Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
Courthouse Convalescent Center, (CCN: 31-5228),	)	Date: September 21, 2007
Petitioner,	)	Docket No. C-04-439
	)	Decision No. CR1655
v.	)	
Centers for Medicare & Medicaid Services.	)	

DECISION

This matter is before me on the Centers for Medicare & Medicaid Services (CMS's) Cross-Motion for Summary Judgment (CMS Br.). I rule in favor of CMS and grant their Cross-Motion for Summary Judgment. Therefore, I sustain CMS's determination for the imposition of a per-instance civil money penalty (CMP) of $3,100 for one day, April 3, 2004, and grant its motion for summary judgment.

I. Background

Courthouse Convalescent Center (Petitioner) is a skilled and long term care nursing facility located in Cape May Courthouse, New Jersey. On April 7, 2004, the New Jersey Department of Health and Senior Services (state agency) conducted a complaint survey at Petitioner's facility to determine whether it was in compliance with federal requirements for nursing home participants. The survey found that Petitioner was not in compliance with participation requirements at an immediate jeopardy level for a past noncompliance that occurred on April 3, 2004. The state agency found that the noncompliance constituted substandard quality of care at 42 C.F.R. § 483.25(h)(2) concerning adequate supervision to prevent accidents, but because the deficiency was a past noncompliance,

the deficiency was assigned Tag F 698. By notice dated May 4, 2004, CMS advised Petitioner that it agreed with the state agency findings and of its determination to impose a per-instance CMP of $3,100 based on the instance of noncompliance of April 3, 2004. On July 2, 2004, Petitioner filed a request for hearing. This case was assigned to me for a hearing and decision.

Petitioner filed a motion on September 15, 2004 requesting that proceeding in this case be stayed in order to allow the parties to continue their efforts to settle the matter and to pursue alternative dispute resolution. Petitioner subsequently filed its Report of Readiness to litigate the case along with a Motion requesting leave to file a Motion for Summary Judgment. On November 1, 2004, CMS filed a notice of Issues for Summary Judgment and noted that the parties had conferred and agreed to file cross-motions for summary judgment. The parties also submitted a joint briefing schedule.

My decision is based on the memoranda and other pleadings filed by both parties, and on the documents attached to those memoranda. CMS submitted 25 proposed exhibits (CMS Exs. 1-25) with its Memorandum of Law and Reply Memorandum of Law in Opposition to Petitioner's Motion for Summary Judgment and in Support of CMS'S Cross-Motion for Summary Judgment (CMS Br.). Petitioner submitted 40 proposed exhibits, marked CCC Exs. 1-40, with its Cross-Motion for Summary Judgment (P. Br.). Petitioner marked its exhibits with the abbreviation CCC, however, to comply with Departmental Appeals Board practice, I have labeled each exhibit as Petitioner's Exhibit or P. Ex. Thereafter, Petitioner submitted P. Exs. 41-50 with its reply brief (P. Reply Br.) and P. Exs. 51-55 with its sur reply brief (P. Sur Reply Br.). Without objections from either party, I have admitted the proposed exhibits as CMS Exs. 1-25 and P. Exs. 1-55 into evidence.

II. Issue

The issues in this case are:

> Whether the facility was in substantial compliance with federal participation requirements set forth at 42 C.F.R. §§ 483.25(h)(2);
>
> and
>
> Whether the amount of the CMP imposed by CMS is reasonable, if noncompliance is established.

III. Applicable Law and Regulations

The Social Security Act (Act) (42 U.S.C. § 1320a-7a(c)(4)) sets forth requirements for nursing facility participation in the Medicare and Medicaid programs, and authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations implementing the statutory provisions. Act, sections 1819, 1919. The Secretary's regulations governing nursing facility participation in the Medicare program are found at 42 C.F.R. Part 483.

To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. The regulations define the term "substantial compliance" to mean "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. Under the statute and the "quality of care" regulation, each resident must receive and the facility must provide the necessary care and services to allow a resident to attain or maintain the highest practicable physical, mental, and psycho social well-being, in accordance with the resident's comprehensive assessment and plan of care. Act, section 1819(b); 42 C.F.R. § 483.25.

If a facility is not in substantial compliance with program requirements, CMS has the authority to impose one or more of the enforcement remedies listed in 42 C.F.R. § 488.406, which include the imposition of a CMP. *See* Act, section 1819(h). The regulations specify that a CMP that is imposed against a facility will fall into two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMPs, of from $3,050 per day to $10,000 per day, is reserved for deficiencies that constitute "immediate jeopardy" to a facility's residents, and in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1), (d)(2). The lower range of CMPs, of from $50 per day to $3,000 per day, is reserved for deficiencies that do not constitute "immediate jeopardy," but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(2). There is only a single range of $1,000 to $10,000 for a per-instance CMP, which applies whether or not immediate jeopardy is present. 42 C.F.R. §§ 488.408(d)(1)(iv); 488.438(a)(2).

"Immediate jeopardy" is defined to mean "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.*

Appeal rights attach to certain initial determinations made by CMS as set forth in the regulations. The level of noncompliance, in this case immediate jeopardy, can be appealed but only if the *range* of CMP that can be collected could change or if the facility's nurse's aide training program will be affected due to a finding of substandard quality of care. 42 C.F.R. §§ 498.3(b)(14)(i), (ii) and 498.3(d)(10)(i), (ii). A per instance CMP can be from $1,000 to $10,000. There is no specifically defined range of per instance penalty for findings of immediate jeopardy. 42 C.F.R. § 488.438(a)(2). Thus, a finding of immediate jeopardy can have no effect on a range of penalties.

In determining the amount of the CMP, the following factors specified at 42 C.F.R. § 488.438(f) must be considered:

1. The facility's history of noncompliance, including repeated deficiencies;
2. The facility's financial condition;
3. The factors specified at 42 C.F.R. § 488.404; and
4. The facility's degree of culpability.

When a CMP is imposed, CMS must make a prima facie case that the facility has failed to comply substantially with federal participation requirements. To prevail, a long-term care facility must overcome CMS's showing by a preponderance of the evidence. *Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd*, *Hillman Rehabilitation Center v. United States Department of Health & Human Services, Health Care Financing Administration*, No. 98-3789 (GEB), slip op. at 25 (D.N.J. May 13, 1999).

The Act and regulations make a hearing before an administrative law judge (ALJ) available to a long-term care facility against whom CMS has determined to impose a CMP. Act, section 1128A(c)(2); 42 C.F.R. §§ 488.408(g), 498.3(b)(12), (b)(13). The hearing before an ALJ is a de novo proceeding. *Anesthesiologists Affiliated, et al.*, DAB CR65 (1990), *aff'd,* 941 F.2d 678 (8th Cir. 1991).

IV. Findings and Discussion

I make findings of fact and conclusions of law (Findings) to support my decision in this case. I set forth each Finding below in *italics* as a separate heading followed by a discussion of these Findings.

A. CMS is entitled to summary judgment in this case.

Summary judgment is appropriate when there is no genuine issue as to any material fact and one of the parties is entitled to judgment as a matter of law. Fed. R. Civ. P. 56. If the moving party meets this burden, the onus shifts to the opposing party to establish that a

genuine issue as to a material fact does exist. The opposing party will have shown that genuine issues of material fact are present "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248, 249 (1986). To accomplish this, the opposing party must go beyond mere allegations, and come forward with factual evidence that creates a genuine issue of material fact. All reasonable inferences are to be drawn in the opposing party's favor. *Pollock v. American Tel. & Tel. Long Lines,* 794 F.2d 860, 864 (3rd Cir. 1986).

Under Rule 56 a "material fact" is a fact which, if it exists, may affect the outcome of a case. A "genuinely disputed" material fact exists when opposing parties advance different versions of an event. The concept of a genuine dispute as to the facts is critical to understanding how summary judgment works. A fact offered by a party is not in dispute simply because the opposing party asserts that it is in dispute. In order for there to be a dispute as to the facts the opposing party must offer a version of events that differs materially from the version offered by the moving party.

Furthermore, Rule 56 draws a distinction between facts and conclusions that are based on facts. A disagreement between parties as to the meaning of facts is not an impediment to summary judgment under Rule 56. The trier of fact always has the authority to draw conclusions from facts, whether the case is disposed of by summary judgment, or after a hearing. Thus, arguments about the meaning of facts – as opposed to disputes as to what facts exist – constitute no impediment to granting summary judgment in a case.

I have considered all of the evidence submitted before me, and conclude that all inferences drawn from such evidence, casts no doubt as to the propriety of granting CMS's motion for summary judgment inasmuch as there is no issue of material fact to be tried. CMS's motion is properly supported by the documentary evidence.

Both parties maintain that this matter can be decided on motions for summary judgment. The parties conferred and agreed to file motions for summary judgment, and proposed a briefing schedule. CMS has filed a request for summary judgment and Petitioner responded by filing a cross motion for summary judgment. Both parties maintain that there are no genuine issues of material fact and argue that the case should be decided based on their respective motions for summary judgment. In the case before me, the parties dispute several facts: how Resident 1 left the Alzheimer's/Dementia unit, how Resident 1 left the floor on which the Alzheimer's/Dementia unit was located, whether the receptionist was notified or interviewed about the elopement, whether the resident went to a 7-Eleven or an Acme store when outside of the facility, how many streets Resident 1 crossed during the time she was outside the facility, whether any of these streets were major streets, the route she took while outside the facility, and the accuracy of the surveyor's interviews with staff members. However, none of these disputes

concern material facts in the matter before me. The parties do not dispute the material facts and inasmuch as there are no material facts in dispute, summary judgment is proper without an evidentiary hearing.

B. Petitioner was not in substantial compliance with the program participation requirement found at 42 C.F.R. § 483.25(h)(2).

Petitioner is a skilled and long-term care facility located in Cape May Courthouse, New Jersey. The April 7, 2004 survey found that Petitioner was not in substantial compliance, at an immediate jeopardy level (level J), with the regulation at 42 C.F.R. § 483.25(h)(2) which provides:

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psycho social well-being, in accordance with the comprehensive assessment and plan of care.
>
> (h) *Accidents.* The facility must ensure that -
>
> . . . .
>
> (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

In cases concerning compliance with 42 C.F.R. § 483.25(h), the focus is on the language of the regulation; i.e., the facility **must ensure** each resident receives adequate supervision to prevent accidents according to a comprehensive assessment and a plan of care (emphasis added). The facility's duty, as stated in the regulation, is an affirmative duty. The Departmental Appeals Board (Board) has explained the requirements of 42 C.F.R. § 483.25(h)(2) in numerous decisions. *Golden Age Skilled Nursing & Rehabilitation Center*, DAB No. 2026 (2006); *Estes Nursing Facility Civic Center*, DAB No. 2000 (2005); *Northeastern Ohio Alzheimer's Research Center*, DAB No. 1935 (2004); *Woodstock Care Center*, DAB No. 1726, at 28 (2000), *aff'd*, *Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). Section 483.25(h)(2) does not make a facility strictly liable for accidents that occur, but it does require that a facility 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 facility must take "all reasonable precautions against residents' accidents"). A facility is permitted the flexibility to choose the methods of supervision it uses to prevent accidents, but the chosen methods must be adequate under the circumstances. *Id*. Whether supervision is

"adequate" depends in part upon the resident's ability to protect himself or herself from harm. *Id*. Based on the regulation and the cases in this area, CMS meets its burden to show a *prima facie* case if the evidence demonstrates that the facility failed to provide adequate supervision and assistance devices to prevent accidents, given what was reasonably foreseeable. *Alden Town Manor Rehabilitation & HCC*, DAB No. 2054, at 5-6, 7-12 (2006). An "accident" is "an unexpected, unintended event that can cause a resident bodily injury," excluding "adverse outcomes associated as a direct consequence of treatment or care (e.g., drug side effects or reactions)." State Operations Manual (SOM), App. P, page PP-105, Guidance to Surveyors for Long Term Care Facilities, Part 2, F324, Quality of Care (Rev. 274, June 1995), *Woodstock Care Center*, DAB No. 1726, at 4. The Board has consistently found that an elopement constitutes an "accident" under 42 C.F.R § 483.25(h)(2).

The evidence establishes a *prima facie* showing of a violation of 42 C.F.R. § 483.25(h)(2) in this case, i.e., CMS has produced sufficient evidence that, absent conflicting evidence, shows a violation occurred. *Meadow Wood Nursing Home*, DAB No. 1841, at 7 (2002); *Emerald Oaks*, DAB No. 1800, at 16 (2001). Resident 1 was outside the facility without the knowledge of the staff and without supervision. Thus, the burden is upon Petitioner to either rebut the *prima facie* case or to show affirmatively, that more likely than not, it was in substantial compliance. *Emerald Oaks*, DAB No. 1800 at 16.

On April 3, 2004, Resident 1, who was residing on Petitioner's Alzheimer's/Dementia unit, eloped from the facility, crossed several streets, went to a store, slipped when leaving the store, and ended up at a nearby hospital. Petitioner admits that Resident 1 crossed at least two roads during the elopement. P. Reply Br. at 8. Petitioner admits that Resident 1 became confused while outside the facility and could not find her way back to the facility. Petitioner was unaware of Resident 1's location until the nearby hospital telephoned to say that Resident 1 was in the hospital emergency room. Resident 1 did not receive any care at the hospital. No injuries were noted as a result of Resident 1's slip. After the elopement, Resident 1 continued to reside on the secured Alzheimer's/Dementia unit. She was required to wear a Wanderguard and was not allowed out of the unit or the facility unsupervised. These facts are not in dispute.

Resident 1, a 69 year old female with a PhD from Harvard, was admitted to the facility on March 5, 2004, one month prior to her elopement. CMS Ex. 9, at 5. Prior to being admitted, Resident 1 was hospitalized from March 1 to March 5, 2004. The hospital assessed Resident 1 as having dementia, chronic alcoholism, and confusion. CMS Ex. 9,

at 7-8. At the time of her admission, she was diagnosed with senile dementia,[1] was assessed as having "very poor" cognitive status, had a history of smoking, and required placement on the facility's secure Alzheimer's/Dementia unit. CMS Ex. 9, at 10-11. Resident 1 was non-ambulatory at the time of her admission. *Id.* At admission, Resident 1 was not assessed as an elopement risk because she was not able to ambulate. Resident 1 was unsteady on her feet and unable to walk. *Id.* at 5. Resident 1 was also assessed as agitated and lacking in safety awareness. *Id.* Resident 1's condition improved in her first month at the facility. She became ambulatory and her cognitive status also improved.

A physician's order, dated March 5, 2004, allowed Resident 1 to leave the facility with family or friends, but did not allow her to leave the facility unsupervised. CMS Ex. 18, at 38; P. Ex. 21. This order was continued through April and May, 2004. *Id.* at 33, 36. Therefore, both before and after the elopement, Resident 1 was not to leave the facility unsupervised. Resident 1's care plan specified that she "will not go out of facility unsupervised."[2] Resident 1's care plan also stated that she was alert, agitated, at risk for falls, and disoriented to time, place, and person. CMS Ex. 9, at 12-13.

Progress notes on Resident 1 showed she required observation (CMS Ex. 18, at 90, 92), had no safety awareness (*Id.* at 90), was confused (*Id.* at 93, 94, 98, 101*),* wandered without purpose (*Id.* at 95), wandered independently with agitation (*Id.* at 95), and wandered into the hallway (*Id.* at 100). Petitioner objects to the use of the word "wander" as indicative of an individual unaware of her actions but instead claims that the word "wander" is an indication that Resident 1 was determined to improve her walking and increase her balance.

On March 12, 2004, an initial Minimum Data Set (MDS) assessed Resident 1 with long and short term memory problems, severely impaired cognitive skills, and as requiring the assistance of one staff person to ambulate. CMS Ex. 18, at 48.

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[1] The documents provided to me show that at times Resident 1 was diagnosed as having senile dementia, while at other times she was diagnosed with alcohol induced dementia.

[2] It is not clear if this notation in the care plan was written before or after the elopement, although it would make more sense if the notation was made after the elopement. What is clear is that both before and after her elopement, Resident 1 was residing on the secured Alzheimer's/Dementia unit.

On March 16, 2004, Ms. Holly Miller, a nurse at the facility, wrote in a nursing note when referring to Resident 1 leaving the facility for an outside appointment, "Husband stated 'You'll never get her back here [without] a fight and all she will want to do is buy cigarettes.'" CMS Ex. 18, at 94; P. Ex. 25, at ¶ 23. The nursing staff should have assessed Resident 1 to determine if she was an elopement risk in light of a stated desire that she wanted to leave the facility to buy cigarettes and the fact that she was now ambulatory. It failed to do so. Surveyor Newcomb, testified that the combination of Resident 1's return to ambulation and her husband's acknowledgment that Resident 1 would want to leave the facility to buy cigarettes put Petitioner on notice that Resident 1 might be an elopement risk. Ms. Newcomb asserted that these facts should have prompted Petitioner to reassess Resident 1 to determine if she was an elopement risk. CMS Ex. 24, at ¶¶ 3, 40; CMS Ex. 25, at ¶ 4. Petitioner did not point to any intervention that was adopted after notification of Resident 1's desire to go buy cigarettes. As Resident 1 become ambulatory and expressed a desire to leave the facility, Petitioner failed to respond in any manner.

Petitioner attempts to explain away Ms Miller's nursing note. Petitioner points to a declaration made by Ms. Miller in which she states, "My intent noting this was only to record the husband's acknowledging that the resident wanted to leave the facility and she wanted to get cigarettes." P. Ex. 25, at ¶ 23. Petitioner continues by stating that the resident's husband did not drive and that he was an avid bird watcher and did not want to give up time from his bird-watching hobby to assist or care for the resident when the resident would be out of the facility. *Id.* at ¶ 25; P. Br. at 7. Petitioner's argument is irrelevant. Petitioner's attempt to explain away this nursing note fails miserably. This nursing note undercuts Petitioner's claim that it had no notice that Resident 1 was an elopement risk. Petitioner did have notice that Resident 1 wanted to leave the facility and did not act on that notice.

A second MDS was prepared on March 18, 2004 which showed that Resident 1 had improved but that she continued to have short term memory problems and still required the assistance of one staff member to ambulate. *Id.* at 57.

On March 25, 2004, the resident's psychiatrist evaluated her as confused and disoriented. CMS Ex. 18, at 198. The evaluation also documented her to be "confused and disoriented," "delusional somewhat," "speaks in fabrication primarily," "unable to ambulate without assistance," and "still denies alcoholism." *Id.*

Occupational Therapy (OT) notes on March 25, 2004, indicated that Resident 1 was at risk for falls and that her safety awareness was impaired. *Id.* at 179-180. OT notes for March 27, and 29 show cognitive deficits. *Id.* at 190. Physical Therapy (PT) notes dated March 29 stated Resident 1 is “unaware of safety issues.” *Id.* at 187. PT therapy notes on March 30 also raised safety concerns. *Id.* at 188.

On April 3, 2004, Resident 1 eloped from the facility. At the time of the elopement, Resident 1 was not identified as a wanderer or an elopement risk, did not have one on one monitoring and did not have a Wanderguard. CMS Ex. 3, at ¶ 36. On April 3, 2004, at 10 a.m., Resident 1 was noted to not be on her unit, a search was conducted of the facility and the immediate periphery of the facility. *Id.* at 103. At or about 10:30 a.m., the local hospital telephoned the facility that Resident 1 had appeared at the hospital emergency room. Resident 1 was picked up by Petitioner from the hospital by car and was subsequently examined by the facility. No injuries were noted. The Incident /Accident Report (CMS Ex. 8), dated April 3, 2004, notes that Resident 1 was not in her room or on the unit at 10 a.m., that an unsuccessful search of the facility was conducted, and that at 10:30 a.m. the hospital emergency room called that Resident 1 had “checked herself in” the emergency room. *Id.* at 2. There is a dispute as to which individual at the nursing home first noticed that Resident 1 was missing, but the identity of that person is not material to the matter before me. CMS Br. at 25-27. The facility admits in its report faxed to the state agency on April 6, 2004 that the resident “can now ambulate 100 feet with CGA [Contact Guard Assistance]; her gait and balance are poor” and that Resident 1 was “attempting to check herself into the hospital” at 10:30 a.m. *See* CMS Ex. 6. Petitioner in its brief now contends that the characterization in the Incident/Accident Report of Resident 1 “checking herself” into the hospital was incorrect.

The surveyor interviewed Resident 1 on April 7, 2004, three days after the elopement. Surveyor Newcomb’s impression was that Resident 1 appeared confused and not totally coherent when she was interviewed. CMS Ex. 3, at ¶ 74. There is also some confusion as to whether Resident 1 went to an Acme store or a 7-Eleven store when she left the building. Both parties agree that Resident 1 went to a store to buy cigarettes, that she slipped while outside, was uninjured, but due to confusion she ended up going to a nearby hospital instead of returning to the facility. The hospital contacted the facility to inform Petitioner that Resident 1 was in the hospital’s emergency room. Resident 1 did not receive any medical treatment while at the hospital’s emergency room. Resident 1 was picked up by Petitioner’s staff from the emergency room and returned to Petitioner’s Alzheimer’s/Dementia unit.

Pat Schaefer, the Director of Nursing (DON), told the surveyor when interviewed after the elopement, that Resident 1 was placed on the secure Alzheimer's/Dementia unit because she had a history of dementia, agitation, and had no safety awareness but had no history of prior elopement. CMS Ex. 3, at ¶ 35; CMS Ex. 7 at 3.

After the elopement, an April 8, 2004 MDS documented that Resident 1 still had short term memory problems, episodes of disorganized speech, unsteady balance, periods of restlessness and that her mental function varied over the course of the day. CMS Ex. 18, at 63-64. Resident 1's care plan states decreased episodes of wandering as a goal and "will not go out of facility unsupervised." CMS Ex. 9, at 13. Resident 1's care plan also documents that Resident 1 is at risk for falls. CMS Ex. 9, at 12. Both of these statements on the care plan are undated. Thereafter, Resident 1's care plan was updated on April 24, 2004. The updated care plan noted a potential for elopement, wandering, desire to return home, supervision for a majority of her activities of daily living due to cognitive deficits, history of falls, unsteady gait, and poor safety awareness. CMS Ex. 18, at 43-44. Also, on April 24, 2004, a wandering assessment was done that noted that Resident 1 was confused, disoriented, had indications or diagnosis of dementia, and assessed Resident 1 as requiring a Wanderguard. *Id*. at 81. Numerous progress notes after the elopement described Resident 1 as confused, forgetful, and that the facility did not let Resident 1 go outside unsupervised. CMS Ex. 18, at 105, 108, 109, 110.

A physical therapy progress summary dated April 7, 2004 states that Resident 1 has a "balance deficit" and is "easily thrown off balance." P. Ex. 32, Attachment A, at 2. A physical therapy note dated April 14, 2004 states that the "[p]atient requires DS [distant supervision] within the nursing unit and CS [contact supervision] on uneven surfaces." P. Ex. 32, Attachment A, at 3. Physical therapy was discontinued on April 16, 2004, but physical therapy notes indicated that Resident 1 was to ambulate only with supervision from the nursing staff and required supervision on uneven surfaces. P. Ex. 32, Attachment A, at 6; CMS Ex. 25, at 30. A nursing note dated May 14, 2004 notes Resident 1 "exhibits short term memory loss, repeats herself at times [and] has to think about a question before answering." CMS Ex. 18, at 112. Resident 1 was discharged from the facility and returned home on June 1, 2004.

Resident 1 admits, in her own declaration made after her discharge and her return home, that "as I came out of the door of the 7/11 [7-Eleven], I was confused when I looked out and could not distinguish between the two buildings I saw before me. I ended up in the hospital building instead of the nursing home." P. Ex. 20, at ¶¶ 15-16. The fact that Resident 1 mistook the red brick hospital for the primarily tan color nursing home and could not recall what direction she had just come from minutes earlier is evidence that Resident 1 had short term memory problems on the date of the elopement. Petitioner admits to this. Also in her post elopement statement, Resident 1 admits that during her

elopement she slipped when she exited the store. Resident 1 had been assessed to be at risk for falls. Nine days after the elopement, Resident 1 fell in the nursing home on April 12, 2004 and fractured her hand. CMS Ex. 18, at 106, 107.

There is no dispute that Resident 1 was confused while outside the facility, during her elopement. Resident 1 ended up at a nearby hospital rather than returning to the facility. The parties dispute how similar these two buildings look. The facility building is primarily a tan color with some red brick and the hospital is a red brick building. CMS Ex. 17; P. Ex. 44, 46, 47. However, there is no dispute as to the material fact that Resident 1 was confused and could not find her way back to the facility.

Petitioner never assessed whether Resident 1 was an elopement risk at admission, possibly because Resident 1 was non-ambulatory. Thereafter, Petitioner failed to assess whether Resident 1 was an elopement risk when Resident 1's condition changed and she became ambulatory. Further, when Resident 1's husband let the facility know that his wife, who was a smoker, would want to go get cigarettes, that put the facility on notice of her desire to leave the facility. At that point, the facility knew that Resident 1 had the desire to leave the facility and was ambulatory enough to leave the facility. Petitioner does not deny the existence of Resident 1's husband's statement and does not deny that Resident 1 became ambulatory. Nevertheless, the facility did nothing to prevent an attempt to elope. The existence of these factors coupled with a secured Alzheimer's/Dementia unit that was not secure makes Resident 1's elopement foreseeable.

There emerges from these facts a picture of Resident 1 that is clear. On the day of her elopement, Resident 1 was on the path to recovery from her alcohol induced dementia but she was far from able to go outside unsupervised. On the day of her elopement, Resident 1 was confused, somewhat disoriented, and had short term memory problems. In addition, she had an unsteady gait with balance problems, was at risk for falls, and had poor safety awareness. During the course of her elopement, Resident 1 was in danger of falling, had to contend with traffic, cross a minimum of two roads and had to walk outside where the surfaces were not even.[3]

Petitioner claims that the facility never had an elopement before. Petitioner argues that it had no notice that R1 was an elopement risk and that therefore, Resident 1's elopement was not foreseeable. Further, Petitioner states that R1 had never exhibited any exit seeking behaviors. This argument is undercut by the March 16, 2004 statement made by the resident's husband. On that date, the facility was on notice that Resident 1 wanted to

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[3] CMS contends that there was an area that was not paved but filled with red gravel that Resident 1 may have crossed during her elopement. CMS Ex. 18, at 188.

leave the facility to buy cigarettes. It was clearly foreseeable that Resident 1, once she was able to ambulate again, was an elopement risk and she required some intervention to address that risk. Petitioner failed to respond in any way to that risk.

Petitioner claims that Resident 1 was almost at the top of her physical recovery in her physical therapy. P. Br at 3. Resident 1 was reading magazines and playing crossword puzzles and remembered to take her coat when she eloped and that she described herself as walking safely while outside. Petitioner also points out that Resident 1 had a PhD. Petitioner claims that additional restraints, such as a Wanderguard, would be a violation of Resident 1's autonomy, independence, and dignity prior to April 3, 2004 and that Resident 1 was improving so much that she was eventually discharged on June 1, 2004.

In effect, Petitioner argues that Resident 1 was capable of leaving the facility unsupervised. Petitioner relies on declarations of staff and expert witnesses to support this argument. However, this argument is not supported by the documentary exhibits provided and is without merit. The facility's care plan goals and other assessments document that Resident 1 was in need of supervision, before the elopement, after the elopement occurred, and even while she was on the secured unit.

Petitioner argues that Resident 1 was cognitively able to be outside the facility without supervision because she "planned" her elopement. Petitioner argues that Resident 1 remembered to take her coat with her, did not encounter any difficulties and merely reasonably became confused between the nursing home and the hospital once she was outside the facility. P. Br. at 11. This argument is also speculative and unsupported by evidence. Petitioner submits Resident 1's declaration made after her discharge from the facility as evidence of her cognitive status. Petitioner's proffered evidence of the resident's mental status at some later date fails to raise a genuine issue of material fact regarding her mental status on April 3, 2004, the date of her elopement.

Petitioner also relies on the opinion of Dr. Jackson, an outside expert, that it is common practice in the nursing home industry for staff "to implement actions for residents' [sic] whose care is 'of concern' to the surveyors, even when the staff feels that there is no real indication for the intervention (as long as it doesn't 'hurt' the resident) . . ." P. Ex. 38, at ¶ 1(d). I find Dr. Jackson's opinion irrelevant as none of the staff, in their statements, stated that the assessments or documentation they prepared while they were caring for Resident 1 were inaccurate or false in any way. Petitioner's reliance on Dr. Jackson's expert opinion on other matters is misplaced because his declaration does not go to the facts in issue but rather his opinion revolves around the facts which are not genuine issues of material facts.

Petitioner stresses that Resident 1 did not decline in its care, but rather Resident 1 improved to such an extent that she was discharged three months after admission. Indeed, Petitioner is correct in this matter. However, Resident 1's eventual improvement to the point of being discharged does not mean that on April 3, 2004, the date of Resident 1's elopement, she was able to be outside the facility, crossing streets and walking on uneven surfaces unsupervised.

Petitioner maintains that, "Given such a short time in the facility, would a reassessment [for an elopement risk] been appropriate? Would it not be wise to wait and see if the resident had a relapse and lost the ability to walk . . . ? There is no regulation that demands a reassessment for risk when a resident is improving . . ." P. Reply Br. at 3. Petitioner fails to recognize that Resident 1 had never had an elopement evaluation because at the time of admission she was not ambulatory. However, upon becoming ambulatory, Petitioner had a duty to consider the possibility of elopement by Resident 1. Petitioner failed to perform that duty.

CMS has also established that Petitioner had notice of the lack of security on the Alzheimer's/Dementia Unit at the time of Resident 1's April 3, 2004 elopement. The door to the Alzheimer's/Dementia unit was a delayed egress door and was in working order at the time of Resident 1's elopement. To exit the secured Alzheimer's/Dementia unit, a release bar on the side of the door must be pushed or a lock release button inside the unit to the left of the door can be pushed between 10-15 seconds to unlock the doors. CMS Ex. 3, at ¶ 170; CMS Ex. 7, at 4. At the time of the survey, the surveyor observed a family member push the emergency release button and exit the unit through its double doors. CMS Ex. 3, at ¶ 21. Exiting the secured unit was that easy. *Id.*; *see also* CMS Ex. 1, at 3. The nurses station, just to the side of the exit doors, was not always staffed by Petitioner's employees. CMS Ex. 3, at ¶ 22; CMS Ex. 16. Petitioner did not assign a staff member to constantly monitor the door but instead stated that staff would observe the door as they went about performing their other duties. P. Ex. 24, at ¶ 61(U). The surveyors also noted that at 12:00 p.m. during the survey, the exit door to the Alzheimer's/Dementia Unit was ajar because someone had just opened the door and the door had not completely closed afterwards. CMS Ex. 3, at ¶ 23; CMS Ex. 24, at ¶ 34; CMS Ex. 7, at 6.

The risk of elopement resulting from an inadequately secured "secure" unit is obvious. Once material facts evidencing the lack of security are established, then the facility has reasonable notice that there is a risk of an elopement, especially in this case where Resident 1's condition changed so drastically since admission and went from being non-ambulatory to ambulatory.

Petitioner had actual notice that ambulatory residents were able to get out of the secured unit by themselves and therefore that the secure unit was not, in fact, secure. Staff members acknowledged that residents with senile dementia would follow staff and visitors off the unit before being redirected. P. Ex. 25, at ¶ 18. It was also commonly known at the facility that Resident 2, an 86 year old man with dementia and short term memory problems, was known to wander and exhibit exit seeking behaviors. Resident 2 would leave the locked Alzheimer's/Dementia unit by himself and go to the adjoining unit to sit in its day room. CMS Ex. 7, at 4, 5; CMS Ex. 10, at 3, 10. Resident 2 did have a Wanderguard on his right ankle. CMS Ex. 10, at 3. The precise method Resident 2 used to leave the secure unit is unclear. He could have pushed the release button, followed another person off the unit, or exited though the door when it was ajar. Petitioner provided no evidence of its claim that Resident 2 was allowed to go off the unit by the staff. Petitioner did note, however, that cognitively impaired Resident 3, who was documented to have wanted to elope, never succeeded in eloping. In Resident 2's case the facility seems to rely solely on the fact that Resident 2 wore a Wanderguard on his ankle. Resident 1 was not required to wear a Wanderguard until after her elopement. Neither Petitioner's attempt to explain Resident 2's leaving the Alzheimer's/Dementia unit nor Petitioner's reference to Resident 3 addresses its failure to provide adequate supervision to Resident 1 or its failure to make the Alzheimer's/Dementia unit secure.

Petitioner admits that no specific person was assigned to monitor the door, but that it was the entire staff's responsibility to watch the residents who might seek to use the door. Petitioner's general reliance on the entire staff to oversee the residents does not compensate for its failure to have someone constantly monitor the door or for having a door that could so easily be opened by impaired residents.

The door to the Alzheimer's/Dementia unit did not have a keypad code and Resident 1 did not wear a Wanderguard. Petitioner argues that "the academic skills of this resident would have allowed her to memorize the numeric keypad code if one was in place the day of the event. Petitioner also asserts that if the resident had been required to wear a Wanderguard there is always a possibility that she would have removed it given her scientific mind - holding a PhD in entomology." P. Sur-reply Br. at 19. Petitioner's arguments, on these points, are unpersuasive and speculative and present no genuine issue of material fact.

Petitioner also attempts to recast the Alzheimer's/Dementia unit as a "programming unit" and claims that the residents on this unit are not at risk for elopement or for safety issues. P. Br. at 12. I find this argument without merit. Whatever this unit is termed, it was a unit where residents required supervision. The placement of a resident on a secured unit indicates that an assessment has been made that the resident would not be safe outside the unit unsupervised. Resident 1 was placed on the Alzheimer's/Dementia unit for a reason.

The Alzheimer's/Dementia unit was the least restrictive environment for the resident based on her assessments. CMS Ex. 24, at ¶ 28. Further, Petitioner claims that after the date of the elopement, Resident 1 was returned to the Alzheimer's/Dementia unit because there was no room elsewhere in the facility and not because she required continued supervision. Petitioner claims that the staff discussed moving Resident 1 out of this unit but decided not to because of Resident 1's rapid improvement. Petitioner claims that the staff decided to let Resident 1 remain on the Alzheimer's/Dementia unit so that she could benefit from the attention and program services received in this unit. However, no documentary evidence was provided to support this claim which is contradicted by Resident 1's medical records. Resident 1's medical records show that Resident 1 was still cognitively impaired and required supervision while ambulating.

The Alzheimer's/Dementia unit had a door with delayed egress, which required a wait of 15 seconds to get out of the door. The door to Petitioner's "secured" unit could be opened by anyone pressing one button on the side of the doors, or by pressing on a release bar. Any resident could have left the Alzheimer's/Dementia unit. No staff was assigned to monitor the door. The doors were not locked. The doors did not have an alarm and Resident 1 did not have a Wanderguard. The elevator located on the other side of the Alzheimer's/Dementia unit door was not alarmed in any manner. It is troubling that the facility was so lax in its supervision when it knew that its secure unit was not, in fact, secure and the delayed egress system could so easily be evaded. It must also be stressed that the facility did not have staff assigned to constantly monitor the doors of the unit. A facility should be able to show that there are redundancies of protection or multiple interventions that provide adequate supervision to prevent elopement. *Mitchell Village Care Center,* DAB CR1589, at 9 (2007). The facts as presented by the evidence advanced by CMS are not in dispute. These facts fully support CMS's case that the Alzheimer's/Dementia unit was not adequately secure to prevent Resident 1's elopement.

I conclude that CMS has established that Petitioner failed to do all it reasonably could to provide adequate supervision to this resident: she was able to leave the facility undetected, initially none of the staff were even aware that she was missing, and, as a consequence of this lack of supervision, it was likely that Resident 1 could have suffered serious injury, harm, impairment, or death. To prevail, Petitioner must show that it took reasonable measures to protect Resident 1 from accidents. Whatever system Petitioner chooses to use – whether it is an alarm, one-to-one supervision, or someone stationed at the door to supervise entry and exit – must be adequate and appropriate to supervise its residents so to minimize or prevent risks of accidents. Here Petitioner has not rebutted CMS's prima facie showing or shown affirmatively that it was in substantial compliance with the regulatory requirement to provide adequate supervision and assistance devices. Petitioner has not shown that it did all that it reasonably could do to protect Resident 1

from being outside alone and unsupervised. The facts clearly support CMS's motion for summary judgment. Petitioner has not established a genuine issue of material fact in this matter that it is entitled to a finding in favor of its motion for summary judgment.

C. The determination that the deficiency posed immediate jeopardy is not subject to my review in this case.

The surveyors concluded that the violation of 42 C.F.R. §§ 483.25(k) posed immediate jeopardy for Resident 1. The regulations are clear that the scope and severity determination of immediate jeopardy can be appealed but only if the range of CMP that can be imposed could change or if the facility's nurse's aide training program would be affected due to a finding of substandard quality of care. 42 C.F.R. §§ 498.3(b)(14)(i), (ii) and 498.3(d)(10)(i), (ii). The evidence does not show that Petitioner had a nurse aide training program. Further, there is but a single range for per-instance CMPs and the amount of an per-instance CMP is not affected by whether or not there is immediate jeopardy. 42 C.F.R. §§ 488.408; 488.438. As noted in *Rosewood Living Center*, DAB CR1293, at 17 (2005), "a determination of immediate jeopardy is irrelevant to the issue of what is reasonable in per-instance civil money penalties. A determination of immediate jeopardy is a necessary prerequisite to imposing a per-diem civil money penalty in excess of $3,000, but is not a prerequisite to imposing a per-instance penalty in any amount up to $10,000. *See* 42 C.F.R. § 488.438(a)(1)(i), (ii), (a)(2)." Thus, the immediate jeopardy finding is not subject to appeal or my review in this case. Nevertheless, I will consider whether or not the immediate jeopardy finding is an indication of the seriousness of the deficiency when deciding the reasonableness of the remedy.

D. The amount of the per-instance CMP assessed against Petitioner is reasonable.

CMS imposed a $3,100 per-instance CMP for the deficiency cited under 42 C.F.R. § 483.25(h)(2). I find that the per-instance CMP imposed against Petitioner is reasonable. In fact, Petitioner has not challenged the amount of the CMP imposed.

Prior to discussing whether the CMP in this case is reasonable, I noted that although the immediate jeopardy finding is not reviewable, the elopement before me had a likelihood of serious harm to Resident 1. Resident 1 was a confused and disoriented individual who had only recently regained her ability to ambulate. Her gait was still unsteady, she was at risk from falls. In fact, she slipped while leaving the store, although fortunately she was not injured. CMS claims that she had to cross two roads of two lanes each, one four lane

road and that the area contains an intersection of three major roads without a street light. CMS Ex. 3, at 3. Petitioner admits that Resident 1 had to cross at least two roads. Despite the dispute of how many roads Resident 1 crossed, the danger of significant harm to a confused, disoriented individual of unsteady gait, who lacked safety awareness when crossing even one road unsupervised is obvious.

As noted above, a per-instance CMP can range from $1,000 to $10,000. In considering whether the amount of the $3,100 CMP imposed by CMS is reasonable, I applied the four factors listed in 42 C.F.R. § 488.438(f). The factors are: the facility's history of noncompliance; the facility's financial condition; the factors specified in 42 C.F.R. § 488.404; and the facility's degree of culpability which includes, but is not limited to, neglect, indifference, or disregard for resident care, comfort, or safety. The factors to be considered under 42 C.F.R. § 488.404 include the scope and severity of the deficiency and the facility's prior history of noncompliance with reference to the cited deficiency.

No evidence was presented to me concerning the facility's history of compliance or its financial condition. In light of the lack of security on the Alzheimer's/Dementia unit and the likelihood of serious harm to Resident 1 as a result of being outside unsupervised, the amount of the per-instance CMP is clearly reasonable.

V. Conclusion

I grant CMS's Cross-Motion for Summary judgment. Thus, I sustain CMS's determination to impose a per-instance CMPs totaling $3100 against Petitioner.

/s/

Alfonso J. Montano
Administrative Law Judge