Although Pinehurst suggests that it kept those doors locked and alarmed at all times after May 28, 2004, Pinehurst produced no documentary or testimonial evidence of such a practice. Pinehurst also failed to rebut the evidence that Resident A was capable of disabling or switching off the front door alarm.

Pinehurst suggests that staff monitoring of Residents A and B compensated for any problems with the security of its exit doors. Pinehurst contends that after Resident A's elopement on May 28, 2004, it amended Resident A's plan of care to include interventions such as "redirecting" the resident and closer or more frequent monitoring. RR at 20. Pinehurst also asserts that its staff knew that it needed to watch Resident A more closely and that post-May 28 corrective measures prevented Resident A from leaving the facility multiple times on May 29 and June 23, 2004. Id.

In addition, Pinehurst asserts that it modified Resident B's plan of care to include additional measures such as providing "reality orientation," "diversional activities," administering medication ordered by his physician, and monitoring his whereabouts every hour. RR at 20-21. Pinehurst also suggests that there was no deficiency in its supervision of Resident B because he was "immediately followed" and brought back to the facility on July 3, 2004. Id. at 20.

In addition to amending the plans of care of Residents A and B, Pinehurst asserts that it conducted in-servicing of staff regarding wandering residents on July 19, 2004. RR at 21. Pinehurst also asserts that the nursing staff monitored the front exit door from the administrative offices and receptionist's desk, and that residents in the dining and activity rooms were monitored from the main hallway through the glass walls in those rooms. Id. at 22. Finally, Pinehurst asserts that it ordered and installed a "Wanderguard" system, a security system that automatically locks a door when a resident with a special bracelet approaches. Id.; Tr. at 29.

We find these contentions unpersuasive for several reasons. First, Pinehurst failed to demonstrate that staff monitoring of Residents A and B between May 28 and the July 21 survey provided an adequate level of supervision for these residents in the absence of properly alarmed exit doors in the facility's dining room and activity room, all of which led outside to unsecured areas. Although the plans of care for Residents A and B were amended to call for closer monitoring, there is no contemporaneous documentary evidence that such monitoring was instituted and no evidence about how this monitoring was actually performed in order to ensure the residents' safety.⁸ Furthermore, no Pinehurst employee testified from personal knowledge about how Residents A and B and other elopement-prone residents were monitored during the period. Also, Pinehurst admits that staff in-servicing on the elopement problem did not occur until July 19, 2004, the day before the July 21 survey began.⁹ RR at 21.

Pinehurst's claim that residents were adequately monitored in areas with unsecured exit doors is belied by Surveyor Campbell's personal observations of Resident B. Surveyor Campbell testified that at 8:40 a.m. on July 21, 2004, he saw a staff member let Resident B into the dining room and then leave him alone there.

⁸ The plan of care for Resident B stated that staff would "monitor [his] whereabouts every hour" but did not specify what this monitoring entailed or how it would be accomplished. CMS Ex. 39, at 22. During the August 3 survey, Pinehurst's director of nursing informed a surveyor that Resident B started to receive one-on-one monitoring sometime during the state survey agency's most recent prior visit (which was the July 21 survey), although she was unsure precisely when that measure was implemented. CMS Ex. 49, at 10.

⁹ Surveyors were in the facility on July 20 and 21, 2004. See CMS Ex. 35, at 2.

Tr. at 54-55. Surveyor Campbell testified that he continued to observe Resident B to ensure that he did not leave the facility through the dining room's unsecured and unalarmed exit doors. Tr. at 55-56. Surveyor Campbell further testified that Resident B was in the dining room alone and unobserved by staff for a long enough period that he could have left the facility undetected through one of those doors. Tr. at 95-96.

We note also the absence of any evidence that Pinehurst tried to determine why or how Resident A managed to leave the facility undetected on July 4, 2004 despite the close monitoring this resident allegedly received after his initial elopement on May 28, 2004. In addition, Pinehurst has not alleged or explained why its discovery of Resident A in the parking lot on July 4, 2004, or the spotting of Resident B outside the facility on July 3, 2004 by an employee on lunch break, should be regarded as a direct consequence of effective monitoring, as Pinehurst suggests, rather than mere fortuitous occurrences. Indeed, there is no evidence that any Pinehurst staff member saw Residents A and B leave the facility on those dates, and the nursing notes suggest the residents were not observed leaving. In sum, Pinehurst failed to establish that its monitoring of elopement-prone residents was adequate to compensate for unlocked or inadequately alarmed exit doors.

The record substantiates that Pinehurst ordered and installed a Wanderguard alarm system that improved the security of its exit doors. Tr. at 457. However, that system was not installed until sometime after the July 21 survey, and there is evidence that it was not working properly during the August 3 survey. See Tr. at 68-70, 457.

Pinehurst asserts that its measures were "successful in stopping elopements on more occasions than they occurred." RR at 22. However, the facility's success in preventing some elopements does not necessarily prove that the facility provided adequate supervision. "The regulation focuses not on whether an accident occurs but, rather, on whether the facility has provided supervision and assistance devices adequate to prevent an accident." Kenton Healthcare, LLC, DAB No. 2186, at 13 (2008).

In short, substantial evidence supports the ALJ's finding that Pinehurst failed to take the "basic preventative steps" of adequately securing all exit doors to which elopement-prone residents had access. Pinehurst also failed to prove that it instituted effective monitoring of elopement-prone residents to compensate for its inadequately secured exit doors. For these

reasons, we affirm the ALJ's conclusion that Pinehurst was not in substantial compliance with section 483.25(h)(2).

- b. *CMS's determination that Pinehurst's noncompliance with 42 C.F.R. § 483.25(h)(2) placed residents in immediate jeopardy is not clearly erroneous.*

CMS determined that an immediate jeopardy situation existed on May 28, 2004 as a result of Pinehurst's noncompliance with section 483.25(h)(2). See CMS Ex. 35, at 3. As discussed, Pinehurst has the burden of proving that this determination is clearly erroneous. The ALJ concluded, and we concur, that Pinehurst has not met that heavy burden. In fact, although Pinehurst indicates that it takes exception to the immediate jeopardy determination (RR at 3), Pinehurst makes no argument in this appeal about the seriousness of the noncompliance found by CMS; Pinehurst merely contends that there was no noncompliance concerning its supervision of elopement-prone residents, a contention that the ALJ properly rejected based on substantial evidence. See RR at 21-22. We thus affirm the ALJ's conclusion that CMS's immediate jeopardy determination was not clearly erroneous.

- c. *Pinehurst's noncompliance with 42 C.F.R. § 483.25(h)(2) was at the level of immediate jeopardy from May 28, 2004 through July 21, 2004.*

The ALJ found that the immediate jeopardy stemming from Pinehurst's noncompliance with section 483.25(h)(2) continued through July 25, 2004. According to the relevant SOD, however, the state survey agency determined that Pinehurst had removed the immediate jeopardy during the July 21 survey. CMS Ex. 35, at 3. We see no indication that CMS disagreed with that determination, and our review of the record found insufficient evidence that the condition of immediate jeopardy stemming from the violation of section 483.25(h)(2) persisted after July 21, 2004. Accordingly, in order to conform the ALJ Decision to the evidence of record, we modify it to state that the condition of immediate jeopardy stemming from Pinehurst's noncompliance with section 483.25(h)(2) existed from May 28, 2004 through July 21, 2004, not through July 25, 2004 (as the ALJ found). This change has no effect on the remedies imposed because the immediate jeopardy period for tag F223 (April 6, 2004 through July 25, 2004) completely overlaps the immediate jeopardy period for tag F324 (May 28, 2004 through July 21, 2004). Thus, our correction to the end-date of the latter immediate jeopardy period does not reduce the number of

days for which immediate jeopardy was found and for which Pinehurst was subject to the \$3,050 per-day CMP imposed by CMS.

- d. *Following the immediate jeopardy period, Pinehurst remained in a state of noncompliance with 42 C.F.R. § 483.25(h)(2) from July 22, 2004 through August 2, 2004.*

The state survey agency and CMS determined that Pinehurst did not come back into substantial compliance with section 483.25(h)(2) until August 3, 2004. See CMS Ex. 35, at 3; P. Ex. 5, at 5. Pinehurst does not contend that it corrected this residual noncompliance prior to August 2, 2004. Thus, we amend the ALJ Decision to state that Pinehurst was not in substantial compliance with section 483.25(h)(2), at a level less than immediate jeopardy, from July 22, 2004 through August 2, 2004.

6. **Tag F225, August 3 survey:** *The ALJ's conclusion that Pinehurst was not in substantial compliance with the reporting requirement in 42 C.F.R. § 483.13(c)(2) is supported by substantial evidence and free of legal error.*

Regarding the August 3 survey, the ALJ concluded that Pinehurst was not in substantial compliance with the reporting requirement in section 483.13(c)(2), which states that a SNF must "ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures" (emphasis added).¹⁰ See ALJ Decision at 25. The ALJ based his conclusion on survey findings that Pinehurst had failed to investigate and follow up on allegations by Resident 8 that a

¹⁰ The ALJ incorrectly indicated that the reporting requirement is contained in section 483.13(c)(1)(ii). ALJ Decision at 25. Section 483.13(c)(1)(ii) prohibits a SNF from employing persons (1) found guilty by a court of law of abusing, neglecting, or mistreating residents or (2) who have had a finding entered against them in a State nurse aide registry concerning abuse, neglect, mistreatment, or misappropriation. Pinehurst submits that it did not employ such persons, but the ALJ made no finding that it did. Rather, the ALJ clearly intended to conclude that Pinehurst was not in substantial compliance with the reporting requirement in section 483.13(c)(2), as the surveyors found.

nurse aide had slapped her, and an allegation by Resident 9 that another facility employee had spoken harshly or mistreated her. Id. (citing CMS Ex. 45, at 1-11). Pinehurst does not dispute that the residents' allegations described "mistreatment" or "abuse" within the meaning of section 483.13(c)(2), nor does Pinehurst dispute that the alleged violations of that regulation were, as CMS described them, serious enough to constitute a lack of substantial compliance. The chief issue is whether substantial evidence supports the ALJ's conclusion that the alleged violations actually occurred.

In its request for review, Pinehurst contends that it investigated the allegations by Residents 8 and 9 and found them to be unsubstantiated. RR at 23-24. The record confirms that a Pinehurst staff member – social worker Susan Davidson – investigated the allegations. But this fact does not undermine the ALJ's conclusion because the basis for the deficiency citation was Pinehurst's failure to initiate a full investigation, using established procedures, by notifying the facility's administrator and other state officials "immediately" of the allegations. See Tr. at 104-07 (testimony by surveyor Susan Richardson). The ALJ found, and the record shows, that Resident 8 first complained that she had been slapped by a nurse aide in February 2004. ALJ Decision at 25; CMS Ex. 47, at 5. Pinehurst does not allege or show that this allegation was reported immediately to the administrator or to other officials. See CMS Ex. 47, at 6; Tr. at 104-09. Similarly, Pinehurst did not show that it reported Resident 9's allegation (made in July 2004) immediately to the administrator and other officials. In addition, the ALJ found, and Pinehurst does not dispute, that Pinehurst failed to notify state officials (via "24-hour" and "5-working day" reports) about Resident 9's allegations until it was prompted to do so during the August 3 survey. Thus, we conclude that substantial evidence supports the ALJ's conclusion that Pinehurst was not in substantial compliance with its reporting obligations under section 483.13(c)(2) during the August 3 survey.

7. ***Tag F226, August 3 survey:*** *The ALJ's conclusion that Pinehurst was not in substantial compliance with the requirement in 42 C.F.R. § 483.13(c) that a SNF develop and implement written policies and procedures prohibiting mistreatment and abuse is supported by substantial evidence and free of legal error.*

Based on the August 3 survey, the ALJ concluded that Pinehurst was not in substantial compliance with the requirement in section

483.13(c) that a SNF "develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property" (emphasis added).¹¹ See ALJ Decision at 25. Like the noncompliance discussed in the previous section, the ALJ's conclusion regarding section 483.13(c) concerns how Pinehurst handled allegations that staff abused or mistreated Residents 8 and 9. The ALJ based this conclusion on the following findings:

Here Petitioner did not follow its anti-abuse policy, which provides, in part, that Petitioner shall immediately complete an incident report listing the residents or staff involved, date, time, location, etc., and timely investigate a reported incident. It did not investigate the allegations of abuse of Residents 8 and 9 until weeks after the incidents allegedly occurred, and neglected to promptly complete an incident report. I find that Petitioner failed to comply with its own policies and procedures in violation of [section 483.13(c)].

ALJ Decision at 25.

Pinehurst challenges those findings by repeating its assertion that it investigated the allegations concerning Residents 8 and 9. See RR at 24-25. As indicated, the record establishes that social worker Susan Davidson investigated Resident 8's allegation on February 24, 2004 and Resident 9's allegation on July 16, 2004, summarizing her findings on a form entitled "Investigation of Unwitnessed Accident."¹² P. Ex. 21, at 1; P. Ex. 22, at 1. According to Pinehurst's resident abuse policy, the Investigation of Unwitnessed Accident form may be used in conjunction with, or in lieu of, an "incident report form," in order to identify potential abuse or other harmful behavior. CMS Ex. 25, at 5. That policy further indicates that the "identification" of possible abuse or other harmful behavior on an incident report or other comparable document (such as the form completed by Ms. Davidson) is only the "first step" of the investigation. *Id.* In addition, the policy requires staff to submit the incident report

¹¹ The ALJ indicated that the requirement to develop and implement written policies and procedures on mistreatment, abuse, neglect, and misappropriation is contained in section 483.13(c)(1)(i). However, that requirement is contained in section 483.13(c), not 483.13(c)(1)(i).

¹² Ms. Davidson re-investigated Resident 8's allegation on July 16, 2004. P. Ex. 21, at 3.

immediately to the administrator, who is then responsible for initiating an investigation of the report and for ensuring that the results of an investigation and decisions made "are fully and appropriately documented and appropriately distributed and that required documentation is completed and filed according to laws and regulations." *Id.* at 7-8. Pinehurst does not point to any evidence that Ms. Davidson "immediately" sent her reports to the facility's administrator, as required by the resident abuse policy. Assuming she did, the available evidence indicates that the administrator did not fully act on these reports until the August 3 survey, weeks or months after the allegations were first made. *See* CMS Ex. 47, at 7; CMS Ex. 48, at 20; P. Ex. 21, 4. Thus, while there is evidence that a single Pinehurst employee investigated the allegations of abuse involving Residents 8 and 9 shortly after they were made (contrary to what the ALJ found), that investigation did not fulfill the requirements of Pinehurst's resident abuse policy. For these reasons, we affirm the ALJ's conclusion that Pinehurst was not in substantial compliance with its obligation under section 483.13(c) to "implement" its resident abuse policy.

8. ***Tag F469, August 3 survey:*** *The ALJ's conclusion that Pinehurst was not in substantial compliance with 42 C.F.R. § 483.70(h)(4) during the August 3 survey is supported by substantial evidence and free of legal error.*

A SNF must "[m]aintain an effective pest control program so that the facility is free of pests and rodents." 42 C.F.R. § 483.70(h)(4) (emphasis added). The relevant SOD states that during an inspection of Pinehurst's kitchen on August 2, 2004,

a roach was observed crawling along the sink where the garbage disposal was located and a roach was observed crawling along the floor near a sink where a storage area was located. There were multiple dead roaches noted along the wall behind the stove, oven, warmer and microwave oven. A dead roach was also observed on the wall between the receptacles for the flour and sugar.

P. Ex. 5, at 21. At the hearing, surveyor Susan Richardson testified that she personally made these observations. Tr. at 109-12. She also testified that she saw food left out in the kitchen after it had been closed for the night. Tr. at 110.

The ALJ found that Pinehurst "did in fact have a pest control policy in place." ALJ Decision at 26. However, he concluded

that the policy was ineffective, citing Surveyor Richardson's observation of dead and live roaches. Id.

Pinehurst asserts in this appeal that it had a program to address pests and rodents but does not dispute the ALJ's conclusion that the program was ineffective. RR at 25-26. Nor does Pinehurst assert – or cite evidence – that it reasonably thought that its program was effective in keeping the facility free of pests and rodents. The facility's kitchen was not free of roaches during Surveyor Richardson's inspection, and the undisputed fact that food was left out overnight indicates that Pinehurst did not take preventative steps to control pests. For these reasons, we affirm the ALJ's conclusion that Pinehurst was not in substantial compliance with section 483.70(h)(4) during the August 3 survey.

9. *CMS had a basis for imposing CMPs that ran from April 6, 2004 through August 24, 2004, and the ALJ properly concluded that the CMPs imposed by CMS were reasonable in amount.*

The regulations authorize CMS to impose a per-day CMP for "the number of days a facility is not in substantial compliance with one or more participation requirements[.]" 42 C.F.R. § 488.430(a). A per-day CMP must fall within one of two ranges – an upper range of \$3,050 to \$10,000, or a lower range of \$50 to \$3,000. Id. § 488.438(a). The upper range is reserved for deficiencies that constitute immediate jeopardy (or for some "repeated" deficiencies). Id. § 488.438(a)(1)(i), (d)(2). The lower range is for deficiencies that do not constitute immediate jeopardy but either caused "actual harm" or had the "potential for more than minimal harm." Id. § 488.438(a)(1)(ii).

A SNF may challenge the reasonableness of a CMP amount in an ALJ proceeding. CarePlex of Silver Spring, DAB No. 1683, at 11 (1999). In deciding whether a CMP amount is reasonable, an ALJ may consider only those factors specified in the regulations. Id.; see also 42 C.F.R. § 488.438(e), (f). Those factors include the SNF's financial condition and history of noncompliance. 42 C.F.R. § 488.438(f).

CMS imposed the following CMPs for the deficiencies found during the July 15, July 21, and August 3 surveys: (1) a \$3,050 per-day CMP for the period April 6, 2004 through July 25, 2004; and (2) a \$100 per-day CMP for the period July 26, 2004 through August 24,

2004.¹³ As a preliminary matter, we note a minor error in the ALJ Decision concerning the \$100 per-day CMP. The ALJ stated that the \$100 per-day CMP continued to accrue "through" August 25, 2004, by which he presumably meant that the CMP remained in effect on that day. However, CMS declared Pinehurst to be in substantial compliance "effective August 25, 2004." P. Ex. 7. Thus, a CMP could be lawfully imposed only through August 24, 2004. Accordingly, we modify the ALJ Decision to state that the \$100 per-day CMP remained in effect from July 23, 2004 through August 24, 2004.

We next consider Pinehurst's objections to the CMPs. Pinehurst contends that the CMPs are unwarranted because it was in substantial compliance with all participation requirements and that if any noncompliance did occur, it was not serious enough to place residents in immediate jeopardy. RR at 26. As discussed earlier, we uphold the ALJ's conclusions that Pinehurst: (1) was not in substantial compliance with various participation requirements at the level of immediate jeopardy from April 6, 2004 through July 25, 2004; and (2) was not in substantial compliance at a lower level of seriousness (i.e., less than immediate jeopardy) from July 26, 2004 through August 24, 2004. Thus, we conclude (as the ALJ did) that CMS had an adequate legal basis to impose CMPs during those periods.

Having determined that CMS had a sufficient basis to impose the CMPs, we next consider whether the ALJ erred in concluding that the CMP amounts were reasonable. Pinehurst contends that \$3,050 per-day CMP for the period of immediate jeopardy is "excessive" and "unreasonable" because of its (allegedly) unblemished compliance history, tenuous financial condition, and other factors.¹⁴ RR at 26-28. This argument is unavailing. When CMS

¹³ CMS also imposed a DPNA from July 23, 2004 through August 24, 2004. P. Ex. 7. Pinehurst does not challenge the imposition of that remedy, other than to argue there was no basis to impose any remedy because it was in substantial compliance, a contention that the ALJ properly rejected based on substantial evidence. The ALJ did, however, incorrectly state that CMS had established a basis for the imposition of a DPNA "through August 25, 2004." In fact, CMS determined, and the record reflects, that a basis for the DPNA existed only through August 24, 2004. See P. Ex. 7. Thus, we correct the ALJ Decision to state that a basis existed to impose a DPNA from July 23, 2004 through August 24, 2004.

¹⁴ In its reply brief, Pinehurst contends that its current
(continued...)

decides to impose a per-day CMP, it must set the per-day penalty amount within the appropriate range specified in section 488.438(a)(1). As the ALJ correctly noted, \$3,050 per day is the minimum amount that CMS could impose for the period of immediate jeopardy. As such, this CMP is reasonable as a matter of law, regardless of Pinehurst's financial condition, compliance history, or other factors.¹⁵ Magnolia Estates Skilled Care, DAB No. 2228, at 28-29 (2009) (citing cases).

As for the post-immediate jeopardy period of noncompliance (July 26 through August 24, 2004), the ALJ concluded that \$100 per day was a reasonable amount. ALJ Decision at 28. Pinehurst does not dispute that conclusion, and so we affirm it without further discussion.

10. *CMS was legally authorized to start the \$3,050 per-day CMP accruing on a date preceding the July 2004 surveys.*

Pinehurst contends that it was "inappropriate" for the \$3,050 per-day CMP to start accruing on April 6, 2004. RR at 27. Pinehurst submits that this CMP should have started accruing no

¹⁴(...continued)

five-star quality rating on CMS's Nursing Home Compare website supports a reduction of the CMP imposed. Reply Br. at 3-4. However, this is not a factor that the regulations authorize an ALJ or the Board to consider in deciding whether the CMP amount is reasonable.

¹⁵ Pinehurst argues that the CMPs imposed in this case violate the excessive fines clause of the Eighth Amendment to the Constitution. RR at 28-29. That issue is not properly before us. First, the Board generally does not address issues that could have been presented to the ALJ but were not. See, e.g., Estes Nursing Facility Civic Center, DAB No. 2000, at 8-9 (2005). Pinehurst failed to present its constitutional argument to the ALJ, and we see no reason why it could not have done so. Second, to the extent Pinehurst is challenging the validity of the regulations which authorized the remedies imposed by CMS in this case, that challenge is beyond the scope of our review. See Sentinel Medical Laboratories, Inc., DAB No. 1762, at 9 (2001) (finding it "well established that administrative forums, such as this Board and the Department's ALJs, do not have the authority to ignore unambiguous statutes or regulations on the basis that they are unconstitutional"), aff'd sub. nom., Teitelbaum v. Health Care Financing Admin., No. 01-70236 (9th Cir. Mar. 15, 2002), reh'g denied, No. 01-70236 (9th Cir. May 22, 2002).

earlier than the date of the surveys that identified the immediate jeopardy. Id. at 27-28. In support of this contention, Pinehurst points to ALJ and Board decisions in which the CMP started accruing on the date of the survey that found the noncompliance, rather than on the date of the pre-survey incidents that were evidence of the noncompliance. Id. at 27-28.

The Board has held that the Act and regulations authorize CMS to impose a CMP for noncompliance that predates the survey that identifies that noncompliance. See Aase Haugen Homes, Inc., DAB No. 2013, at 5-7 (2006) (concluding that the ALJ committed no error in evaluating whether the SNF was in substantial compliance on days on which CMS alleged that noncompliance occurred rather than as of the time of the survey which identified the alleged noncompliance); Mountain View Manor, DAB No. 1913, at 11-15 (2004) (holding that CMS lawfully imposed a CMP for a period of immediate jeopardy that began prior to the survey). For example, section 488.440(a)(1) of the regulations provides that the per-day CMP "may start accruing as early as the date that the facility was first out of compliance, as determined by CMS or the State." Emphasis added. This provision on its face permitted CMS to impose a CMP for the noncompliance that it found to exist prior to the July surveys. Aase Haugen Homes at 6. We thus reject Pinehurst's contention that CMS improperly imposed a \$3,050 per-day CMP for the days of noncompliance predating those surveys.

Conclusion

For the reasons discussed above, we modify the Findings that introduce sections II.C.1, II.C.5, II.C.8, II.C.9, and II.C.11 of the ALJ Decision to read as follows:

II.C.1: Petitioner manifested an immediate jeopardy level failure to comply with 42 C.F.R. § 483.13(b) (Tag 223) from April 6, 2004 through July 25, 2004.

II.C.5: Petitioner manifested an immediate jeopardy level failure to comply with 42 C.F.R. § 483.25(h)(2) (Tag 324) from May 28, 2004 through July 21, 2004; Petitioner remained in a state of noncompliance with 42 C.F.R. § 483.25(h)(2), at a level less than immediate jeopardy, from July 22, 2004 through August 2, 2004.

II.C.8: Petitioner failed to comply with 42 C.F.R. § 483.13(c)(2) (Tag 225).

II.C.9: Petitioner failed to comply with 42 C.F.R.

§ 483.13(c) (Tag 225).

II.C.11: CMS's determination to impose CMPs of:
(a) \$3050 per day for each day Petitioner was not in substantial compliance at the immediate jeopardy level from April 6, 2004 through July 25, 2004; and (b) \$100 per day for each day Petitioner was not in substantial compliance from July 26, 2004 to August 24, 2004, are reasonable.

We affirm and adopt all of the ALJ's other Findings.

_____/s/
Sheila Ann Hegy

_____/s/
Leslie A. Sussan

_____/s/
Judith A. Ballard
Presiding Board Member