Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of: Plum City Care Center, Petitioner, - v. - Centers for Medicare & Medicaid Services.	DATE: September 29, 2009 Civil Remedies CR1926 App. Div. Docket No. A-09-95 Decision No. 2272

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Plum City Care Center (Plum City, Petitioner) appeals the March 19, 2009 decision of Administrative Law Judge (ALJ) Stephen T. Kessel in Plum City Care Center, DAB CR1926 (2009) (ALJ Decision). After an evidentiary hearing, the ALJ concluded that Plum City failed to comply substantially with the Medicare participation requirement at 42 C.F.R. § 483.25(h)(2) relating to the prevention of accidents, that its noncompliance was at the immediate jeopardy level, and that a $10,000 per-instance civil money penalty (CMP) was reasonable in amount. The ALJ also stated that, as a consequence of his decision, the applicable regulations provided for the loss of Plum City's authority to conduct a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for a period of two years.

On appeal, Plum City takes exception to the ALJ's conclusion that Plum City failed to substantially comply with section 483.25(h)(2), arguing that some of the factual findings on which the ALJ based this conclusion are not supported by substantial evidence and that the ALJ applied erroneous legal standards in

reaching this conclusion. In addition, Plum City argues that any noncompliance did not pose immediate jeopardy and that the remedies imposed by CMS were not reasonable.

For the reasons discussed below, we affirm the ALJ Decision.

Case Background[1]

CMS advised Plum City by letter dated September 18, 2007 that it was imposing a $10,000 per-instance CMP based on findings made in a survey by the Wisconsin Department of Health and Family Services on July 30, 2007. CMS's letter also stated that Plum City was prohibited from offering or conducting a NATCEP for a two-year period from July 30, 2007.

The surveyors found that Plum City did not meet the requirement for long-term care facilities at 42 C.F.R. § 483.25(h)(2) and that its noncompliance with this requirement posed immediate jeopardy beginning July 13, 2007. This requirement is one of several quality of care requirements in section 483.25. The lead-in language for that section states:

> Each 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 483.25(h) provides in relevant part:

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

The surveyors also determined the immediate jeopardy was removed on July 16, 2007. During an August 23, 2007 revisit survey, the

---

[1] Except where noted, this factual background is drawn from undisputed facts in the ALJ Decision and the case record. These undisputed facts are summarized here for the convenience of the reader but should not be treated as new findings.

surveyors found that Plum City was in substantial compliance as of August 17, 2007.

The survey findings related to Plum City's care of Resident 7, an elderly woman admitted to Plum City in January 2006 whose diagnoses included dementia manifested by confusion, severely impaired decision-making, disorganized speech and altered perception along with short-term and long-term memory problems, abnormal convex curvature of her spine, osteoporosis, moderately impaired vision with glaucoma, and blindness in one eye. ALJ Decision at 3. Resident 7 had fallen prior to her admission as well as during the early part of her stay. Id. Plum City's falls risk determinations identified her as at high risk for falls due to her cognitive and physical impairments and as requiring a one-person assist with transfers and a one to two person assist with walking. CMS Ex. 12, at 22. She was able to ambulate in a wheelchair without any assistance. CMS Ex. 7, at 48.

As of October 2006, Plum City's interventions to protect Resident 7 from falls while out of bed included a wheelchair with a self-releasing seatbelt and an alarm.[2] ALJ Decision at 3. In addition, in February 2007, Plum City replaced the resident's standard height wheelchair with a low wheelchair (also equipped with the same type of seatbelt). Id. Plum City periodically checked whether Resident 7 could release the seatbelt herself to ensure that the seatbelt did not constitute a restraint. P. Ex. 30, at 5.

On July 13, 2007, after determining that Resident 7 was not able to release the seatbelt herself, Plum City removed the seatbelt on a trial basis. ALJ Decision at 3. According to the director of nursing (DON), the interdisciplinary team agreed to this trial after facility staff reported that Resident 7 had not recently attempted to transfer herself from the wheelchair or leaned forward in the wheelchair to touch the floor. Id. at 3-4; P. Ex. 30, at 7. A July 13 entry in Resident 7's plan of care noted the removal of the seatbelt and stated that the resident should be monitored for attempts to self-transfer and

---

[2] As discussed later, the alarm would sound when the resident attempted to release the seatbelt. The ALJ Decision erroneously describes the alarm as a chair alarm or a pressure alarm.

wheelchair positioning. CMS Ex. 7, at 76.
After the seatbelt was removed, facility staff observed the resident lean forward in her wheelchair on several occasions. In addition, facility staff observed Resident 7 attempting to stand up from her wheelchair on several occasions. ALJ Decision at 4. Notwithstanding these observations, no changes were made in Resident 7's plan of care. Id. at 5.

On July 16, Resident 7 was attending a social event in the facility's dining room. ALJ Decision at 5. She was observed leaving the room in her wheelchair and was subsequently found on the floor near the door to the dining room. Tr. at 56-57. No facility staff observed her fall from the wheelchair. ALJ Decision at 5. Her injuries from the fall included a broken neck. Id. at 6.

Analysis

Below, we address in turn Plum City's exceptions to the ALJ's findings of fact and its exceptions to the ALJ's conclusions of law. We then address Plum's City's arguments that CMS's determination of immediate jeopardy was clearly erroneous and that the remedies imposed were not reasonable.[3]

Our standard of review on a disputed finding of fact is whether the ALJ decision is supported by substantial evidence on the record as a whole. Our standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. 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/guidelines/prov.html.

[3] We do not separately address Plum City's arguments that it met its burden to show it was in substantial compliance with section 483.25(h)(2). See RR at 21-30. Plum City makes many of the same arguments as part of its exceptions to the ALJ's findings of fact and conclusions of law, which we address in the text below. We see no need to address the remaining arguments since they challenge findings in the Statement of Deficiencies or arguments made by CMS on which the ALJ did not rely.

I. Plum City's exceptions to the ALJ's findings of fact

Plum City takes exception to "six separate findings of fact upon which [the ALJ] based his ultimate conclusion that Plum City was not in substantial compliance with" section 483.25(h)(2). Request for review (RR) at 8. As discussed below, we conclude for each challenged finding that it is supported by substantial evidence in the record as a whole or is not material to the outcome.

A. The ALJ's finding that Plum City removed a pressure alarm from Resident 7's wheelchair is not a material finding.

The ALJ found that Resident 7 had "a self-releasing seatbelt and a chair alarm" (which he also referred to as a "pressure alarm") on her wheelchair and that Plum City removed both of these devices on July 13. ALJ Decision at 3, 4. In addition, he stated that had this alarm been present, it "might have given the staff a chance to react to the resident's movement and to protect her." Id. at 8. The ALJ continued: "Petitioner has offered no satisfactory explanation for its decision to remove the pressure alarm[.]" Id. Plum City points out, and CMS agrees, that, contrary to what the ALJ found, the record establishes that Resident 7 did not have a chair/pressure alarm on her wheelchair and that the alarm that was removed was instead the seatbelt alarm. RR at 9-10 (citing exhibits); CMS Br. at 6, n.5.

The ALJ's more general finding of noncompliance, however, is not dependent on the finding that Resident 7 had a pressure alarm on her wheelchair that was removed. The key issue is not the sufficiency of the measures Plum City took to prevent Resident 7 from falling prior to the time it removed the seatbelt on her wheelchair on July 13, but rather whether Plum City took adequate measures to prevent her from falling after it removed the seatbelt and became aware that she was attempting to stand up from her wheelchair and was leaning forward in her wheelchair. The ALJ's observation that a pressure alarm on the wheelchair could have helped to protect the resident from falling after the seatbelt was removed is a valid one irrespective of whether there was a pressure alarm on the wheelchair before the seatbelt was removed. Moreover, the fact that Plum City had previously used an alarm (of whatever type) undercuts its suggestion that use of an alarm would have been inappropriate for Resident 7.

Plum City also argues that the fact that Resident 7 had an alarmed seatbelt on her wheelchair, as opposed to a pressure alarm, shows that Plum City correctly determined the resident had not attempted to stand up from her wheelchair in the months prior to removal of her seatbelt, since the seatbelt alarm would have gone off if she had made any such attempt. RR at 10-11. Even assuming this is true and that Plum City could have reasonably considered a lack of any recent attempts to stand in deciding whether it was safe to remove the seatbelt, however, that does not matter here. The basis on which ALJ found noncompliance was Plum City's failure to take adequate measures to prevent Resident 7 from falling once it was aware that she was attempting to stand up from her wheelchair (and was leaning forward in the wheelchair) in the absence of the seatbelt. While Plum City seeks to justify its removal of the seatbelt on the ground that, once Resident 7 could no longer remove it herself, the seatbelt was considered a restraint, that issue is also irrelevant to the basis for the noncompliance finding.

B. The precise number of times that Resident 7 was observed trying to stand after her seatbelt was removed is immaterial.

The ALJ Decision recounts the following attempts by Resident 7 to stand after her seatbelt was removed:

> On July 13, . . . staff on three occasions observed the resident attempting to stand, either by pulling on the back of a chair, or by using a handrail in Petitioner's hallway. CMS Ex. 7, at 94. On July 14 a nurse observed the resident making several attempts to stand up from her wheelchair before and during supper. CMS Ex. 7, at 24. A nursing assistant also observed the resident attempting to rise from her wheelchair on July 14. P. Ex. 25, at 1.

ALJ Decision at 4. According to Plum City, however, "it is clear from all of the other evidence in the case" that the July 13 date on the first exhibit cited by the ALJ (CMS Exhibit 7, at 94) "is in error, and the three attempts it refers to are actually the same as those which occurred on 7/14." RR at 11.

The exhibit cited by the ALJ as evidencing attempts to stand on July 13 states in relevant part that "[s]taff did observe on 3 occasions during the pm of 7-13-07 that [R7] attempted to stand by pulling herself up on the back of a chair in the dining room and twice on the hand rail in the hall." CMS Ex. 7, at 94.

This document is a report by the Director of Nursing (DON) on the "Incident follow up Investigation." Considered by itself, this exhibit would constitute substantial evidence that Resident 7 attempted to stand on July 13. The record as a whole, however, suggests that the date on this exhibit is wrong and that Resident 7's attempts to stand all occurred on July 14, as Plum City argues. Except for the date, the descriptions in the incident report of Resident 7's attempts to stand up from her wheelchair are consistent with the descriptions of her attempts to stand on July 14 in the other documents cited by the ALJ. In addition, the "24-hour report" notes that Resident 7 made no attempt to get out of the wheelchair on July 13 (P. Ex. 4, at 1) but that she made several attempts to do so on July 14 (P. Ex. 4, at 2). Consistent with this report, a nurses note for 9:55 pm on July 13 states "Resident has made no attempt to get out of wheelchair." CMS Ex. 7, at 23. Moreover, the two second shift nurses on July 13 stated that they had observed no such attempts during their shifts and that none of the certified nursing assistants had reported such attempts to them. See P. Ex. 31A, at 2; P. Ex. 21, at 3.

The ALJ's finding that Resident 7 attempted to stand on July 13 is not material to the finding of noncompliance, however. Plum City admits that Resident 7 made three attempts to stand up from her wheelchair on July 14. RR at 12, citing P. Exs. 25, at 1; 29, at 2, 36, at 1-2. As indicated above, according to the DON, part of the interdisciplinary team's rationale for removing the seatbelt was that Resident 7 was no longer attempting to stand up from the wheelchair. Any attempts by Resident 7 to stand after the seatbelt was removed thus undercut the facility's rationale for removing the seatbelt and put the facility on notice that Resident 7 was at risk of falling in the absence of the seatbelt. This in turn constitutes substantial evidence in support of the ALJ's conclusion that Plum City failed to substantially comply with section 483.25(h)(2) because it did not take action to mitigate this risk following the resident's attempts to stand. This conclusion does not depend on the precise number of times that Resident 7 was observed attempting to stand after the seatbelt was removed. Moreover, as we discuss next, Resident 7 engaged in other behaviors that put Plum City on notice that it needed to take further action to prevent her from falling.

C. The ALJ's finding that Resident 7's behaviors put her at great risk of falling is supported by substantial evidence.

The ALJ found that Resident 7's behavior of leaning forward in her wheelchair (as well as her attempt to stand up from the wheelchair) "put her at great risk" of falling. ALJ Decision at 7. Plum City does not dispute that Resident 7 was observed leaning forward in her wheelchair on three occasions after the seatbelt was removed (on July 13, 15 and 16) but before she fell. RR at 12. Also, as noted above, Plum City admits at least that she was observed making three attempts to stand. Plum City argues, however, that the ALJ's finding that this "put her at great risk" is not supported by substantial evidence because it "ignores the undisputed evidence that the wheelchair in question had a low seat . . . and thus reaching forward towards R7's feet or the floor would not have required the degree of 'leaning' or bending that is normally associated with touching the floor from a standard height chair." RR at 13.

The ALJ in fact recognized that the low wheelchair provided Resident 7 with "some protection" but found that because she was leaning forward from the chair (as well as attempting to stand up), "the chair was not in and of itself sufficient to protect the resident against obvious risks." ALJ Decision at 7. The ALJ reasonably treated the behavior of leaning forward as increasing her fall risk, despite the fact that the low wheelchair provided some protection. As noted above, part of the interdisciplinary team's rationale for removing the seatbelt was that Resident 7 was no longer leaning forward in the wheelchair to touch the floor. Thus, the ALJ could reasonably infer that the facility's own staff thought at the time that if she were leaning forward, that would pose a fall risk, despite the low wheelchair.

D. The ALJ's finding that Plum City did not revise its care plan to provide an increased level of surveillance from that which had been ordered previously is supported by substantial evidence.

The ALJ Decision states that the "care plans and other documents generated by Petitioner's staff for Resident # 7 do not suggest that the monitoring that was ordered beginning" on July 13 "represented an increased level of surveillance from that which had been ordered previously." ALJ Decision at 5, n.3. Plum City argues that, contrary to what the ALJ found, it provided

for increased monitoring of Resident 7 when the seatbelt was removed. RR at 13-14. Plum City points to a May 8, 2006 entry in the resident's plan of care stating "Monitor position frequently when up in [wheelchair], Reposition PRN." Id. at 13, quoting CMS Ex. 7, at 76. Plum City contrasts this with the July 13, 2006 care plan entry, which refers to the "trial reduction" in seatbelt use and states: "Will monitor attempts to transfer self [illegible] and [wheelchair] positioning." Id.

The evidence on which Plum City relies shows that Plum City did add a requirement to the resident's plan of care to monitor her for any attempts to stand up from her wheelchair, as well for positioning. Both plans, however, merely direct staff to "monitor" the resident. In addition, the revised plan does not address how often the monitoring should occur, and the fact that staff were to monitor for attempts to stand as well as for positioning would not necessarily mean that they had to observe her more frequently than before. In any event, as the ALJ found, the revised plan certainly does not give any explicit instruction to staff on the level of supervision expected, nor did Plum City provide evidence of any policy explaining to staff what is required in order to "monitor" a resident. Moreover, the revised plan does not assign responsibility for monitoring to any particular staff members.

The record does show that at least some staff members were made aware of this new requirement to monitor Resident 7 for attempts to stand and/or were told to "closely monitor and supervise her" since the seatbelt was being removed. See, e.g., P. Ex. 30, at 8 (DON's declaration stating that staff members were informed through various means including shift change reports and other oral instructions "that they were expected to closely monitor and supervise Resident 7, to record all attempts to self-transfer or other occasions when her positioning or posture might be moving toward unsafe wheelchair position").[4]

---

[4] Plum City asserts that the declarations of "the entire nursing staff on duty over the weekend" of July 14-15 corroborate the DON's declarations. RR at 14 (citing exhibits). However, not all of these declarants stated that they were aware of a requirement to monitor Resident 7 for attempts to stand or were told to closely monitor and supervise her since her seatbelt had been removed. See P. Exs. 25, 35. In addition, the Statement of Deficiencies states, and Plum City does not

(Continued. . .)

As noted previously, however, the key issue here is whether Plum City took adequate measures to prevent Resident 7 from falling after it became aware that she was attempting to stand up from her wheelchair and leaning forward in the wheelchair. Although Plum City added monitoring for her standing behavior to Resident 7's care plan at the time it removed the seatbelt, Plum City does not dispute the finding that it made no change to the care plan once it learned that, in the absence of the seatbelt, Resident 7 was engaging in the behaviors that it had identified as putting her at risk for falls. Moreover, even if the staff was alerted at the time the seatbelt was removed to closely monitor her, that does not establish that the level of supervision provided was adequate to meet the risks the staff knew about once they had observed her attempting to stand up from her wheelchair and leaning forward in the wheelchair.

E. The ALJ's finding that the staff member who responded to the fall had her back to Resident 7 at the time of the fall is supported by substantial evidence.

Describing the circumstances of Resident 7's July 16 fall, the ALJ stated in part: "The staff member who responded to the fall was about 25 feet away when the incident occurred and had her back turned to the resident at the moment of the fall. . . . The fall was, in fact, brought to the staff's attention only by the loud noise caused by the incident." ALJ Decision at 5-6 (citations and footnote omitted). Plum City argues that nothing in the exhibits cited by the ALJ establishes that the staff member to whom the ALJ was presumably referring – the activity aide -- had her back turned to the resident at the time of the fall and that one of these exhibits shows that the aide was scooping popcorn in the dining room at the time of the fall, "suggesting that she was facing generally in [Resident 7's] direction." RR at 15 (citing exhibit).

We conclude, however, that the ALJ's finding that the activity aide had her back turned to Resident 7 at the time of the fall

(Continued. . .)

dispute, that one nurse (whose declaration was not provided) told the surveyor that he was not given any instructions regarding Resident 7 on the weekend following the removal of her seatbelt. CMS Ex. 3, at 10.

is supported by substantial evidence. On cross-examination, the aide responded in the negative to the question "when R7 fell, were you facing her at that time?" Tr. at 54. She then responded in the affirmative to the question "And you turned because you heard a loud, slapping noise, right?" Tr. at 55. This colloquy directly supports the ALJ's finding that the aide had her back to the resident, in contrast to the exhibit Plum City says merely suggests that she was facing the resident.

In any event, it is immaterial whether the activity aide had her back turned or was facing the resident since Plum City admits that this aide "was not watching [Resident 7] at the precise moment of the fall, which occurred in the hallway." RR at 15. In addition, Plum City states that the aide was responsible for watching the resident only when she was in the dining room, in effect admitting that the aide was no longer responsible for watching the resident at the time of the fall. Id.

Plum City argues nevertheless that at the time of the fall, "the resident was clearly not 'unsupervised,' as the ALJ's finding suggests," since the resident "was within the line-of-sight" of at least two other staff members (the Assistant DON and one CNA). RR at 15-16 (citing exhibits). However, it was merely happenstance that Resident 7 was in their line of sight at the time of the fall since the care plan did not specify line-of-sight supervision. Moreover, even if being in their line of sight constituted some form of supervision, the issue is whether Plum City met the regulatory requirement to ensure that Resident 7 received adequate supervision and assistance devices to prevent accidents. The ALJ reasonably questioned whether line-of-sight supervision by staff who were 10-25 feet away from the resident at the time of her fall would have been adequate in the absence of an alarm to alert staff if Resident 7 tried to stand. See ALJ Decision at 6, n.6, 8-9. Furthermore, the adequacy of supervision and assistance devices must be considered in light of the potential harm and mental and physical capacities of the resident. Plum City does not explain how providing only line-of-sight supervision and a low wheelchair met the regulatory requirement in light of Resident 7's high risk for falls resulting from her cognitive and physical impairments.

F. The ALJ properly dismissed Plum City's assertions as to the cause of Resident 7's fall as speculative.

Before the ALJ, Plum City argued that section 483.25(h)(2) requires a facility to protect its residents only against foreseeable accidents and that Resident 7's fall was unforeseeable. Plum City asserted that the fall occurred when the resident pitched forward from her wheelchair, not as a result of her attempting to stand up from the wheelchair or leaning forward from the wheelchair. See ALJ Decision at 6. The ALJ found this argument without merit, stating in part, "Petitioner is speculating as to how the accident occurred. No member of Petitioner's staff observed the accident." ALJ Decision at 7. On appeal, Plum City denies that it was speculating as to the cause of the fall. According to Plum City, the testimony of the activity aide that she saw Resident 7's feet coming up off the floor after she heard the sound of the impact supports a finding that Resident 7 had pitched forward rather than fallen as a result of trying to stand up from her wheelchair. RR at 16 (citing transcript).[5]

The ALJ's characterization of Plum City's assertions is accurate. Plum City admits that "no staff member actually observed the start of [Resident #7's] fall." RR at 16. The activity aide admitted that when she saw Resident 7, the resident was already out of the wheelchair. Tr. at 55. Thus, any conclusion as to the cause of the fall was necessarily speculative.

In any event, regardless of how Resident 7 actually fell, it was foreseeable that she would fall from her wheelchair in some manner since Plum City knew she was engaging in behaviors that

---

[5] Plum City also argues that it was "highly unlikely" that Resident 7, in an attempt to stand up, could have gotten far enough out of the wheelchair seat to fall without drawing the attention of at least one of the staff members who had her in their direct line of sight immediately prior to the accident. RR at 16. Plum City argues further that the nature and location of the resident's injuries "suggested" that she had been thrown from the wheelchair in a forward motion. Id. at 17. Plum City's own language in effect acknowledges the speculative nature of these arguments.

posed a fall risk.[6] As the Board has previously stated, "[f]oreseeability does not require being able to foresee that an accident will happen in the same way or result in similar injuries. Cf. Josephine Sunset Home, DAB No. 1908 (2004) (rejecting the proposition that an accident cannot be considered foreseeable unless it previously 'occurred to the same person in the precise manner,' and further stating that '[f]or a risk to be foreseeable, it need not have been made obvious by having already materialized')." Sunbridge Care and Rehabilitation for Pembroke, DAB No. 2170, at 20 (2008), aff'd, Sunbridge Care & Rehab v. Leavitt, No. 08-1603 (4th Cir. July 22, 2009). The finding of noncompliance is supported even if Resident 7's known behaviors did not in fact cause her July 16 fall. Plum City was aware that she was engaging in these behaviors and therefore that the premises on which it had determined that the seatbelt could safely be removed were not valid and that further protective measures were needed. Yet Plum City did not take such measures.

II. Plum City's exceptions to the ALJ's conclusions of law

Plum City argues that the ALJ's conclusion that Resident 7 was not adequately supervised was based on erroneous legal standards that were contrary to the standards articulated in Board decisions. As discussed below, this argument has no merit.

Plum City argues first that in concluding that Resident 7 was not adequately supervised, the ALJ "relied exclusively upon his finding that no staff member was observing her at the time of the fall." RR at 18, citing ALJ Decision at 6, n.6 (stating that "[t]he close proximity of one or more staff members at the time of the fall is simply irrelevant if these staff members were not directly supervising her"). Plum City argues that the ALJ's conclusion was contrary to Board decisions holding that section 483.25(h)(2) does not require that a resident be monitored at all times. Plum City cites to statements in three Board decisions: Burton Health Care Center, DAB No. 2051, at 15 (2006) ("CMS points to nothing in the record that indicates that

---

[6] Although Plum City does not refer to the possibility that Resident #7 fell out of her wheelchair as the result of leaning forward in the wheelchair, we discussed above why we agree with the ALJ that such behavior also presented a fall risk.

Burton had determined that, in order to provide the resident with one person support for toileting, staff needed to keep the resident in their sight at all times. . ."); Lebanon Nursing and Rehabilitation Center, DAB No. 1918, at 15, n.5 (2004) ("In other cases, . . . nurse experts have testified about levels of supervision that do not necessarily mean being right next to the resident. . ."); Madison Health Care, Inc., DAB No. 1927, at 11, n.3 (2004) ("The Board noted in Lebanon that the fact that a resident is unattended at a particular moment does not necessarily equate to being unsupervised and that expert testimony may establish levels of supervision 'that do not necessarily mean being right next to the resident.'").

Contrary to what Plum City argues, the ALJ did not rely "exclusively" (or even necessarily) on his finding that no staff member was observing Resident 7 at the time of her fall. Moreover, Plum City takes the statements from past Board decisions out of context. For example, in Burton, the Board explained the applicable legal standard as follows:

> In . . . Woodstock Care Center, DAB No. 1726 (2000), aff'd, Woodstock Care Ctr. v. Thompson, 363 F.3d 583 (6th Cir. 2003)[, the Board] analyzed the wording, context, and history of section 483.25(h)(2) and, based on that analysis, set out a framework for evaluating allegations of noncompliance with that requirement. Woodstock at 25-30 (citing 54 Fed. Reg. 5316, 5332 (Feb. 2, 1989)). The Board determined that, although section 483.25(h)(2) does not hold a facility strictly liable for accidents that occur, it does require the facility to take reasonable steps to ensure that a resident receives supervision and assistance devices designed *to meet his or her assessed needs* and to mitigate foreseeable risks of harm from accidents. Thus, while a facility is permitted the flexibility to choose the methods it uses to prevent accidents, the chosen methods must be adequate *under the circumstances*. Id. Moreover, what are adequate supervision and assistance devices for a particular resident *depends on the resident's ability to protect himself from harm*. Id. The Board has identified this as the applicable standard in subsequent decisions as well. [Citations omitted.]

Burton at 9 (italics added). The ALJ correctly applied this legal standard here when he determined that Resident 7 was not adequately supervised based on the particular facts of the case.

These facts included that Plum City identified attempts by the resident to stand up from her wheelchair and her leaning forward in the wheelchair as posing a risk of falls, that the seatbelt was removed without putting in place any other assistive devices to mitigate the risk from these behaviors, and that Plum City was aware the resident was engaging in these behaviors after it removed the seatbelt.

Plum City also argues that, contrary to prior Board decisions, the ALJ based his conclusion that Plum City failed to adequately supervise Resident 7 solely on her July 16 fall. Plum City relies primarily on the Board's statement in Lebanon that "[w]hile actual falls are relevant in determining the nature of the accident risk and what a facility knew or reasonably should have known about the risk, the mere fact of a fall as an outcome is not determinative where other evidence is presented on the adequacy of what was provided under the individual circumstances." RR at 20, quoting Lebanon at 13-14. According to Plum City, the ALJ in the present case relied solely on the fact that Resident 7 fell while no one was looking at her, without regard to other evidence.[7] This mischaracterizes the ALJ Decision, which states in relevant part:

> Petitioner would have contravened the regulation's supervision requirements had *no accident occurred* on July 16. Whether an accident occurred or not the staff was on notice that the resident was engaging in behavior that put her at great risk. And, despite that knowledge, the staff did not enhance the supervision and protection it was giving to the resident. The potential for harm resulting from that failure to supervise is in and of itself sufficient to establish a violation of the regulation's requirements.

ALJ Decision at 7 (italics in original). Thus, the ALJ Decision is consistent with Lebanon.

---

[7] Plum City asserts that the ALJ disregarded the cause of the fall, the presence of several staff in the vicinity of the resident at the time of the fall, the changed care plan when the seatbelt was removed, and the use of the low wheelchair. RR at 20-21. We explained above why these were not sufficient to establish that Plum City provided adequate supervision.

III. The ALJ did not err in concluding that Plum City's noncompliance posed immediate jeopardy and that a $10,000 per-instance CMP was reasonable.

CMS is authorized to impose a per-instance CMP ranging in amount from $1,000 to $10,000 for one or more deficiencies that constitute actual harm that is not immediate jeopardy. 42 C.F.R. §§ 488.408(d)(2)(ii), 488.438(a)(2). The criteria for determining the amount of a per-instance CMP include the seriousness of a deficiency or deficiencies, a facility's compliance history, its culpability, and its financial condition. 42 C.F.R. §§ 488.438(f)(1)-(4), 488.404. In addition, approval of a facility's NATCEP is prohibited where there is a finding of substandard quality of care, which is defined to include one or more deficiencies relating to quality of care requirements under section 483.25 "which constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm." See, e.g., Social Security Act, §§ 1819(f)(2)(B)(iii)(I)(b), 1819(g)(2)(B)(i); 42 C.F.R. § 488.301. As indicated previously, CMS adopted the state survey agency's finding that Plum City's noncompliance with section 483.25(h)(2) posed immediate jeopardy that was isolated in scope. Immediate jeopardy is defined as "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. A facility may appeal a determination of immediate jeopardy (the level of noncompliance) which results in a remedy "only if a successful challenge on this issue would affect—(i) The range of civil money penalty amounts that CMS could collect . . . ; or (ii) A finding of substandard quality of care that results in the loss of approval . . . of its nurse aide training program." 42 C.F.R. § 498.3(b)(14); see also section 498.3(d)(10)(ii). CMS's determination of immediate jeopardy must be upheld unless it is clearly erroneous. 42 C.F.R. § 498.60(c)(2).

A. CMS's determination of immediate jeopardy was not clearly erroneous.

On appeal, Plum City argues that CMS's determination of immediate jeopardy is clearly erroneous and that the loss of approval of its NATCEP, which flowed from this determination,

was therefore unwarranted. RR at 30. The ALJ stated that it was not technically necessary that he make a finding of immediate jeopardy "because such a finding is not a prerequisite for imposing a per-instance civil money penalty of up to $10,000." ALJ Decision at 10. He nevertheless proceeded to find that "all of the elements of immediate jeopardy are present in this case" and used "the presence of those elements" as a basis for finding that "the seriousness of Petitioner's noncompliance is in and of itself sufficient to justify a $10,000 per instance penalty[.]" Id. In particular, the ALJ stated:

> The evidence establishes that Resident # 7, by virtue of her dementia and medical conditions, is an individual who is highly susceptible to serious injury or death from falling. Failure to provide the resident with the protections mandated by regulation created a high probability that she would fall and, at the least, sustain serious injuries. And, in fact, the resident sustained life-threatening injuries as a consequence of the fall she experienced while unsupervised by Petitioner's staff. Moreover, even if the fall had not occurred and the resident were uninjured, the extreme level of risk - in and of itself - that Petitioner's actions created would be enough to support a finding of immediate jeopardy.

Id. at 10-11.

The ALJ appears to have overlooked that Plum City was entitled to review of CMS's determination of immediate jeopardy since, in the absence of immediate jeopardy, there was no basis for the loss of approval of its NATCEP. Nevertheless, implicit in his decision is the conclusion that CMS's immediate jeopardy determination was not clearly erroneous. For the reasons discussed below, we conclude that Plum City has not shown that the ALJ's conclusion is erroneous.

Plum City relies on an opinion rendered by Dr. Dohlman, Resident 7's treating physician (who was also Plum City's medical director) based on his March 6, 2008 examination of the resident. According to Plum City, Dr. Dohlman "opined that the resident did not sustain a serious injury, within [the meaning of section 488.301], as a result of the fall and that she has returned to her pre-injury status." RR at 31. Dr. Dohlman stated in part that although "an injury did occur from [Resident

7's] fall, "serious harm did not result. She did not sustain paralysis, or loss of body function. . . . She is neurologically intact. The injury did not affect her long term survivability or quality of life. Her lifestyle did not change, nor is the care she receives any different than before her fall." P. Ex. 32, at 5.

Dr. Dohlman's characterization in his declaration of Resident 7's broken neck as not a "serious injury" is disingenuous. On cross-examination, Dr. Dohlman admitted that the fracture she suffered was a "serious injury" because it "has the potential to result in death." Tr. at 17. Even absent this admission, the ALJ could reasonably discount the opinion in Dr. Dohlman's declaration based on other evidence in the record, including that that the fracture "was diagnosed as being unstable," that "[f]urther displacement of the fracture could have caused" paralysis or death, and that since she was not a candidate for surgical repair of her broken neck due to her age and medical condition, "the resident would always be at risk for further exacerbation of her injury, including paralysis and death." ALJ Decision at 6, citing CMS Ex. 7, at 98 and 111 (hospital admission and discharge summaries). Even if Resident 7 regained her ability to function at the same level as prior to the injury, that does not mean that the risk that her injury could be exacerbated no longer existed. While Dr. Dohlman did state that "[i]t's most probable . . . there would be no changes in the neck" since "[i]t's most likely that fibrosis has developed which would help to stabilize the fracture" (P. Ex. 32, at 5), this was clearly speculation on his part.

Since Plum City had a deficiency under section 483.25 which constituted immediate jeopardy, the ALJ did not err in upholding the loss of approval of Plum City's NATCEP.

B. The amount of the CMP was reasonable.

Plum City argues further that a per-instance CMP of $10,000 was not warranted because the facility's compliance history "is much better than average," immediate jeopardy (if present) was isolated in scope, and no culpability or aggravating factor was shown. RR at 31. As noted, the ALJ relied solely on the seriousness of the noncompliance, which he found posed immediate jeopardy, in concluding that the CMP amount here was reasonable. Plum City does not explain why the fact that the immediate jeopardy was isolated in scope would undercut the ALJ's

conclusion. While $10,000 was the maximum amount permitted by the regulations for a per-instance CMP, the ALJ correctly pointed out that it would have been within CMS's discretion to impose a per-day CMP of up to $10,000 for each day of noncompliance, so that the $10,000 per-instance CMP "is actually a modest penalty when compared to what CMS might have imposed." Id. at 11, n.11.

Moreover, contrary to what Plum City argues, its actions demonstrated a high degree of culpability, which is defined as including "neglect, indifference, or disregard for resident care, comfort or safety."[8] 42 C.F.R. § 488.438(f)(4). Although the ALJ made no express finding of culpability, he found, among other things, that Plum City "knew almost from the inception of its staff's decision to remove Resident #7's seatbelt . . . that the resident was engaging in behavior that put her at grave risk for injury" yet "did not react to the overwhelming evidence of increased risk to Resident # 7 by enhancing the protection that they provided to her." ALJ Decision at 10. This meets the definition of culpability and further supports the ALJ's conclusion that a $10,000 per-instance CMP was reasonable.

With respect to Plum City's compliance history, the record shows that a June 2006 survey found two level "D" deficiencies (isolated with no actual harm but a potential for more than minimal harm that is not immediate jeopardy) and that no deficiencies were found in the three surveys prior to that. CMS Ex. 2, at 1-2. Even if we disregard the noncompliance found in June 2006, however, the Board has previously held that "although a 'history of noncompliance' is one of the factors to be considered, the absence of a history of noncompliance is not a mitigating factor." Western Care Management Corp., d/b/a Rehab Specialties Inn, DAB No. 1921, at 93 (2004), citing Franklin Care Center, DAB No. 1900 (2003) and 42 C.F.R. § 488.438(f). Thus, Plum City's compliance history is not a basis for finding that a $10,000 per-instance CMP was unreasonable.

Accordingly, we sustain the ALJ's determination that the CMP amount was reasonable.

---

[8] Furthermore, section 488.438(f))4) states that "[t]he absence of culpability is not a mitigating circumstance in reducing the amount of the penalty."

Conclusion

For the foregoing reasons, we affirm the ALJ's decision to uphold the remedies imposed by CMS.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Judith A. Ballard
Presiding Board Member