Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Azalea Court
Docket No. A-10-76
Decision No. 2352
December 22, 2010

FINAL DECISION AND PARTIAL REMAND ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Petitioner Azalea Court, a skilled nursing facility in Florida that participates in the Medicare program, requests review of the May 25, 2010 decision of Administrative Law Judge (ALJ) Alfonso J. Montaño. *Azalea Court*, DAB CR2134 (2010) (ALJ Decision). The ALJ determined that Azalea Court was not in substantial compliance with Medicare participation requirements and sustained the imposition of civil money penalties (CMP) totaling $264,200, a denial of payment for new admissions (DPNA), and loss of the ability to operate a nurse aide training program for two years.

For the reasons discussed below, we sustain the ALJ's determination that Azalea Court was not in substantial compliance with two Medicare participation requirements at the level of immediate jeopardy. We also sustain his determination that the noncompliance with those regulations continued through May 21, 2008 and constituted immediate jeopardy from January 27 through April 14, 2008. However, we conclude that the basis for the ALJ's determination that the immediate jeopardy under those regulations remained unabated from April 15 through April 19, 2008 is not supported by the record; accordingly, we reverse that determination. We remand the case for an ALJ to address whether the noncompliance with requirements the ALJ did not address (42 C.F.R. § 483.10(a)(1), (2)) provided a basis for concluding that immediate jeopardy continued to exist from April 15 through April 19, 2008.

Applicable law

Federal law and regulations provide for imposing remedies on nursing facilities that do not comply substantially with requirements for participation in the Medicare and Medicaid programs. Sections 1819 and 1919 of the Social Security Act (Act) (42 U.S.C. §§ 1395i-3, 1396r); 42 C.F.R. Parts 483, 488, and 498. "Substantial compliance" is defined as "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health and safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. "Noncompliance means any deficiency that causes a facility to not be in substantial compliance." *Id*.

A long-term care facility found not to be in substantial compliance is subject to various enforcement remedies, including CMPs. 42 C.F.R. §§ 488.402(c), 488.406, 488.408. CMS may impose per-day CMPs ranging from $3,050 to $10,000 for each day of noncompliance at the immediate jeopardy level, and from $50-$3,000 for each day of noncompliance at less than the immediate jeopardy level. 42 C.F.R. §§ 488.408(d)(iii)-(iv), (e)(iii)-(iv). Once a facility is found not in substantial compliance, the remedies imposed continue until "[t]he facility has achieved substantial compliance, as determined by CMS or the State based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit . . . ." 42 C.F.R. § 488.454(a)(1).

A facility 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 the 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 facility "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. (We explain in our analysis why we do not agree with Azalea Court's argument that this allocation of the burden of persuasion violates the Administrative Procedure Act.)

Standard of Review

The Board's standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. The Board's 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 – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs*, http://www.hhs.gov/dab/divisions/appellate/guidelines/prov.html; *Batavia Nursing and Convalescent Inn*, DAB No. 1911, at 7 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 143 F. App'x 664 (6th Cir. 2005).

Background and ALJ Decision[1]

The Florida Agency for Health Care Administration (State Agency) completed a recertification survey of Azalea Court on April 11, 2008, and revisit surveys on April 30, and May 22, 2008. ALJ Decision at 1-2. Based on those surveys, CMS determined that

[1] The information under this heading is drawn from the ALJ Decision, the record before the ALJ and the parties' submissions on appeal. It is presented to provide a context for the discussion of the issues raised on appeal, and is not intended to replace, modify, or supplement the ALJ's findings of fact or conclusions of law.

Azalea Court was out of substantial compliance with four participation requirements at the immediate jeopardy level, and with 26 participation requirements at a level less than immediate jeopardy. *Id*. at 5-6; P. Ex. 17 (Statement of Deficiencies (SOD) from April 11, 2008 survey, with Azalea Court's plan of correction (POC)). CMS determined that the immediate jeopardy level noncompliance began January 27, 2008, that all immediate jeopardy was abated on April 20, 2008, and that the facility had attained substantial compliance effective May 22, 2008, the date of the last survey. CMS imposed CMPs of $3,050 per day for the period January 27 through April 19, 2008, $250 per day effective upon abatement of the immediate jeopardy through May 21, 2008, a DPNA from April 26 through May 21, 2008, and the loss of the ability to operate a nurse aide training and/or competency evaluation program (NATCEP) for two years.[2] ALJ Decision at 1-2, *citing* CMS Exs. 1, at 12-19; 21; 31.

Before the ALJ, Azalea Court presented no evidence or arguments to rebut the 26 findings of noncompliance at less than the immediate jeopardy level. Thus, the ALJ upheld those findings, concluding that the allegations in the SOD were sufficient to establish a prima facie case that Azalea Court did not disprove or rebut. ALJ Decision at 6. In his decision, the ALJ addressed only two of the four immediate jeopardy-level deficiencies, citing Board decisions holding that an ALJ "is not required to make findings of fact and conclusions of law on deficiencies that are not necessary to support the CMP imposed." *Batavia Nursing and Convalescent Center* at 21-24; 42 C.F.R. § 488.438(a)(1) ($3,050 is the minimum per-day CMP that CMS is permitted to impose for immediate jeopardy).

The immediate jeopardy citations the ALJ addressed concern two residents. One, identified as Resident 37 (R. 37), was a mentally compromised 79-year-old man who eloped from the facility undetected. The other, identified as R. 3, took numerous medications with side effects, including drowsiness, and fell asleep in his wheelchair while smoking, igniting a towel on his lap. The ALJ sustained CMS's determination that Azalea Court failed to comply substantially with requirements of both 42 C.F.R. §§ 483.25(h) (F-tag 323) and 483.13(c) (F-tag 224) with respect to each of these two residents.[3] Section 483.25(h) requires that a facility ensure that the resident environment "remains as free of accident hazards as is possible" and that each resident "receives adequate supervision and assistance devices to prevent accidents." 42 C.F.R.

[2] Azalea Court does not dispute the DPNA or loss of NATCEP. As the period of noncompliance at a level lower than immediate jeopardy continued until May 21, 2008, more than three months after the date on which Azalea Court was first determined to be out of substantial compliance, CMS also had authority to impose, and did impose, the remedy of DPNA. Accordingly, we sustain the DPNA that CMS imposed for the period April 26 through May 21, 2008 without further discussion. As we sustain the imposition of a CMP in excess of $5,000, we also sustain the revocation of Azalea Court's NATCEP authority for two years, an action required under the statute and regulations in light of that remedy. *See* Act §§ 1819(f)(2)(B)(iii), 1819(h)(2)(D), 1919(f)(2)(B)(iii); 42 C.F.R. § 488.417.

[3] "F-tags" are used on the statement of deficiencies and in the guidance that CMS issues to surveyors to designate the specific regulatory requirements at issue for each deficiency.

§§ 483.25(h)(1), (2). These requirements are part of the overarching requirement in the introductory language in section 483.25 that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." Section 483.13(c), "Staff treatment of residents," requires, *inter alia*, that "[t]he facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property."

R. 37

R. 37 had diagnoses that included Alzheimer's disease, delirium and visual problems. He had difficulty making himself understood and understanding others, took antipsychotic, antianxiety, antidepressant, and hypnotic drugs, and was on a behavior management program. ALJ Decision at 8, *citing* CMS Ex. 18, at 1, 6. Azalea Court records from December 2, 2007 and January 1, 2008 describe the resident as a "wanderer" with "some behavior issues." *Id., citing* CMS Ex. 18, at 6. They also assess R. 37 as "a risk for elopement" and "[a]t risk for further elopement [with a history] of trying to get out of facility." *Id., citing* CMS Ex. 18, at 8. They also state that he had poor safety awareness and "[w]ould open exit door and sets the alarm." *Id*. To deal with these behaviors, Azalea Court determined that the resident would "always need supervision." *Id., citing* CMS Ex. 18, at 7. Azalea Court fitted R. 37 with a WanderGuard bracelet, and staff, among other measures, were to observe his whereabouts at all times and check his WanderGuard bracelet for placement and function.[4] *Id*. The WanderGuard used by the facility triggers an alarm when a resident wearing a WanderGuard bracelet approaches to within a certain distance of a door equipped to respond to the WanderGuard.[5] *Id*. at 9-10; Transcript of Hearing (Tr.) at 67, 69-71.

On January 27, 2008, R. 37 left the facility without the knowledge of its staff and was spotted wandering alone on a major four lane road by a motorist who alerted the facility at approximately 5:30 pm. Facility staff retrieved the resident and noted that his WanderGuard bracelet, which had been tested and found functioning earlier in the day, was not functioning. CMS Ex. 18, at 11-12. Azalea Court states that R. 37's WanderGuard bracelet "was no longer functioning" but does not deny that the bracelet did not function because it had expired, as CMS states. Azalea Court Request for Review (RR) at 8-9; CMS Brief in Response to RR (Br.) at 11 (expiration of resident's WanderGuard bracelet was "likely . . . the primary cause of the resident's elopement"); *see* Tr. at 414-15 (testimony of Ms. Dickerson, an Azalea Court consultant, that during the investigation of R. 37's elopement the facility's Risk Manager reported to her that the resident's WanderGuard had expired and was not functioning); Tr. at 313-15 (Azalea

[4] "WanderGuard" is a brand name, which the parties and the ALJ referred to as wanderguard or Wanderguard.

[5] Another type of WanderGuard system automatically locks the door and prevents the resident from exiting.

Court consultant Mr. Mehaffey, who was familiar with the elopement, did not dispute repeated questions which assumed that R. 37's WanderGuard bracelet had expired). Azalea Court also does not dispute that such bracelets are effective for only three months and then need to be replaced. Tr. at 274; P. Post-Hearing Reply at 6 n.1.

The ALJ concluded that Azalea Court was not in substantial compliance with section 483.25(h) because it "failed to take all reasonable steps to ensure that [R. 37] received supervision to meet his assessed needs and to mitigate the foreseeable risks of harm from accidents, which, in this case, was his elopement." ALJ Decision at 13. The ALJ also found noncompliance with section 483.25(h) because the circumstances surrounding this incident indicated that Azalea Court was not providing residents an environment as free from accident hazards as is possible. *See id*. at 20 (failure to take systemic measures to prevent elopement created a safety hazard for other residents at risk of elopement). The ALJ also concluded that Azalea Court was not in substantial compliance with section 483.13(c) because it "negligently failed to protect its residents." *Id*. at 18.

R. 3

R. 3, a 45-year-old male, had been admitted to the facility on February 5, 2008, with diagnoses that included bilateral below the knee amputations, paraplegia, depressive disorder, gastric anomaly, constipation, insomnia, decubitus ulcer, and cellulitis. *Id*. at 14, *citing* CMS Ex. 9, at 5, 23. At the time of the survey, R. 3 was on "numerous drugs," including Ambien, Procrit, Remeron, Fentanyl, Percocet, Amitriptyline, Pepcid, Levaquin, and Methadone, medications whose side effects "may impair thinking or include drowsiness, dizziness, or fainting." *Id.*, *citing* CMS Br. at 14-15, Tr. at 143-45, and CMS Ex. 9, at 48, 72-73, 78-79, 88-89.

R. 3 was a smoker. The facility completed a "smoking safety screen" of the resident on February 5, 2008, which indicated on the one hand that he could smoke safely, but, on the other hand, that the resident exhibited side effects from medications including sedation, drowsiness or dizziness; the latter indication required the facility to select the type of supervision that the resident required "and explain why." *Id*. *citing* CMS Ex. 9, at 22. The listed side effects notwithstanding, the screener indicated on the form that the resident was "[a]ble to smoke independently," an option not available for residents suffering sedative side effects. *Id*.

Nurse's progress notes indicate that on March 25, 2008, at 12:30 a.m., a nurse leaving the facility observed R. 3 sitting outside in front of the facility door sleeping with a lighted cigarette in his mouth; the nurse took the cigarette out of the resident's mouth and awakened the resident. The nurse then counseled the resident on "smoking when he is sleepy & the danger that could happen with a lighted cigarette." *Id*. at 15, *citing* CMS Ex. 9, at 40, and P. Ex. 2, at 13. The nursing note further stated that the resident "refused to go in facility to go to bed." *Id*. On April 9, 2008 at 1:00 a.m., the resident was observed in his wheelchair asleep in his room, with "an iron plugged on his table." *Id.*, *citing* CMS Ex. 9, at 41, and P. Ex. 2, at 14. During the survey on April 11, 2008, at 9:30

a.m., a surveyor saw R. 3 on the patio, asleep in his wheelchair, with a lit cigarette that had burned a hole in a towel on his lap, causing it to smolder. The surveyor's notes report: "Towel smoldering – smoke coming out edges of hole glowing red." *Id*., *citing* CMS Ex. 19, at 34 (surveyor's notes), and P. Ex. 2, at 16. The resident was awakened, and he poured water onto the towel to extinguish the combustion. *Id*.

The ALJ concluded that Azalea Court was not in substantial compliance with 42 C.F.R. § 483.25(h) because it failed to address adequately the risks posed by R. 3's smoking and failed to provide proper safety devices, such as "smoking aprons," to address the risk posed by residents smoking in areas where they were known to gather to smoke.

The ALJ concluded that Azalea Court was not in substantial compliance with section 483.13(c) because it neglected to respond adequately to the smoking incidents with appropriate care planning assessments to determine what interventions and supervision R. 3 required. ALJ Decision at 18. The ALJ also concluded that Azalea Court was not in substantial compliance with section 483.13(c) in its treatment of R. 3's pressure sore wounds, as it "neglected to obtain wound care consultations for the resident, failed to provide an ordered wheel chair cushion, and failed to specifically rebut" the surveyor's observations of R. 3's improper wound care treatment on April 9, 2008. *Id*. at 19.

The ALJ further concluded that CMS's determination that the noncompliance with the two regulations posed immediate jeopardy to resident health and safety was not clearly erroneous, and he sustained the remedies CMS imposed. *Id*. at 19-23.

Analysis

Azalea Court argues that the ALJ's determination that it was out of substantial compliance with the participation requirements at 42 C.F.R. §§ 483.25(h) and 483.13(c) are legally erroneous and not supported by substantial evidence. Azalea Court does not dispute the ALJ's finding that Azalea Court did not challenge the lower-level deficiencies, which continued through May 21, 2009.

1. *The ALJ's determination that Azalea Court was not in substantial compliance with section 483.25(h) based on the circumstances surrounding R. 37's elopement and R. 3's smoking is supported by substantial evidence and free of legal error.*

With regard to R. 37's elopement, the ALJ concluded that Azalea Court was not in substantial compliance with section 483.25(h) because Azalea Court "did not have a sufficient system for responding when a wanderguard alarm went off," even though "not all wanderguarded doors were visible from the nursing station," and Azalea Court "did not have designated staff to investigate when an alarm went off." ALJ Decision at 13, *citing* Tr. at 77-78, 150; P. Ex. 22. These deficiencies in its system, the ALJ concluded, raised the possibility that a resident might elope unnoticed, which endangered any resident who needed WanderGuard protection, not just R. 37. The ALJ also noted with

respect to R. 37 – who left the facility unobserved and was found along a major four lane road – that Azalea Court failed to follow the instruction in the resident's care plan that staff observe his whereabouts at all times. *Id*. at 14. The ALJ also found that residents had obtained the WanderGuard code used to silence the alarm (with Azalea Court's knowledge), and that although the WanderGuard bracelets were effective for only 90 days, Azalea Court did not have a system in place to trigger when they needed to be replaced. *Id*. at 13.

Azalea Court asserts that it "did present substantial evidence regarding the extensive system it had in place for responding when a Wanderguard alarm went off." RR at 9. Yet, Azalea Court does not identify that evidence, provides no citations to such evidence in the record, and does not describe its system for responding to WanderGuard alarms, beyond alleging, without citation, that "[a]ll of the staff are to respond when an alarm sounds." *Id*. at 10-11. For the reasons below, we conclude that the ALJ's finding that Azalea Court did not have an adequate response system is supported by substantial evidence.

Azalea Court argues that it had a system for responding to WanderGuard alarms but that the alarm did not go off when R.37 eloped because his WanderGuard bracelet malfunctioned. RR at 8-9. However, the fact that R. 37's WanderGuard malfunctioned is itself evidence of a systemic failure, the undisputed absence of a system for triggering when bracelets needed replacement. Azalea Court asserts that staff tested R. 37's bracelet less than eight hours prior to his elopement. Although that fact appears to be undisputed, frequent testing does not change the fact that without a triggering system related to expiration dates, there was still a foreseeable risk that a WanderGuard would not function even if it had been tested recently. This risk is illustrated by the evidence, some from Azalea Court's own consultant witnesses, that R. 37's bracelet failed because it had expired.

Furthermore, the ALJ's finding that Azalea Court lacked a sufficient system for responding to WanderGuard alarms was based not just on R. 37's elopement but also on evidence about defects in Azalea Court's system obtained during the surveyors' investigation of that elopement. This evidence included the undisputed facts that Azalea Court did not have designated staff to investigate when an alarm went off, that facility staff could not see all WanderGuard-alarmed doors from the nursing station, that staff members who deactivated alarms were not required to notify other staff regarding the outcome, that the facility did not assure that the exit doors were monitored when the alarm system was tested during the survey, and that no staff responded when the alarm went off during that test. ALJ Decision at 13, 17-18. Azalea Court's focus on R. 37's WanderGuard failure does not address these systematic problems which support the ALJ's conclusion that the risk posed by the absence of a system to respond to WanderGuard alarms "extended to any facility resident assessed to need wanderguard protection." *Id*. at 13.

Azalea Court asserts that its staff did not respond to the alarm when it was tested during the survey only because staff knew that the alarm was being tested. RR at 10. Azalea Court cites a statement in the SOD that Azalea Court's unit manager, one of the staff at the nursing station during the test, told the surveyor during an interview that the staff knew the alarm was triggered by the facility's administrator, who had accompanied the surveyor. P. Ex. 17, at 125. Azalea Court presented no corroborating testimony from facility staff, however, and another surveyor testified that the surveyor and the administrator conducted the test with no prior announcement to staff and that one purpose of the test had been to observe the facility's response. Tr. at 94-95, 119-21. Accordingly, the ALJ could justifiably discount the unit manager's after-the-fact statement to the surveyor. The failure of even one staff person to respond to the alarm during the survey supports the ALJ's rejection of Azalea Court's claim that "[a]ll of the staff are to respond when an alarm sounds." RR at 10-11.

Azalea Court also argues that "[t]he ALJ erred when he found that R. #37 should have been continuously monitored by staff and therefore the facility should have known when he eloped." RR at 12. We disagree. In support of his finding that R. 37 should have been "continuously monitored," the ALJ cited the instructions in the resident's care plan to observe his whereabouts "at all times." ALJ Decision at 14. Azalea Court does not even address the care plan requirement, much less state why the instruction does not support the ALJ's finding. Instead, Azalea Court disputes the ALJ's additional reliance on testimony by the facility Risk Manager, Ms. Davis, that the resident should have been "continuously monitored by a staff member." *Id*. at 9, 10 (*citing* Tr. at 286), 14. According to Azalea Court, Ms. Davis merely "admitted that had the resident been participating in the special program for wandering demented residents, he would have been under continuous monitoring." RR at 12, 17, *citing* Tr. at 286. Since Ms. Davis did not use the conditional language that Azalea Court attributed to her, we find no reason to question the ALJ's characterization of her testimony or his finding, based on her testimony and the care plan, that the resident should have been continuously monitored.

Azalea Court also disputes what it characterizes as the ALJ's assumption "that residents without cognitive impairment would intentionally enter the code to allow an impaired resident to elope or escape " RR at 9; *see also* 10, 11; ALJ Decision at 12-13. The ALJ did find that cognitive residents were given or otherwise had access to the alarm codes, and Azalea Court does not deny this. However, he made no finding that those cognitively aware residents intentionally deactivated the alarm to permit mentally compromised residents to leave the facility. He found instead that Azalea Court did not plan for the possibility that this could occur. ALJ Decision at 13. Azalea Court fails to recognize that when residents have the code, they may use it to silence the alarm, in which case staff might not know that an elopement has occurred. Whether a resident who knows the code intentionally uses it to deactivate the alarm so that a resident can elope is irrelevant since the accident hazard exists regardless of such intent. Azalea Court argues that keeping the alarm code from residents would infringe upon their rights or otherwise amount to unlawful restraint. RR at 9, 11. However, Azalea Court has not explained

why this would be the case, especially since the type of WanderGuard system that Azalea Court employed does not lock doors to prevent egress.

Azalea Court argues further that "[c]ontinuous monitoring is not required by the regulation" [section 483.25(h)] and that "[t]here is no requirement in the regulations for continuous or one-on-one monitoring" of residents. RR at 12, 17. This reflects a position that runs throughout Azalea Court's appeal, that its failure to have taken measures the regulations do not specifically require cannot support a determination that Azalea Court was not in substantial compliance. Thus, for example, Azalea Court argues that "[t]here is absolutely no requirement in [§ 483.25(h)] that all doors in a facility be visible from nurses' stations," that insuring "that residents did not know the code to the Wanderguard . . . is not required by the regulation [§ 483.13(c), which we address below]," and that "[t]here is absolutely no requirement in the regulation regarding how Petitioner should prevent elopements or accidents or protect the safety of residents." RR at 16, 18, 20; *see also* P. Reply at 2.

These arguments fail, for two reasons. First, the Board has explained that the federal requirements are based on an "outcome-oriented" approach, in which the regulations establish outcomes facilities must achieve, but provide each facility with flexibility to select methods to achieve them that are appropriate to its own circumstances and needs. *Virginia Highlands Health Rehabilitation Center*, DAB No. 2339, at 5 (2010), *citing Lake Mary Healthcare*, DAB No. 2081, at 17 (2007). However, a facility's "chosen methods must constitute an 'adequate' level of supervision under all the circumstances." *Windsor Health Care Center*, DAB No. 1902, at 5 (2003), *aff'd*, *Windsor Health Care Ctr. v. Thompson*, No. 04-3018 (6th Cir. Apr. 13, 2005). Thus, a facility's failure to take measures that are reasonably necessary, under the circumstances, to achieve an outcome required by the regulation, such as the requirements in 42 C.F.R. § 483.25(h) to ensure that the resident environment remains as free of accident hazards *as is possible* and that residents receive supervision adequate to prevent accidents, is indeed evidence of noncompliance, even though the regulation does not specify the particular measures that the facility must or may take to achieve these outcomes. For this reason, the absence from either section 483.25(h) or 483.13(c) of, for example, a requirement that exit doors be visible from the nursing station, does not mean that the absence of such visibility is irrelevant in evaluating whether a facility is providing adequate supervision and assistance devices to prevent accidents.

Second, the Board has observed that where a facility itself requires that specific measures be taken, either in its policies or in the care plans it develops for its residents, those measures are evidence of the facility's evaluation of what must be done to attain or maintain a resident's "highest practicable physical, mental, and psychosocial well-being" as required by the overarching introductory language to section 483.25. *Desert Lane Care Center*, DAB No. 2287, at 9-10 (2009), *citing Kenton Healthcare, LLC*, DAB No. 2186, at 22 (2008). The Board thus held in *Desert Lane* that "a facility's failure to fully employ those measures as intended in its policies may thus be evidence that the facility failed to provide residents with the services required by specific subsections of section

483.25." In *Cedar Lake Nursing Home*, DAB No. 2288 (2009) *aff'd, Cedar Lake Nursing Home v. U.S. Dep't of Health & Human Servs.*, 619 F.3d 453 (5th Cir. 2010,) the Board held that the plan of care developed to prevent a resident from eloping "was, in effect, Cedar Lake's policy for preventing her from eloping," and concluded that Cedar Lake failed to comply substantially with section 483.25(h) where, among other things, it "did not follow the plan of care it developed to prevent her from eloping," including failing to provide the degree of monitoring and supervision required in the plan of care. DAB No. 2288, at 6-7 and 7 n.4; *see also Spring Meadows Healthcare Center*, DAB No. 1966, at 17 (2005) ("the clearest case of failure to meet [section 483.25] is failure to provide one of the specific services outlined in the subsections or failure otherwise to follow the plan of care based on the comprehensive resident assessment"); *Venetian Gardens*, DAB No. 2286, at 4 (2009) ("Board has repeatedly stated that a facility's failure to follow its care plan or a doctor's order may be grounds for concluding that the facility is not in substantial compliance with section 483.25 quality of care standards.").

Here, less than a month before R. 37 eloped, Azalea Court determined to address the resident's "risk for further elopement" related to his history "of trying to get out of facility" by placing in his care plan an instruction to "[o]bserve [his] whereabouts at all times." CMS Ex. 18, at 8 (care plan, Jan. 1, 2008). The care plan instruction represents Azalea Court's determination of measures necessary to keep the resident from eloping, and the ALJ properly cited the undetected elopement as evidence of Azalea Court's failure to follow that plan and to comply substantially with the adequate supervision requirement in section 483.25(h)(1). While Azalea Court asserts that "an effective care plan" was among the "extensive measures [it had] in place to prevent the elopement of Resident #37," RR at 8, Azalea Court's failure to implement the care plan's instructions to observe the resident's whereabouts *at all times* rendered that care plan ineffective as a tool for shielding the resident from the risk of harm due to his eloping.

In addition to concluding that Azalea Court was not in substantial compliance with section 483.25(h) with respect to the elopement of R. 37, the ALJ concluded that Azalea Court was not in substantial compliance with that regulation because of its failure to address the risks posed by R. 3's smoking. The ALJ found that Azalea Court did not prepare an incident report or conduct an investigation after the resident was found asleep with a lit cigarette on March 25 and near a plugged in iron on April 9, 2008. ALJ Decision at 15-16. The ALJ found that the incident with the iron presented a risk of injury to the resident or others. *Id*. at 20. He also found that for over two months after completing the February 5, 2008 smoking safety screen of the resident, which indicated that the resident exhibited side effects from medications and required supervision while smoking, Azalea Court neither assessed R. 3's smoking in light of the potential side effects of his medications nor care planned for R. 3's smoking behavior in light of those potential side effects. *Id*. at 14, 16. He also found that the facility failed to provide adequate safety devices such as "smoking aprons" in areas where residents were known to congregate and smoke. *Id*. at 17.

Azalea Court does not dispute the substance of these findings, but questions their significance, and mischaracterizes the ALJ's findings and the bases for his conclusions. Azalea Court asserts that "[a]fter prolonged use of medication which may cause sedation, Resident #3 did not feel sedated" and, thus, no new smoking assessments or care plans were necessary. RR at 12. Azalea Court's assertion is contradicted by the fact that the only safety smoking screen of R. 3 in the record (dated February 5, 2008) indicates that the resident exhibited sedative side effects from medications. *See* CMS Ex. 9, at 22 (showing that the screener checked "no" in response to the statement/question "[r]esident/patient does not exhibit side effects from medications including sedation, drowsiness or dizziness"). The safety screen instructions stated that the presence of "no" responses to some or all of the several statement/questions meant that the screener was supposed to "[s]elect the type of supervision required and explain why," whereas "yes" responses to all of the statements/questions meant that the screener could simply select whether the individual could smoke independently or with assistance. *Id*. Azalea Court cites the opinion of Mr. Mehaffey, its consultant, and Ms. Dawkins, another Azalea Court consultant and former Vice President of Clinical Services, that the "no" response actually meant that that R. 3 did <u>not</u> exhibit side effects from medications. Tr. at 326-28. The ALJ rejected this view as insufficient to impeach the credibility of the exhibit because Azalea Court did not produce testimony by the staff person who completed the smoking safety screen. ALJ Decision at 14 n.9, *citing* Tr. at 326-28. We agree that the "no" on the screening form, in context, indicates that the resident exhibits side effects, absent any confirmation by someone with personal knowledge that it did not have that meaning for R. 3. But even if that question was confusing, as Azalea Court asserts, Azalea Court does not allege that there was anything confusing in the screen's requirement that the presence of a "no" answer to any statement/question meant that the screener could not select the option of permitting the resident to smoke independently, as happened here.

In addition, while the ALJ noted the testimony of Ms. Dawkins that the sedative effects of medications such as the resident was taking diminish after long-term use, he also found that the record lacked documentation that this was the case with R. 3.[6] ALJ Decision at 16, *citing* Tr. at 362-68. On appeal, Azalea Court points to no documentation of any clinical determination by the facility that R. 3's sedative side effects diminished. The absence of such evidence adversely affects the persuasiveness of Ms. Dawkins' testimony because she repeatedly cautioned that each individual reacts differently to a drug, that reactions are "very resident specific," and that an "individual assessment" of a resident would be required to determine if he or she had developed a tolerance to sedative side effects of his or her medication. Tr. at 362-65. While Ms. Dawkins was familiar with R. 3 and opined that he could smoke independently, she did not indicate that she or anyone in the facility had determined based on an individual assessment of the resident that he had developed a tolerance to the sedative side effects of his medications.

[6] The facility's explanation that it charts "by exception" and would not have noted the absence of sedative side effects of medications known to produce such effects falters when applied to residents who smoke, given that the facility's smoking safety screen required documentation of the presence or absence of such side effects. Azalea Court also cites no evidence that instances of insomnia, such as were observed in R. 3, rule out the possibility of sedative side effects, as Azalea Court seems to argue. RR at 13.

However, Ms. Davis did testify that that R. 3 should not have been designated to smoke independently after the incident on March 25, 2008. ALJ Decision at 16, *citing* Tr. at 285. Azalea Court's explanation that Ms. Davis merely "indicated that it would have been a good idea for the resident's smoking status to be reevaluated," RR at 13-14, misstates the unequivocal nature of her testimony. She was specifically asked, "should that resident have been designated to smoke independently?" and she replied "no." Tr. at 285.

Azalea Court also argues that "neither assessment nor care plans are required by this particular regulation" (section 483.25(h)). RR at 17. This is not correct. There are other regulations dealing more specifically with assessments and the development of care plans. 42 C.F.R. §§ 483.20 ("Resident assessment"); 483.20(k) ("Comprehensive care plans"). However, section 483.25 effectively incorporates those requirements by requiring in its introductory language that a facility provide each resident "the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, *in accordance with the comprehensive assessment and plan of care*." 42 C.F.R. § 483.25 (emphasis added). Such "care and services," the Board has found, include monitoring and adequately documenting the resident's condition, following established facility policies, providing care consistent with the resident assessment and care plan and ensuring the sufficiency of care plans. *The Laurels at Forest Glenn*, DAB No. 2182, at 6 (2008).

Furthermore, the facility's care plan for R. 3 required the facility to assess the level of supervision that this resident required while smoking. The Board has held that a facility's care plan indicates the facility's assessment of what the resident needs, and that failure to follow the care plan may be grounds for concluding that the facility is not in substantial compliance with section 483.25 quality of care standards. *See, e.g.*, *Venetian Gardens* at 4; *Spring Meadows Healthcare Center* at 17.

In addition, the SOD cited findings about the smoking safety screen and the lack of care planning for R. 3's smoking (and wound care) under sections 483.20(d) and 483.20(k)(1) (F-tag 279,"Comprehensive Care Plans"). The regulations do not prohibit CMS from also including those findings under section 483.25(h) (F-tag 323). P. Ex. 17, at 89-95 (SOD). *See Brian Center Health and Rehabilitation/Goldsboro*, DAB No. 2336, at 6 (2010) (if a given set of facts demonstrates that a facility has violated more than one participation requirement, CMS may, in its discretion, charge the facility with violating any, or all, of the applicable requirements); *see also Oak Lawn Pavilion, Inc.*, DAB No. 1638, at 8-12 (1997), *aff'd, Oak Lawn Pavilion v. HHS*, 2000 WL 1847597 (N.D. Ill. Dec. 14, 2000) (facility not prejudiced by ALJ finding noncompliance with quality of care requirement based in part on facts cited under other unmet requirements because it had notice from SOD that CMS intended to rely on those facts as part of its proof of noncompliance). The ALJ therefore committed no error in basing his conclusion that Azalea Court was not in substantial compliance with section 483.25(h) on his findings that the facility failed to develop new assessments, care plans or smoking screens despite the resident having fallen asleep with a lit cigarette and with a plugged-in iron.

Azalea Court also argues that the ALJ "erred when he concluded that the facility failed to provide necessary safety devices within easy reach of its residents" because, among other things, "[a] designated smoking area is not required by the regulation and independent smokers may smoke outside the building." RR at 15, 17-18. This assertion misses the point. Two facility witnesses confirmed that the facility did have a designated smoking area, a patio, although R. 3 apparently preferred to smoke elsewhere outside the building. Tr. at 356, 418-19. Having undertaken to provide smoking areas for its residents, the facility was responsible for assuring that residents such as R. 3 could smoke there safely, such as by providing the level of supervision required by smoking safety screens (which Azalea Court did not do in the case of R. 3), and furnishing safety devices such as smoking blankets or aprons. It is undisputed that the facility did not provide such protective devices prior to the survey of April 11, 2008, and did not limit smoking to a designated area and arrange for supervision of that area until after the survey.

We thus sustain the ALJ's determination that Azalea Court was not in substantial compliance with section 483.25(h) by both failing to provide proper supervision of R. 37 and having systemic problems that failed to ensure a safe environment for other residents at risk for elopement, and with respect to R. 3 or other residents at risk because they smoked.

2. The ALJ's determination that Azalea Court was not in substantial compliance with section 483.13(c) based on the circumstances surrounding R. 37's elopement and R. 3's smoking and the care of his wounds is supported by substantial evidence and free of legal error.

Section 483.13(c) states that a facility "must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property." The Board has held that multiple or sufficient examples of neglect may support a reasonable inference that a facility has failed to develop or implement policies and procedures that prohibit neglect. *Dumas Nursing and Rehabilitation, L.P.*, DAB No. 2347, at 15 (2010), *citing Barn Hill Care Center*, DAB No. 1848, at 10 (2002); *accord*, *Liberty Commons Nursing and Rehab Center – Johnston*, DAB No. 2031 (2006) (applying holding), *aff'd*, *Liberty Commons Nursing & Rehab Ctr. – Johnston v. Leavitt*, 241 F. App'x 76 (4th Cir. 2007). Azalea Court's policies prohibit the neglect of residents and, like CMS's regulations, define "neglect" as "[f]ailure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."[7] P. Ex. 24, at 1 (Azalea Court's abuse policies); 42 C.F.R. § 488.301.

As we discussed in the previous section, Azalea Court did not have systems for responding to WanderGuard alarms (including failure to designate staff to investigate alarms, even through not all exits were visible from the nursing station) and for tracking

[7] CMS guidance instructs surveyors to use the deficiency tag under which it cited this deficiency, F-tag 224, "for deficiencies concerning mistreatment, neglect, or misappropriation of resident property." CMS State Operations Manual, App. PP, F224, *cited in* ALJ Decision at 17.

when WanderGuard bracelets expired, and it permitted residents to have the alarm code. The ALJ concluded that noncompliance with section 483.13(c) was shown by three different sets of facts – those relating to R. 37's elopement, those relating to R. 3's smoking, and those relating to care of R. 3's wounds. We do not need to reach the issue of whether each set of facts found by the ALJ is sufficient individually to show noncompliance with section 483.13(c), since we conclude that the facts together show noncompliance. Azalea Court's elopement protocol required (among other things) that Azalea Court evaluate the effectiveness of individualized interventions and modify them as indicated for individual residents, and review and revise its interventions following an elopement and communicate those modifications to its care-giving staff. P. Ex. 16, at 52, 56, 58. The protocol also required that Azalea Court develop systematic modifications to its strategies for reducing elopement risk to address identified elopement risk issues, evaluate the effectiveness of its implemented modifications, and provide ongoing staff education related to elopement prevention. *Id*. at 65. While the ALJ did not enumerate these specific elements of Azalea Court's elopement policy, he determined that the facility's failure to protect residents from the risks of elopement constituted violations of its protocol. *See* ALJ Decision at 13 (Azalea Court's practice of providing the alarm code to residents was a "systemic problem in its elopement protocol" that it failed to address prior to the April 11 survey); 20 (residents could still elope until the facility, among other actions, "examined its protocol for reacting to wanderguard alarms").

Azalea Court also neglected to conduct another smoking safety screen of R. 3 after February 5, 2008 to determine what types of interventions and supervision were required for him to smoke safely. It neglected to do so despite the fact that the facility's extant smoking screen showed that he suffered sedative side effects of his medications and required supervision while smoking, and despite having observed him to have fallen asleep with a lit cigarette. One of Azalea Court's own witnesses, Ms. Davis, testified that R. 3 violated the smoking policy on March 25, 2008 (when he fell asleep with a lit cigarette in his mouth), and that after this incident he should not have been permitted to smoke independently. Tr. at 285, *cited in* ALJ Decision at 16. While the ALJ noted that Azalea Court's smoking policy is not in the record, Azalea Court does not dispute that it had a smoking policy or that R. 3 violated it as Ms. Davis testified. ALJ Decision at 16 n.12.

The ALJ also referred to Azalea Court's treatment of R. 3's pressure sore wounds, as it "neglected to obtain wound care consultations for the resident, failed to provide an ordered wheel chair cushion, and failed to specifically rebut" the surveyor's observations of R. 3's wound care treatment on April 9, 2008. *Id*. at 19. Azalea Court argues that the ALJ erred in crediting the written testimony of a surveyor, Ms. Lucas, from a deposition in a state proceeding, that she observed a new pressure sore and three older, previously undocumented pressure sore wounds on the resident during the April 11, 2008 survey. ALJ Decision at 18-19. Azalea Court argues that facility staff testified at the hearing that the resident had no new wounds, and that Ms. Lucas mistook pink scar tissue from a healed wound for a new pressure sore. RR at 19.

Azalea Court's argument is misplaced because the ALJ did not rely on Ms. Lucas's testimony as to the new and undocumented wounds. Instead, he stated that "[e]ven if I accept all that Petitioner says to be true [i.e., that R. 3 had no new wounds], Petitioner still neglected to obtain wound care consultations for the resident, failed to provide an ordered wheel chair cushion, and failed to specifically rebut Ms. Lucas' observations of Resident 3's wound care treatment on April 9, 2008."[8] ALJ Decision at 19. The ALJ noted Ms. Lucas's written testimony that R. 3 had told her, and two facility staff persons had confirmed, that R. 3 had not received two wound care consultations that his physician had ordered. The ALJ also noted Ms. Lucas's testimony that on April 8, 2008, the wound care nurse who changed the resident's dressing failed to wash his hands and, when applying an enzyme medication that eats away dead tissue, improperly applied it to healthy tissue as well. *Id. citing* CMS Ex. 19, at 40, 43, 45-47, and P. Ex. 27, at 21-22 (indicating that the wound care nurse "slabbed" the enzyme medication over the entire area, not just the wound bed). While Azalea Court argues that the ALJ "erred in finding that Petitioner neglected to obtain wound care consultations for Resident #3, [and] failed to provide an ordered wheelchair cushion," it cites no evidence to support this argument. RR at 21. Indeed, Azalea Court admits that "wound care consults had not yet been attained," and Ms. Dawkins agreed that a wound care consultation had been missed and that R. 3 did not receive the consultation until April 14, 2008, after the survey. P. Reply at 4; Tr. at 421-22, 443. Azalea Court argues that such findings should not support the deficiency determination because "[t]here is no requirement in the regulation that the Petitioner obtain outside wound care consultations or provide other specific wound care." RR at 21. We explained in a prior section why we rejected a similar argument. The fact that the regulations do not specify that a particular type of care is necessary to meet a requirement does not prevent a finding of noncompliance when the facility itself has determined that type of care is necessary. *See, e.g., Desert Lane Care Center* at 9-10 *and Cedar Lake Nursing Home* at 6-7 (*supra*).

One could reasonably infer from the multiple examples of neglect discussed above that Azalea Court failed to develop or implement policies and procedures that prohibit neglect. Accordingly, we affirm the ALJ's conclusion that Azalea Court was not in substantial compliance with section 483.13(c).

[8] Azalea Court asserts without citation to the record that the wound care nurse "explained [that] the resident's scar tissue, being pink, may have appeared to be a wound to the surveyor who was not familiar with this resident." RR at 19. In fact, the wound care nurse, in his testimony, referred to "the wound" that this resident had at the time of the survey and stated that the resident would not let anyone see or treat "the wound" except for two wound care nurses, which indicates that the resident did have at least one unhealed wound. Tr. at 252. Ms. Dawkins testified that a nurse consultant examined the resident after the survey and found "older" and "long healed" pink areas that were not open. Tr. at 419-21. The nurse consultant apparently did not testify, and her reported observation is not consistent with the wound care nurse's testimony indicating that the resident did in fact have at least one unhealed wound.

3. We reject Azalea Court's argument that the allocation of the burden of proof violates the Administrative Procedure Act.

Azalea Court argues that requiring it to demonstrate before the ALJ that it was in substantial compliance is contrary to section 7(c) of the Administrative Procedure Act (APA), 5 U.S.C. § 556(d), which provides that the burden of proof in an administrative proceeding lies with the proponent of a rule or order. Azalea Court argues that this APA provision puts the burden of persuasion on CMS, since it seeks to impose a CMP on Azalea Court. RR at 26-30. The Board has previously considered and rejected this argument. In *Carrington Place of Muscatine,* DAB No. 2321, at 24 (2010), we observed that the Board "has consistently held, based on analysis of the applicable statutory and regulatory provisions, that allocating the burden of persuasion to the [facility] does not violate APA procedural requirements." *See also Texan Nursing & Rehab of Amarillo, LLC*, DAB No. 2323, at 18 (2010) ("the burden of proof applied by the ALJ is consistent with the Board's decisions on the burden of proof in long-term care facility cases, none of which has been reversed on appeal on that issue.").

The Board in those cases relied on *Batavia Nursing and Convalescent Center*, in which it rejected a similar argument based on the APA, concluding that under the statutes and regulations governing nursing home participation in the Medicare program, a facility is the proponent of an order finding it in substantial compliance. Accordingly, we find no merit to Azalea Court's burden of proof argument.

The Board has also held that the allocation of evidentiary burdens -- requiring the facility to demonstrate substantial compliance by a preponderance of evidence once CMS makes a prima facie showing of noncompliance -- does not violate the facility's constitutional right to due process. *Carrington Place of Muscatine* at 25, *citing Fairfax Nursing Home, Inc.*, DAB No. 1794, at 8 (2001), *aff'd Fairfax Nursing Home v. U.S. Dep't of Health & Human Servs.*, 300 F.3d 835 (7th Cir. 2002), *cert. denied*, 537 U.S. 1111 (2003), *Batavia Nursing and Convalescent Center* at 15, and *Universal Healthcare/King*, DAB No. 2215, at 26 (2008), *aff'd, Universal Healthcare/King v. DHHS*, No. 09-1093 (4th Cir. Jan. 29, 2010). Azalea Court's similar legal arguments here do not persuade us that the Board's prior decisions on this issue were erroneous.

In any event, the ultimate burden of persuasion is relevant only if the evidence is in equipoise, and we agree with the ALJ here that it is not. *See* ALJ Decision at 5, *citing Community Skilled Nursing Centre*, DAB No. 1987, at 4 (2005), *aff'd, Community Skilled Nursing Centre v. Leavitt*, No. 05-4193 (6th Cir. Feb. 23, 2006).

4. We sustain the determination that the noncompliance posed immediate jeopardy.

The regulations governing this appeal require that "CMS's determination as to the level of noncompliance of an SNF or NF must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c). Under that standard, CMS's determination of immediate jeopardy

here is presumed to be correct, and Azalea Court has a heavy burden to demonstrate clear error in that determination. *See Brian Center Health and Rehabilitation/Goldsboro* at 9, *citing Barbourville Nursing Home*, DAB No. 1962, at 11 (2005), *aff'd, Barbourville Nursing Home v. U.S. Dep't of Health & Human Servs.*, No. 05-3241 (6th Cir. April 6, 2006); *Liberty Commons Nursing and Rehab Center – Johnston*; *Maysville Nursing and Rehabilitation Facility*, DAB No. 2317, at 11 (2010). Once CMS presents evidence supporting a finding of noncompliance, CMS does not need to offer evidence to support its determination that the noncompliance constitutes immediate jeopardy; rather, the burden is on the facility to show that that determination is clearly erroneous. *Liberty Commons Nursing & Rehab Ctr. – Johnston v. Leavitt*, 241 F. App'x. 76, at **3–**4.

The facility's burden extends to overcoming CMS's determination as to how long the noncompliance remained at the immediate jeopardy level. As we stated in *Brian Center*, CMS's judgment that a facility's corrective measures were insufficient to abate the immediate jeopardy prior to the date CMS determined "is, in essence, a determination that the level of noncompliance continued to present immediate jeopardy" to residents. DAB No. 2336, at 7. Thus, "[a] determination by CMS that a SNF's ongoing compliance remains at the level of immediate jeopardy during a given period constitutes a determination about the 'level of noncompliance' and, therefore, is subject to the clearly erroneous standard of review under section 498.60(c)(2)." *Id.* at 7-8. For these reasons we reject Azalea Court's argument that the ALJ should have reviewed CMS's immediate jeopardy determination under a substantial evidence standard. RR at 24.

We agree with the ALJ that CMS's determination that the noncompliance with sections 483.25(h) and 483.13(c) posed immediate jeopardy to resident health and safety was not clearly erroneous. ALJ Decision at 20. As noted, R. 37 suffered from Alzheimer's disease, delirium and visual problems, and was taking hypnotic drugs. He eloped and was found "wandering alone on a major 4 lane roadway." P. Ex. 17, at 114. The dangers to such a resident are obvious, as recognized in other Board decisions upholding determinations of immediate jeopardy in cases of mentally or physically compromised residents who made their way to public roads. *See, e.g., Kenton Healthcare, LLC*, DAB No. 2186 (2008) ("there can be little doubt that serious harm is likely to befall vulnerable residents under these circumstances"); *Century Care of Crystal Coast*, DAB No. 2076, at 24 (2007) ("the fact that someone who was severely mentally impaired and unable to care for her own safety could wander off entirely unnoticed and not be sought until strangers rescued her presents significant likelihood that vulnerable residents might encounter the very dangers which Century Care calls the 'usual hazards of wandering away,' such as falls, traffic, etc."); *Golden Age Skilled Nursing & Rehabilitation Center*, DAB No. 2026, at 18 (2006) (resident "exposed to risks of harm from traffic, weather, and uneven terrain."). The risk of serious injury or even death to R. 37 is apparent, and CMS's determination that the noncompliance with respect to this resident posed immediate jeopardy was not clearly erroneous.

Other compromised residents were similarly at risk absent a system for responding to WanderGuard alarms, assuring that WanderGuard bracelets were functioning, providing

the level of supervision called for in resident care plans and preventing residents from obtaining the WanderGuard code. The peril to R. 3, and other residents, posed by his falling asleep with a lit cigarette and igniting a towel in his lap, causing the towel to combust, is similarly apparent. Although Azalea Court disputes Ms. Lucas's deposition testimony that "small blue flames were eating away at the towel" immediately before water was poured onto it, Azalea Court does not challenge the ALJ's finding that Azalea Court did not dispute Ms. Lucas's account that the towel was "smoldering" with "smoke coming out edges of hole glowing red." ALJ Decision at 15, *citing* CMS Ex. 19, at 34. This evidence supports a conclusion that R. 3 faced likely serious burns if he had not been observed and awakened when he was. Furthermore, Azalea Court has not shown any clear error in the ALJ's determination that the failure to provide ordered skin care consultations and needed devices or treatment for R. 3's wound placed him at risk of serious harm.

5. *We uphold the ALJ's determination that Azalea Court was not in substantial compliance from January 27 through May 21, 2008 and that immediate jeopardy existed from January 27 through April 14, 2008 but remand for a determination of whether immediate jeopardy continued from April 15 through 19, 2008.*

Once a facility is found not in substantial compliance, the remedies imposed continue until "[t]he facility has achieved substantial compliance, as determined by CMS or the State based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit . . . ." 42 C.F.R. § 488.454(a). Where noncompliance is cited at the immediate jeopardy level, a facility challenging the duration of the immediate jeopardy must show that the abatement date found by CMS is clearly erroneous. *Brian Center Health and Rehabilitation/Goldsboro* at 7-8.

Here, the ALJ found that Azalea Court's noncompliance and immediate jeopardy began on January 27, 2008, the date that R. 37 eloped, and continued until it was abated on April 20, 2008. ALJ Decision at 22. The ALJ concluded that Azalea Court had not shown CMS's determination of the April 20, 2008 abatement date to be clearly erroneous and that the facility had not shown it returned to substantial compliance before May 22, 2008.[9] *Id*. Although Azalea Court disputes that noncompliance with sections 483.13(c) and 483.25(h) existed at any level, it does not dispute that any noncompliance or immediate jeopardy that did exist began on January 27, 2008. However, Azalea Court argues that it abated the immediate jeopardy before April 20, 2008. Specifically, Azalea Court argues that the immediate jeopardy involving the January 27, 2008 elopement incident (including the systemic defects discovered as a result of that incident) was abated "within twenty-four hours of the resident's elopement" when new systems were

[9] The ALJ stated that "the immediate jeopardy was removed as of April 20, 2008 . . . ." ALJ Decision at 22. His statements that "[t]he CMP of $3,050 per day was effective for 84 days" and that the CMP of $250 per day was imposed "effective April 20, 2008" show that he determined that immediate jeopardy continued through April 19, 2008, and was abated as of April 20, 2008. *Id.* at 2.

put in place to track WanderGuard expiration dates, WanderGuard bracelets were changed on a weekly basis, and the Risk Manager personally verified that all bracelets worked. RR at 25. Azalea Court also asserts that any immediate jeopardy involving the smoking incident (and related systemic defects) was abated by April 13, 2008, when the facility put into place "new policies and procedures" that included allowing smoking only on the "smoking patio," keeping all smoking supplies on the patio, and having a staff member provide 24-hour supervision to smoking residents needing supervision. *Id*.

We uphold the ALJ's finding that Azalea Court's noncompliance and the immediate jeopardy began on January 27, 2008, since Azalea Court does not dispute that date. We also uphold his finding that Azalea Court did not return to substantial compliance until May 22, 2008, the date of the second revisit survey, since Azalea Court made no arguments specifically disputing that finding and did not appeal at all multiple findings of noncompliance that the revisit survey found were not corrected until that date. *See* P. Ex. 17, at 1-4.

As to the duration of the immediate jeopardy, which Azalea Court does dispute, we conclude that the record, as currently developed, does not support the ALJ's finding that the immediate jeopardy was not abated until April 20, 2008. The ALJ's finding was apparently based on the statement "Abated: 4/20/08" in Azalea Court's plan of correction (POC). ALJ Decision at 22, *citing* P. Ex. 17 [at 58]. However, the ALJ overlooked the fact that the quoted statement is preceded by the statement "F-226 = J" which indicates that the abatement date stated on the POC relates to the alleged immediate jeopardy under deficiency F-tag 226, an issue the ALJ did not reach. *See* ALJ Decision at 6 ("In this decision, I discuss only the immediate jeopardy Tags at F 323 and F 224."). As previously noted, the POC does not posit any abatement date with respect to the two requirements the ALJ discussed. *See* P. Ex. 17 at 45-58, 114-26. Furthermore, CMS's May 5, 2008 notice letter refers to, and appears to accept, the State Agency finding, during the revisit survey, "that corrective action taken by your facility removed the immediate jeopardy for tag F224, F226 [section 483.13(c)], and F323 [section 483.25(h)] as of April 15, 2008 and tag F151 [section 483.10(a)(1), (2)], as of April 20, 2008." CMS Ex. 1, at 18. Thus, CMS found that the facility had abated the jeopardy under both of the requirements the ALJ discussed as of April 15, 2008, not April 20, 2008 as the ALJ found. The evidentiary record contains no notice from CMS altering this statement.

While the Board has held that "an ALJ has discretion, as an exercise of judicial economy, not to address findings that are immaterial to the outcome of an appeal," *Alexandria Place*, DAB No. 2245, at 27 n.9 (2009) (citing decisions), the ALJ here failed to address findings of noncompliance, under section 483.10(a)(1), (2) (F-tag 151), that are material to the duration of the immediate jeopardy. Specifically, his conclusion that Azalea Court was not in substantial compliance with section 483.25(h) and 483.13(c) was based only on the deficiencies cited under F-tags 323 and 224, which, CMS found, continued to pose immediate jeopardy only through April 14, 2008, and not on the alleged deficiency cited under F-tag 151, for which CMS found that the immediate jeopardy continued through

April 19, 2008. Based on the current record, therefore, we must reverse the ALJ's determination to sustain the imposition of a CMP of $3,050 per day from April 15 through April 19, 2008.

On the other hand, we conclude that Azalea Court has not shown that the April 15, 2008 abatement date stated in CMS's notice letter for the immediate jeopardy noncompliance under sections 483.13(c) and 483.25(h) is clearly erroneous. Azalea Court's assertion that it corrected the immediate jeopardy surrounding the January 27, 2008 elopement within 24 hours of the elopement is not supported by the record. During the survey on April 11, 2008, more than two months after the elopement, the surveyors found that a number of problems with the facility's elopement prevention system still existed. For example, staff did not respond to the alarm when surveyors tested it, residents knew the code for disabling the alarm system (Azalea Court changed the code only during the survey), and the facility did not have a system for assuring that staff members were designated to respond to an alarm or for staff members to know whether a staff member, rather than a resident, had turned off an alarm. Similarly, although Azalea Court asserts it abated the immediate jeopardy related to the smoking incident by April 13, 2008, the record indicates that Azalea Court did not place an order for protective smoking aprons, the absence of which surveyors had noted, until during the survey, which ended on April 11, 2008. Azalea Court has not presented any evidence that all of these aprons arrived and were ready for use by residents smoking by April 13, 2008.

In addition, Azalea Court's POC tends to undercut its assertion of abatement immediately after the elopement and the unsafe smoking incident and to support the April 15, 2008 abatement date in CMS's notice letter. The POC does not identify dates by which immediate jeopardy under F-tags 323 and 224 was or was to have been abated, but does contain completion dates for corrective measures CMS has stated it deemed necessary to abate the immediate jeopardy for those deficiencies. CMS stated before the ALJ that immediate jeopardy with regard to R. 37 and the risk of elopement continued "until the facility began properly recording the residents' wanderguard bracelet service and expiration dates, changed the wanderguard alarm, took the necessary steps to prevent its residents from learning the wanderguard code . . . and provided the necessary training to its staff regarding these changes." CMS Post Hearing Br. at 11. CMS stated that the immediate jeopardy concerning R. 3 "was not abated until the facility, *inter alia* . . . drafted and implemented an appropriate smoking care plan for Resident No. 3 . . . implemented appropriate interventions to address the resident's smoking in light of the drowsiness side effects of his various medications . . . and . . . provided the necessary training to its staff regarding these changes." *Id*. at 19. Azalea Court's POC posits April 14, 2008 completion dates for most of the measures addressing these issues. For example, the POC states that "[e]lopement drill was completed on all shifts by 4/14/08;" "review of all residents for exit-seeking behavior was completed by 4/14/08;" that there "will be a 24/7 presence" at smoking areas "effective 4/14/08;" and "residents informed during 4/13/08 meeting that access to secured doors would be maintained only by authorized staff." P. Ex. 17, at 49-51, 53, 119, 120.

Azalea Court asserts that the dates in its POC are not "dispositive of when the facility corrected the alleged deficiencies." P. Reply at 6. We reject the facility's attempts to distance itself from the correction dates it chose to put in its POC. A POC is "a plan developed by the facility and approved by CMS or the survey agency that describes the actions the facility will take to correct deficiencies and specifies the date by which those deficiencies will be corrected." 42 C.F.R. § 488.401. The Board "has long rejected" the argument that a facility "can belatedly claim to have achieved substantial compliance at a date earlier than it even alleged [in its POC] that it had done so or that CMS must prove continuing noncompliance on each day for which remedies are imposed." *The Windsor Place*, DAB No. 2209, at 12 (2008), quoting *Cal Turner Extended Care Pavilion*, DAB No. 2030, at 18 (2006); *see also Lake Mary Health Care* at 29 (holding that the burden was on the SNF to show that it timely completed the implementation of its POC). We recognize that the dates posited in Azalea Court's POC for fully correcting its noncompliance are not necessarily dispositive of when that noncompliance ceased to pose immediate jeopardy. However, Azalea Court has not presented any evidence that the immediate jeopardy ended earlier than April 15, 2008 much less evidence that would show CMS's April 15, 2008 abatement date to be clearly erroneous.[10]

For the reasons discussed above, we uphold the ALJ's determinations as to the duration of the noncompliance, the immediate jeopardy and the remedies imposed, except that we reverse his determination that the immediate jeopardy continued during the period April 15 though April 19, 2008. We remand for a determination of whether the alleged noncompliance under section 483.10(a)(1), (2) provides a basis for finding noncompliance at the immediate jeopardy level during that period. We note in connection with the remand that by order dated October 28, 2010, the Presiding Board Member instructed CMS to indicate whether, if the Board concluded that the record did not support the ALJ's determination that immediate jeopardy existed April 15-19, 2008 based on the noncompliance he discussed, CMS would withdraw the immediate jeopardy level CMP for that period or, instead, request a remand for the ALJ to address F-tag 151. CMS responded by requesting that the matter be remanded for an ALJ "to determine the Petitioner's noncompliance as it relates to Tag 151 for the period of April 15-19, 2008 and to determine the reasonableness of the resulting remedies . . . ." CMS Motion for Remand. Azalea Court filed a response opposing CMS's request, arguing that a remand to address F-tag151 is contrary to regulations permitting the Board to reopen a decision within 60 days of the date of notice of the decision, as more than 60 days have passed since issuance of the ALJ Decision. 42 C.F.R. § 498.100. Azalea Court also argues that a remand would violate its right to due process because CMS did not appeal to the Board the ALJ's failure to make findings on F-tag 151, consistent with CMS's proposed CMP, within the 60-day time period for appealing an ALJ decision. 42 C.F.R. § 498.82. Azalea Court argues that it would be prejudiced because the ALJ who heard this case is no longer at the Departmental Appeals Board, and a new ALJ who addressed the remand

[10] We also note that Azalea Court does not argue that if the Board rejected its argument that it abated the immediate jeopardy immediately after the elopement and the April 11 smoking incident (which we have done) that the facility should be found to have abated the immediate jeopardy at some specified date earlier than April 15, 2008.

issues based on the written record would not have had the opportunity to observe witnesses and assess their demeanor. CMS asserts that it has already submitted its complete case, and asks that no new evidence be allowed or new arguments be considered. CMS Reply to Azalea Court's Opposition.

We find no support in the regulations for Azalea Court's position that a remand violates section 498.100. We have not reopened the ALJ Decision under section 498.100 but have reviewed it pursuant to Azalea Court's request. When the Board "reviews an ALJ's decision" it "may either issue a decision or remand the case to an ALJ for a hearing and decision or a recommended decision for final decision by the Board." 42 C.F.R. § 498.88(a). The regulations do not limit the Board's authority during that review to addressing errors of law or fact in the ALJ Decision in the way that Azalea Court argues. Azalea Court disputed the existence of the deficiencies, and the determination that they posed immediate jeopardy through April 19, 2010. The issue of the duration of the period of immediate jeopardy was, thus, properly before us, and it is within our authority to address that issue and to remand for further proceedings on it.

Accordingly, we remand the case to the Civil Remedies Division for assignment to an ALJ to address Azalea Court's appeal of the noncompliance cited under section 483.10(a)(1), (2) (F-tag 151) and to specifically determine whether noncompliance at the immediate jeopardy level existed from April 15 through 19, 2008. We see no reason to limit the ALJ's authority in the manner that CMS seeks, however. Instead, the ALJ may hold whatever further proceedings the ALJ deems necessary consistent with this decision. In light of this instruction, there is no basis for Azalea Court's claim that it will be prejudiced by the assignment of this case to a new ALJ, an assignment necessitated by the fact that the ALJ who decided the case originally is no longer with the Departmental Appeals Board.

6. The per-day CMP amounts are reasonable.

The $3,050 per-day CMP imposed for noncompliance with sections 483.25(h) and 483.13(c) is reasonable as a matter of law since it is the lowest per-day amount that the regulations authorize for immediate jeopardy deficiencies. 42 C.F.R. § 488.438(a)(1). It is not clear whether Azalea Court challenges the reasonableness of the $250 per-day CMP imposed for the noncompliance with participation requirements at less than the immediate jeopardy level. However, if it does, we affirm the ALJ's conclusion that that CMP amount is reasonable.

The ALJ sustained the $250 per-day CMP for the noncompliance at a level that was less than immediate jeopardy, applying the regulatory criteria at 42 C.F.R. §§ 488.438(f)(1)-(4): the facility's history of noncompliance, including repeated deficiencies; the facility's financial condition; the scope and seriousness of the deficiencies, and the facility's degree of "culpability," which "includes, but is not limited to, neglect, indifference, or disregard for resident care, comfort or safety." ALJ Decision at 22. The ALJ stated that he had no evidence about the facility's compliance history or financial condition. He found that the

deficiencies were serious, involving resident elopement, failure to supervise, assess, and care plan for residents' safe smoking, and failure to consult and appropriately treat pressure sores. Contrary to what Azalea Court asserts, the ALJ did find the facility culpable. Specifically, he found that Azalea Court had failed to take remedial measures to re-assess R. 3's smoking after he was found asleep with a lit cigarette, and did not address, and thus conceded, numerous deficiencies that involved quality of care issues. *Id*.

Azalea Court faults the ALJ for not considering its compliance history or financial condition. However, Azalea Court put on no evidence for the ALJ to consider on these issues. *See id*. (stating that he had no evidence with regard to the facility's compliance history or financial condition). The ALJ properly considered all of the factors on which he had evidence. Given the seriousness of the deficiencies, a number of which Azalea Court did not challenge at all, and Azalea Court's failure to cite evidence relating to the regulatory factors showing that the CMP is unreasonable, we conclude that $250 per-day CMP for the period of noncompliance that did not pose immediate jeopardy is reasonable.

Conclusion

For the reasons explained above, we sustain the ALJ's determination that Azalea Court was not in substantial compliance with 42 C.F.R. §§ 483.25(h) and 483.13(c) beginning January 27, 2008 and that this noncompliance constituted immediate jeopardy from January 27 through April 14, 2008. We also sustain the ALJ's imposition of a CMP of $3,050 per day for that period of noncompliance at the immediate jeopardy level. We reverse the ALJ's determination that the immediate jeopardy continued from April 15 through April 19, 2008 and remand the case for further proceedings to determine whether the alleged noncompliance at the immediate jeopardy level under section 483.10(a)(1), (2) provides a basis for continuing the immediate jeopardy level CMP for that period. We sustain the imposition of a CMP of $250 per day from the date the immediate jeopardy was abated through May 21, 2008, as Azalea Court did not challenge

deficiencies cited at a level of noncompliance less than immediate jeopardy on which that remedy was based.

_____/s/_____
Judith A. Ballard

_____/s/_____
Leslie A. Sussan

_____/s/_____
Sheila Ann Hegy
Presiding Board Member