Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Parkview Nursing and Rehabilitation Center
(CCN: 18-5171),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-09-366

Decision No. CR2353

Date: April 8, 2011

DECISION

Petitioner, Parkview Nursing and Rehabilitation Center, was not in substantial compliance with program participation requirements from December 27, 2008 through February 6, 2009, due to violations of 42 C.F.R. §§ 483.483.25(h) and 483.75.[1] There is a basis for the imposition of an enforcement remedy. The determination that the deficiencies posed immediate jeopardy was not clearly erroneous. The civil money penalty (CMP) of $4,250 per day from December 27, 2008 through February 6, 2009, a total CMP of $178,500, is reasonable.

I. Background

Petitioner is located in Paducah, Kentucky, and participates in Medicare as a skilled nursing facility (SNF) and the state Medicaid program as a nursing facility (NF). On February 5, 2009, Petitioner was surveyed by the Kentucky Division of Health Care

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[1] Citations are to the version of the Code of Federal Regulations (C.F.R.) in effect at the time of the survey, unless otherwise indicated.

(state agency) and found not in compliance with program participation requirements. The Centers for Medicare and Medicaid Services (CMS) notified Petitioner by letter dated February 12, 2009, that it was imposing the following enforcement remedies: a CMP of $4,250 per day effective December 27, 2008 and continuing until immediate jeopardy was removed or Petitioner's provider agreement was terminated; a discretionary denial of payment for new admissions (DPNA) effective February 14, 2009; and termination of Petitioner's participation effective February 28, 2009, if Petitioner did not return to substantial compliance before that date. CMS also notified Petitioner that Petitioner was ineligible to conduct a nurse aide training and competency evaluation program (NATCEP) for a period of two years; however, the parties stipulated that Petitioner did not have a NATCEP, and they agreed that there is no issue related to NATCEP authority in this case. CMS notified Petitioner by letter dated February 24, 2009, that a revisit survey conducted on February 17, 2009, determined that: Petitioner returned to substantial compliance on February 13, 2009; the CMP would not continue to accrue after February 6, 2009; and the DPNA and termination would not be effectuated. Joint Stipulation of Fact.

Petitioner requested a hearing before an administrative law judge (ALJ) on March 27, 2009. The case was assigned to me for hearing and decision on April 14, 2009, and an Acknowledgement and Prehearing Order was issued at my direction. On February 9 and 10, 2010, I convened a hearing in Paducah, Kentucky, and a 441-page transcript (Tr.) of the proceedings was prepared. CMS offered CMS exhibits (CMS Exs.) 1 through 20 that were admitted as evidence. Tr. at 22. Petitioner offered Petitioner exhibits (P. Exs.) 1 through 40, and P. Exs. 1 through 36 and 38 through 40 were admitted as evidence. Tr. at 27. CMS called the following witnesses: Surveyor Barbara Huddleston, RN; and Surveyor Brenda Williams-Ambrose, RN. Petitioner called the following witnesses: Carla Kaylor, LPN; Patricia Weisenberger, Petitioner's Social Worker; Carey Webb, Petitioner's Maintenance Director; and Lori Moberly, Petitioner's Administrator. CMS filed its post-hearing brief (CMS Br.) on April 15, 2010 and waived a reply brief. Petitioner filed its post-hearing brief on April 14, 2010 (P. Br.) and its reply brief (P. Reply) on May 10, 2010.

II. Discussion

A. Issues

The issues in this case are:

> Whether there is a basis for the imposition of an enforcement remedy; and
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> Whether the remedy imposed is reasonable.

B. Applicable Law

The statutory and regulatory requirements for participation by a long-term care facility are found at sections 1819 (SNF) and 1919 (NF) of the Social Security Act (Act) and at 42 C.F.R. Part 483. Section 1819(h)(2) of the Act vests the Secretary of Health and Human Services (Secretary) with authority to impose enforcement remedies against a SNF for failure to comply substantially with the federal participation requirements established by sections 1819(b), (c), and (d) of the Act.[2] Pursuant to section 1819(h)(2)(C), the Secretary may continue Medicare payments to a SNF not longer than six months after the date the facility is first found not in compliance with participation requirements. Pursuant to section 1819(h)(2)(D), if a SNF does not return to compliance with participation requirements within three months, the Secretary must deny payments for all individuals admitted to the facility after that date – commonly referred to as the mandatory or statutory DPNA. In addition to the authority to terminate a noncompliant SNF's participation in Medicare, the Act grants the Secretary authority to impose other enforcement remedies, including a discretionary DPNA, CMPs, appointment of temporary management, and other remedies such as a directed plan of correction. Act § 1819(h)(2)(B).

The Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility that is not complying substantially with federal participation requirements. "*Substantial compliance* means 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 (emphasis in original). A deficiency is a violation of a participation requirement established by sections 1819(b), (c), and (d) of the Act or the Secretary's regulations at 42 C.F.R. Part 483, Subpart B. State survey agencies survey facilities that participate in Medicare on behalf of CMS to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-.28, 488.300-335. The regulations specify the enforcement remedies that CMS may impose if a facility is not in substantial compliance with Medicare requirements. 42 C.F.R. § 488.406.

The regulations specify that a CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of a CMP, $3,050 per day to $10,000 per day, is reserved for deficiencies that pose immediate jeopardy to a facility's residents and, in some circumstances, for repeated

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[2] Section 1919(h)(2) of the Act gives similar enforcement authority to the states to ensure that NFs comply with their participation requirements established by sections 1919(b), (c), and (d) of the Act.

deficiencies. 42 C.F.R. § 488.438(a)(1)(i), (d)(2). "*Immediate jeopardy* means 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 (emphasis in original). The lower range of a CMP, $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)(1)(ii).

The Act and regulations make a hearing before an ALJ available to a long-term care facility against which CMS has determined to impose an enforcement remedy. Act §§ 1128A(c)(2), 1866(h); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *Residence at Salem Woods*, DAB No. 2052 (2006); *Cal Turner Extended Care*, DAB No. 2030 (2006); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Anesthesiologists Affiliated,* DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. §§ 488.408(g)(1), 488.330(e), 498.3. However, the choice of remedies or the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance determined by CMS if a successful challenge would affect the range of the CMP that may be imposed or impact the facility's authority to conduct a NATCEP. 42 C.F.R. §§ 498.3(b)(14), (d)(10)(i). The CMS determination as to the level of noncompliance, including the finding of immediate jeopardy, "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). *Woodstock Care Ctr.*, DAB No. 1726, at 9, 38 (2000), *aff'd,* 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g*., *Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). ALJ Review of a CMP is subject to 42 C.F.R. § 488.438(e).

The standard of proof, or quantum of evidence required, is a preponderance of the evidence. The Board has previously addressed the allocation of the burden of persuasion, and I find the reasoning of the Board persuasive, despite Petitioner's arguments to the contrary. However, as discussed hereafter, the allocation of the burden does not impact my decision in this case. CMS has the burden of coming forward with the evidence and making a *prima facie* showing of a basis for imposition of an enforcement remedy. Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense. *Batavia Nursing & Convalescent Inn*, DAB No. 1911 (2004); *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 F. App'x 181 (6th Cir. 2005); *Emerald Oaks*, DAB No. 1800; *Cross*

Creek Health Care Ctr., DAB No. 1665 (1998); *Hillman Rehab. Ctr.*, DAB No. 1611 (1997), No. 98-3789, 1999 WL 34813783 (D.N.J. May 13, 1999).

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold text, followed by my findings of fact and analysis. CMS alleges, based upon the survey that ended February 5, 2009, that Petitioner was not in substantial compliance with program participation requirements from December 27, 2008 through February 6, 2009, due to violations of 42 C.F.R. §§ 483.20(g)-(j) (Tag F278), 483.20(d), and 483.20(k)(1) (Tag F279); 483.25(h) (Tag F323); 483.75 (Tag F490); and 483.75(o)(1) (Tag F520). CMS alleges that each of the alleged violations posed immediate jeopardy to Petitioner's residents.

I have carefully considered all the evidence, including the documents and the testimony at hearing, and the arguments of both parties, though not all may be specifically discussed in this decision.[3] I discuss in this decision the credible evidence given the greatest weight in my decision-making. The fact that evidence is not specifically discussed should not be considered sufficient to rebut the presumption that I considered all the evidence and assigned such weight or probative value to the credible evidence that I determined appropriate within my discretion as an ALJ. There is no requirement for me to discuss the weight given every piece of evidence considered in this case, nor would it be consistent with notions of judicial economy to do so.

1. Petitioner did not violate 42 C.F.R. § 483.20 (g) through (j) as alleged under Tag F278 for the survey that ended on February 5, 2009.

2. Petitioner did not violate 42 C.F.R. § 483.20(d) and (k)(1) as alleged under Tag F 279 for the survey that ended on February 5, 2009.

3. Petitioner violated 42 C.F.R. § 483.25(h) as alleged under Tag F323 for the survey that ended on February 5, 2009, and the violation posed a risk for more than minimal harm.

4. Petitioner violated 42 C.F.R. § 483.75 as alleged under Tag F490 for the survey that ended on February 5, 2009, and the violation posed a risk for more than minimal harm.

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[3] "Credible evidence" is evidence that is worthy of belief. *Black's Law Dictionary* 596 (18th ed. 2004). The "weight of evidence" is the persuasiveness of some evidence compared to other evidence. *Id*. at 1625.

5. The declaration of immediate jeopardy related to the deficiencies based on violations of 42 C.F.R. §§ 483.25(h) and 483.75 was not clearly erroneous.

a. Facts

All the alleged deficiencies are related to Resident 1. Resident 1 was 84 years old in the fall of 2008, when the incidents occurred that are the bases for the alleged deficiencies. She was first admitted to Petitioner in January 2006, and she was readmitted on October 21, 2008, following an October 18, 2008 hospital admission due to two unwitnessed falls that resulted in stitches and complaints of dizziness. P. Exs. 4, 5; CMS Exs. 8, at 1; 9, at 29-31.

Resident 1's diagnoses included: Alzheimer's disease with dementia; severe osteoporosis with a history of pelvic fractures; coronary artery disease; hypertension and hypotension; a history of cerebrovascular accident; anxiety; and depression. P. Exs. 4-5; CMS Ex. 8, at 9. Her Minimum Data Set (MDS) with an assessment reference date of October 28, 2008, shows that her memory was intact, and she was assessed as retaining modified independence in cognitive skills for daily decision-making, i.e., she had some difficulty in new situations only. She was assessed as usually understanding others, perhaps due in part to her impaired hearing, and she had no limit identified with being understood. CMS Ex. 8, at 7. She was assessed as requiring extensive assistance of one person for bed mobility, transfers, walking in her room, locomotion on and off her unit, dressing, toilet use, personal hygiene, and bathing. CMS Ex. 8, at 8. Resident 1's primary means of locomotion was her wheelchair, and she could wheel herself. CMS Ex. 8, at 9. The MDS correctly reflects that she had fallen within the past 30 days. CMS Ex. 8, at 10. Resident 1's Resident Assessment Protocol (RAP) worksheets dated November 2, 2008, show that she was assessed as being at risk for falls and cognitive loss, among other things. CMS Ex. 8, at 27, 33, 37.

Resident 1 had care plans for cognitive impairment and falls, among others. CMS Ex. 8, at 44, 47; P. Ex. 11, at 3, 6. She was assessed as at risk for falls on October 28, 2008, and the recommended interventions of adding non-skid strips by her bed and in front of her tall cabinet are included in her care plan. Tab alarms while in bed and wheelchair and ongoing medication adjustments were also interventions. CMS Exs. 5, at 42; 8, at 47; P. Exs. 7, at 1-2; 11, at 6; 30, at 1. A physician's order dated November 15, 2008, required tab alarms while in bed or wheelchair with regular checks to ensure they were in working condition. P. Ex. 14, at 7.

In May 2008, Resident 1 was assessed as not at risk for elopement. However, on October 13, 2008 and October 28, 2008, she was assessed as at risk for elopement. CMS Ex. 8, at 52-53; P. Ex. 6, at 1-2. Resident 1 had a physician's order dated October 13, 2008, that required her to wear a Wander Guard® alarm bracelet at all times due to her risk for

elopement. P. Ex. 14, at 1. The Wander Guard®, a typical intervention to address a risk for elopement, is not listed as an intervention on the care plans admitted as evidence, and there is no care plan in evidence that addresses Resident 1's risk for elopement. P. Ex. 11, at 1-7; CMS Ex. 8, at 42-48. Daily care guides dated February 2 and 3, 2009, more than three months after the physician's order was issued, list a "secure care bracelet," which is similar to a Wander Guard® bracelet. CMS Ex. 8, at 49-50; Tr. 301-02.

Petitioner's facility includes a courtyard that is surrounded on all sides by various wings of the facility, but has no roof to keep out the elements. CMS Ex. 5, at 7. There is no dispute that on November 15, 2008, Resident 1 was found on the ground in the courtyard, her wheelchair was upright on the pavement, and minutes before she was observed inside the facility indicating that she was looking for her house. It is undisputed that on December 13, 2008, at 7:25 p.m., a nurse assistant found Resident on the floor, and her tab alarm was sounding. CMS Ex. 9, at 17-18. It is also undisputed that on December 27, 2008, at about 7:35 p.m., a staff member heard someone yelling in the courtyard. The staff member found Resident 1 sitting on the ground on her buttocks in water and calling for help. It was raining steadily at the time, and the resident was wet and muddy. Her wheelchair was about twenty feet away, and the tab alarms were attached to the resident's wheelchair but not to the resident when she was found. P. Ex. 31, at 1; CMS Ex. 5, at 28, 32, 45; CMS Ex. 9, at 12. The temperature at the time of the incident was approximately sixty-one degrees Fahrenheit with rain and thunderstorms. P. Ex. 29, at 3. Petitioner's staff assessed the resident's temperature as ninety-six and two tenths degrees Fahrenheit immediately after the incident. CMS Ex. 5, at 33. The resident was placed in a whirlpool bath, and she was observed to be shivering and to have a blue tinge to her fingers and knees. CMS Ex. 9, at 12; P. Ex. 15, at 15.

b. Analysis

A facility is required to "conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity." 42 C.F.R. § 483.20. The regulation specifically requires that the assessment accurately reflect the resident's status. 42 C.F.R. § 483.20(g). The regulation also requires that: the assessment be conducted or coordinated by a registered nurse (42 C.F.R. § 483.20(h)); a registered nurse must sign and certify completion of the assessment, and all professionals who completed a portion of the assessment must sign and certify the assessment (42 C.F.R. § 483.20(i); and anyone who falsely signs or certifies, or causes another to falsely sign or certify, is subject to a CMP (42 C.F.R. § 483.20(j)). The surveyors allege under Tag F278 that Petitioner violated 42 C.F.R. § 483.20(g) through (j) because Petitioner failed to "accurately assess the resident's wandering and exit seeking behaviors," and that resulted in a failure to care plan and implement interventions to ensure Resident 1's safety. CMS Ex. 1, at 2. More specifically, the surveyors allege that the MDS with an assessment reference date of October 28, 2008, does not assess Resident 1 as engaging in "wandering" behavior, which is defined on the MDS as moving "with no rational

purpose, seemingly oblivious to needs or safety." P. Ex. 9, at 3. The surveyors allege that Resident 1 attempted to leave or elope from the facility on October 13, 2008 and indicate that the elopement attempt should have been considered wandering behavior. CMS Ex. 1, at 3. Because I conclude that Petitioner violated 42 C.F.R. § 483.25 and that violation is sufficient to support the modest CMP in this case, it is not necessary to analyze the surveyor's error in great detail. It is sufficient to note that there is ground for a reasonable difference of opinion among professionals as to whether "wandering behavior" and "elopement" or "exit seeking behaviors" are synonymous, sometimes or always.

In the case of Resident 1, the evidence of record does not show that she was wandering, *i.e.,* moving with no rationale purpose and oblivious to needs or safety. Rather than wandering, the evidence shows that in October 2008, Resident 1 deliberately attempted to follow staff out the front door at shift change for the purpose of leaving the facility. CMS Ex. 8, at 53. The surveyors clearly confused the concept of wandering and elopement, concepts that are more clearly distinguished by the State Operations Manual (SOM), app. PP, Tag F323. The evidence does not show that Resident 1 engaged in "wandering" prior to completion of the October MDS, and, thus, Petitioner committed no error on the MDS by not assessing Resident 1 as wandering. I also note that there is no section of the MDS, such as that at P. Ex. 9 for example, which specifically addresses elopement. Although there is no place to reflect an assessment of elopement risk on the MDS, the evidence clearly shows that Resident 1 was assessed for her elopement risk (P. Ex. 60), and, as discussed hereafter, a care planned intervention of using a Wander Guard® as a form of supervision was developed and implemented. Accordingly, I conclude that there was no violation of 42 C.F.R. § 483.20(g) through (j) (Tag F278).

A SNF is required to develop a comprehensive care plan for each resident that meets the resident's medical, nursing, mental, and psychosocial needs that are identified by the comprehensive assessment that is reflected by the MDS. 42 C.F.R. § 483.20(d) and (k). The surveyors allege under Tag F279 that Petitioner violated this regulation because it failed to develop "care plan interventions" for Resident 1's restless behavior and her wandering and exit seeking. CMS Ex. 1, at 8. I agree with the surveyors, based upon the copies of Resident 1's comprehensive care plan that are in evidence (P. Ex. 11, at 1-7; CMS Ex. 8, at 42-48), that there is no specific document that is captioned "care plan" that addresses wandering or exit seeking behavior. I have already noted that I do not see evidence that supports characterizing Resident 1's behavior as wandering within the meaning of the definition used on the MDS. There is no question, however, that Resident 1 did seek to exit Petitioner's facility and elope.

However, the surveyors and CMS are in error in alleging a deficiency under Tag F279 for two reasons. First, it is clear that a physician issued an order on October 13, 2008 for Resident 1 to wear a Wander Guard® at all times due to her risk for elopement. P. Ex. 14, at 1. The order reflects that the resident was both assessed as at risk for elopement

and that there was a planned intervention to use the Wander Guard® as a form of supervision to prevent an elopement. There is no evidence that suggests that the Wander Guard® was not consistently used as ordered after October 13, 2008. The report for the December 27, 2008 incident states that Resident 1 was wearing her Wander Guard®, bracelet but she went out the door to the interior courtyard, which did not have a Wander Guard® alarm system installed. P. Ex. 31, at 1. Second, the surveyors and CMS are in error because the regulations do not specify that a care plan be documented in a particular way or that particular items be included in the "comprehensive care plan." Petitioner's elopement policy requires that appropriate interventions to address a risk for elopement be included in a resident's plan of care, but it does not specify the form of the plan of care. P. Ex. 27, at 2. The SOM explains that, in assessing whether a resident's clinical records are adequate under the documentation requirement of 42 C.F.R. § 483.75(l)(1), the surveyor is to consider whether there is enough documentation for staff to conduct care programs, to revise the program when necessary, and to respond to the changing status of the resident. The surveyor is to assess how the clinical record is used in managing the resident's care and progress. The regulation requires that the clinical record contain sufficient evidence to identify the resident, a record of assessments, the plan of care and services provided, the results of any preadmission screening, and progress notes. SOM, app. PP, F514; 42 C.F.R. § 483.75(l). The SOM and the regulation do not specify the form to be used for a care plan. The surveyors and CMS do not allege a violation of 42 C.F.R. § 483.75(l), and I have no basis for finding Petitioner's clinical records for Resident 1 were inadequate. The records in evidence show that Resident 1 had a comprehensive care plan. The evidence also shows that Resident 1 was assessed as an elopement risk and that there was a planned intervention to use a Wander Guard® as a form of supervision. While the intervention of using the Wander Guard® was not listed on the comprehensive care plan, the evidence of its use is sufficient evidence that the intervention was sufficiently documented in the clinical record for staff to know that its use was required. Accordingly, I conclude that there was no violation of 42 C.F.R. § 483.20(d) and (k)(1) (Tag F279).

I conclude that Petitioner did violate 42 C.F.R. § 483.25(h) and that the violation posed a risk for more than minimal harm to Resident 1. The general quality of care regulation, 42 C.F.R. § 483.25, requires that a facility ensure that each resident receives necessary care and services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care that the resident's care planning team developed in accordance with 42 C.F.R. § 483.20. The quality of care regulations impose specific obligations upon a facility related to accident hazards and accidents.

> The facility must ensure that –
>
> (1) The resident environment remains as free of accident hazards as is possible; and

> (2) Each resident receives adequate supervision and assistance devices to prevent accidents

42 C.F.R. § 483.25(h). The SOM instructs surveyors that the intent of 42 C.F.R. § 483.25(h)(1) and (h)(2) is "to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents." The facility is expected to: identify, evaluate, and analyze hazards and risks; implement interventions to reduce hazards and risks; and monitor the effectiveness of interventions and modify them when necessary. SOM, app. PP, Tag F323.

The Board has provided interpretative guidance for adjudicating alleged violations of 42 C.F.R. § 483.25(h)(1), stating that the standard in the regulation "places a continuum of affirmative duties on a facility. A facility must determine whether any condition exists in the environment that could endanger a resident's safety. If so, the facility must remove that condition if possible, and, when not possible, it must take action to protect residents from the danger posed by that condition . . . Where a facility alleges (or shows) that it did not know that a hazard existed, the facility cannot prevail if it could have reasonably foreseen that an endangering condition existed either generally or for a particular resident or residents." *Maine Veterans' Home – Scarborough*, DAB No. 1975, at 6-7 (2005).

The Board has also explained the requirements of 42 C.F.R. § 483.25(h)(2) in numerous decisions. *Golden Living Ctr. – Riverchase*, DAB No. 2314, at 7-8 (2010); *Eastwood Convalescent Ctr.,* DAB No. 2088 (2007); *Century Care of Crystal Coast*, DAB No. 2076 (2007), *aff'd, Century Care of the Crystal Coast*, 281 F. App'x 180 (4th Cir. 2008); *Liberty Commons Nursing and Rehab - Alamance,* DAB No. 2070 (2007); *Golden Age Skilled Nursing & Rehab. Ctr.*, DAB No. 2026 (2006); *Estes Nursing Facility Civic Ctr.*, DAB No. 2000 (2005); *Northeastern Ohio Alzheimer's Research Ctr.*, DAB No. 1935 (2004); *Woodstock Care Ctr.*, DAB No. 1726 (2000), *aff'd*, *Woodstock Care Ctr. 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 mitigates foreseeable risks of harm from accidents. *Woodstock Care Ctr. v. Thompson*, 363 F.3d at 589 (holding a SNF 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. 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 Rehab. & 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). SOM, App. PP, Tag F323; *Woodstock Care Ctr.*, DAB No. 1726, at 4.

The surveyors allege, under Tag F323, that Petitioner violated 42 C.F.R. § 483.25(h) because Petitioner failed to supervise Resident 1, and she fell. There is no dispute that: on December 27, 2008, Resident 1 was found on the ground in the interior courtyard; she was unsupervised at the time of the accident; and the evidence supports an inference that she fell from her wheelchair or while trying to transfer from the wheelchair. P. Br. at 1-2, 6, 21. Resident 1 was previously assessed as at risk for falls and to be an elopement risk. Also, she had previously fallen in the same courtyard while unsupervised. It was foreseeable that Resident 1 could fall again in the courtyard if unsupervised. Given her diagnosis of severe osteoarthritis, it was also foreseeable that she could suffer more than minimal harm if she fell. This record adequately supports my conclusion that CMS has made a *prima facie* showing of a violation of 42 C.F.R. § 483.25(h). *Golden Living Ctr. – Riverchase*, DAB No. 2314, at 9-10. The issue then is whether Petitioner has rebutted the *prima facie* showing or established an affirmative defense.

Petitioner correctly points out that Resident 1 was at risk for harm for falling anywhere in the facility, not just the enclosed courtyard. P. Br. at 21; P. Reply at 18. There is no question that Resident 1 suffered several falls. Petitioner's position that the courtyard presented no greater risk for falls by Resident 1 than the interior spaces of the facility is not inconsistent with the evidence. However, Petitioner cannot deny that Resident 1, after falling in the interior courtyard on December 27, 2008, was exposed to the elements outside that she would not be exposed to inside, including rain, wet ground, and a temperature of sixty-one degrees Fahrenheit, well below normal interior temperatures.

Petitioner argues that it appropriately protected Resident 1 from foreseeable accident hazards. Petitioner argues that it did assess and plan to mitigate Resident 1's general risk for falls. P. Br. at 21. Both parties discuss at length the potential for increased risks that the interior courtyard posed. CMS argues that the courtyard was not a "safe area" for Resident 1 due to the irregular surfaces and the fact that Resident 1 had fallen there before. CMS does not argue that an interior courtyard is inherently unsafe for all residents, or that interior courtyards or exterior spaces should never be accessible by residents. Rather, CMS correctly focused upon whether it was safe for Resident 1 to be in the Petitioner's courtyard unsupervised. CMS Br. at 22. Petitioner argues that staff did not perceive that "the courtyard per se enhanced" Resident 1's risk for falls. P. Br. at 21-22. Petitioner argues that CMS presented no evidence that staff did anything wrong on December 27, 2008. P Br. at 22-23. Because CMS made a *prima facie* showing of a deficiency, the burden is upon Petitioner to show that staff did nothing wrong on December 27, 2008, not CMS.

It is for Petitioner to show that staff took all reasonable steps to mitigate the foreseeable risk that Resident 1 would suffer an accident, such as following the resident's care plan, making the courtyard safe for her access, supervising her access, or preventing her unsupervised access. As already noted, the risk that Resident 1 would fall was foreseeable based upon her history of falls and falls assessment and that she would fall in the courtyard was foreseeable as she had fallen there before. Petitioner asks that I give great weight to the testimony of Resident 1's caregivers who knew and planned care for her. Petitioner asserts that staff knew that: Resident 1 enjoyed the courtyard; being in the courtyard had a therapeutic effect for her; and it would not be in Resident 1's best interest to restrict her freedom to access that courtyard. P. Ex. 24. I have no doubt that staff perceived that Resident 1 enjoyed the courtyard and that it had a therapeutic effect for her, those matters are clearly within the scope of knowledge and expertise of staff. Whether or not it was reasonable to give Resident 1 unrestricted access to the courtyard at any time of day and during any weather, however, is really the question of whether Petitioner took all reasonable steps to mitigate the foreseeable risk of Resident 1 suffering an accident. That is the issue I must resolve. Whether Petitioner properly balanced the therapeutic benefit of Resident 1 accessing and using the courtyard against the need to mitigate the foreseeable risk to Resident 1 of falling, is another way of viewing the issue. Petitioner assessed Resident 1 to be at risk for falls and had a care plan to address that risk. However, based upon my analysis of the evidence, I conclude that Petitioner failed to monitor and evaluate the effectiveness of its interventions and implement new interventions as necessary to protect Resident 1 from the foreseeable risk that she would fall, inside or outside.

Petitioner's Nurse's Notes show that on September 22, 2008, Resident 1's Trazodone, which is used to treat anxiety and depression, was discontinued at the recommendation of the pharmacist. The Nurse's Notes show that on October 1, 2008, the resident was experiencing increased anxiety about her daughters. On October 13, 2008, she expressed the desire to leave the facility and attempted to leave by following staff out the door. The Wander Guard® bracelet was initiated at that time. On October 16, 2008, the resident was reported to be very disoriented, she feared that a robber was in the facility, she feared for her family, and she expressed that she was being held at the facility against her will. On October 18, 2008, it is reported in the Nurse's Notes at 8:00 a.m. that the resident was found sitting in the bathroom with a large amount of blood on her clothing and in her hair due to a gash on her head. Resident 1 reported that she felt dizzy when standing-up after using the bathroom. Resident 1 was sent to the emergency room and returned to the facility at Noon. She was visiting with family in her room and eating her lunch, but a daughter reported to staff that Resident 1 had fallen again. Resident 1 was again found sitting on the floor in her bathroom with another gash on her head and with abrasions to her knee and cheek. Resident 1 could not explain what happened. According to a daughter, she assisted Resident 1 to the toilet, and the resident requested some privacy. The daughter left the bathroom and the fall occurred. Resident 1 was sent to the hospital where she was admitted. CMS Ex. 9, at 29-30. At the hospital, Resident 1 reported that

she felt dizzy before both falls. The physician that prepared the history and physical reported that it could not be determined whether the resident actually lost consciousness either time, but he speculated that she may have been suffering a "positional vertigo-type" problem. P. Ex. 5. Neither party provided me with a discharge summary, so it is uncertain what her final diagnoses were.

Resident 1 was readmitted to Petitioner on October 21, 2008. The Nurse's Notes reflect that, on October 27, 2008, the tab alarm attached to the resident's wheelchair sounded, and the resident was found to have transferred herself to her bed. Resident 1 was reminded to use the call light to get assistance for transfers. A Nurse's Notes entry on October 31, 2008, shows that Resident 1 continued to self-transfer, setting off her tab alarm. On November 1, Resident 1 requested to go to the bank, and, on November 2, 2008, she incorrectly thought her husband had just died. The Nurse's Notes and Weekly Care Management Review sheets (P. Ex. 16) reflect similar periods of confusion thereafter. The November 2 note states that the resident required frequent redirection to request assistance with transfers. On November 3, she was asking about when she could go home. On November 4, it is noted that Resident 1 was noncompliant with requesting assistance for transfers. CMS Ex. 31- 34. A note on November 14, 2008, states that the resident got lost and had to be redirected back to her room. CMS Ex. 9, at 26. A note at Noon on November 15, 2008, indicates the resident transferred herself to the toilet and set off her alarm. She was redirected to request assistance for transfers. At 8:15 p.m. on November 15, 2008, the resident was found on the ground in the courtyard. The note indicates that it was uncertain how she opened the door and that minutes before she was seen on Wing 2 looking for her house and that she was taken back to her room. The note does not indicate whether any alarm on her wheelchair sounded but does state that the resident may have transferred herself to her wheelchair, suggesting the alarms in the wheelchair were not attached. CMS Ex. 9, at 25-26.

The Incident Follow-up & Recommendation Form completed by the Interdisciplinary Team (IDT or care planning team (Tr. at 271)) for the November 15, 2008, fall provides no more detail but lists as interventions tab alarms in bed and wheelchair, medication changes, and rehabilitation therapy. P. Ex. 30, at 1. On November 16, 2008, it is reported the resident was propelling herself through the halls and into other resident's rooms requesting that someone take her home. CMS Ex. 9, at 25. A November 17 care planning team note in the Nurse's Notes states that tab alarms were to be placed in the bed and wheelchair due to the November 15, 2008 fall in the courtyard. A medication review by the treating physician was also to be requested. Also, on November 17, Resident 1 transferred herself setting off the alarm in her chair. CMS Ex. 9, at 24. A Nurse's Notes entry on November 19, 2008, indicates that the resident does not use her call light. CMS Ex. 9, at 23. A note on November 25, 2008, indicates Resident 1was up and down and set off her chair alarm multiple times. A note dated November 26, indicates the resident was up multiple times without assistance setting off her chair alarm, and she was noted to have said that she does not always do what she is supposed to.

CMS Ex. 9, at 22. On November 28, 2008, it is noted that Resident 1's tab alarms go off frequently, and she has to be reminded over and over to use her call light for assistance. CMS Ex. 9, at 21. A note dated December 5, 2008, indicates that the resident continued to trip her alarms and required redirection. CMS Ex. 9, at 20. A note dated December 9, 2008, indicates that Resident 1 was frequently noncompliant with requesting assistance with toileting. CMS Ex. 9, at 19. A note on December 13, 2008, at 7:25 p.m. indicates that a nurse assistant found Resident on the floor and her alarm was sounding, and the tab was still clipped to her gown. The note does not indicate whether the resident fell from her bed or her wheelchair, but it notes that the wheelchair was away from the bedside and the wheels were locked. CMS Ex. 9, at 17-18. A care planning team note in the Nurse's Notes dated December 16, 2008, indicates that: the December 13, 2008 fall was reviewed; the resident was educated to use her call light and ask for assistance; she was noted to have tab alarms for her bed and wheelchair at all times; she had non-skid strips in front of her bed and closet; she was receiving restorative nursing for range of motion and ambulation; and her Seroquel was increased. A note dated December 17, 2008, at 3:45 p.m. indicates that the resident was found standing at an outside entrance door attempting to open the door with her tab alarm sounding, and her Wander Guard® bracelet in place, though no mention of whether the Wander Guard® alarm sounded or locked the door (Tr. at 346-47), which did not open. CMS Ex. 9, at 16. On December 18, 2008, Resident 1 transferred herself twice, and she was reminded to use the call light and request assistance. On December 20, 2008, it is noted that the resident transfers herself frequently. A note dated December 24, 2008 indicates that she frequently transfers herself setting off her alarm. CMS Ex. 9, at 14. A late entry note for December 21, 2008, indicates that Resident 1 tends to remove her tab alarms and transfers herself. A late entry note for December 23 also indicates that the resident frequently removed her tab alarms and transferred herself. A December 25 note also indicates the resident transfers herself at times. A note dated December 26, 2008 indicates that she wheels herself in her wheelchair around barriers. A note from the morning of December 27, 2008, indicates that the resident frequently transfers herself without requesting assistance. CMS Ex. 9, at 12-13. It is undisputed that subsequently on December 27 at about 7:35 p.m., Resident 1 was found in the courtyard, wet and on the ground, her wheelchair twenty feet away, and the tab alarms in her wheelchair had not been attached. CMS Ex. 9, at 12. It is not indicated in the Nurse's Notes whether the Resident had been in bed or what she may have been doing prior to exiting to the interior courtyard and falling. The Incident Follow-up & Recommendation Form completed by the IDT for the December 27, 2008 incident, indicates that Resident 1 had transferred herself from her bed, that the nurse assistant who put her to bed had attached the tab alarms, and that the resident was found ten minutes later in the courtyard without the tab alarms in her wheelchair having been attached. The incident report does not state whether or not the tab alarms in the bed sounded, but I infer they did not or the residents transfer from her bed to her wheelchair would have been detected. It is noted on the report that the resident's Wander Guard® was not effective as the courtyard doors did not have the system in place. The interventions adopted by the IDT were: to lock or block the courtyard doors; to

temporarily place pull tab alarms on the doors and signs that the courtyard was not to be used between 6:00 p.m. and 6:00 a.m.; fifteen minute checks were imposed for Resident 1 but only until the doors to the courtyard were secured; and a Wander Guard® style system was to be installed on the courtyard doors when available. P. Ex. 31, at 1; P. Ex. 38; Tr. at 399-400, 428.

Resident 1's care plan from October 2008 identified her as at risk for falls and included the following printed interventions with a goal of keeping her free from falls: therapies to evaluate and treat as needed; assess medication as a contributing factor for falls; non-skid strips by the bed and clothing cabinet; well-fitting shoes with non-slip soles; call light in easy reach and promptly answered, with reminders and encouragement to use it; keeping frequently used items within reach; toileting every two hours and as necessary; bed and chair alarms checked every shift (a hand-written note indicates "tabs alarm"); assistance of one or two staff for transfers and ambulation; assistive device for bed mobility, transfers, or ambulation, though the type of device is not specified; ensuring the resident had her glasses on and hearing aid operating prior to getting out of bed; and monitoring and encouraging the use of proper footwear. Numerous hand-written entries appear on the copy of the falls care plan provided by Petitioner. An entry dated December 4, 2008, is for exercises to strengthen Resident 1's bilateral lower extremities. An entry dated December 13, 2008, possibly following the fall on that date, indicates that the resident was to be educated to use the call light for assistance for all transfers. An entry dated December 27, 2008, clearly after the fall on that date, indicates that the resident is to be checked every fifteen minutes. An entry dated January 21, 2009, appears to be instructions related to exercising. A note dated February 6, 2009, required that floor sensor alarms be placed at the bedside. There are no interventions dated on or about the time of the November 15, 2008 fall. P. Ex. 11, at 6. A Fall Risk Evaluation dated October 28, 2008 indicates that non-skid strips were to be placed by the resident's bed and cabinet and that she was to have bed and chair alarms (P. Ex. 7, at 2) consistent with the care plan (P. Ex. 11, at 6). The October 31 Nurse's Notes entry refers to Resident 1 setting off her tab alarms when self-transferring. CMS Ex. 9, at 33. Thus, the IDT listing of tab alarms in bed and chair as an intervention following the November 15 fall (P. Ex. 30, at 1; CMS Ex. 9, at 24, Tr. at 433) is not considered to be an addition or change to Resident 1's care plan. Similarly, following the December 13, 2008 fall, the IDT listed educating the resident to use her call light and request assistance, non-skid strips in front of her bed and closet, and tab alarms for her bed and wheelchair (CMS Ex. 9, at 16), but none of these were new interventions. I see no evidence that the IDT adopted any new interventions that were added to the resident's care plan to address the resident's standing and self-transfers except the temporary fifteen-minute checks, within the days following the December 27, 2008 fall. P. Ex. 31; CMS Ex. 9, at 11.

The evidence shows that contrary to Petitioner's assertions, Petitioner did not do what was reasonable to minimize the foreseeable risk that Resident 1 was going to fall on November 15, 2008, December 13, 2008, and December 27, 2008, without regard to

where those falls occurred. The resident fell prior to her hospitalization on October 18, 2008. When she returned on October 21, 2008, she was assessed as at risk for falls, and interventions including bed and chair alarms, education to use her call light for assistance with transfers, therapies, medication assessments, non-skid strips, among others were adopted and, presumably implemented. However, within days, it became apparent that the resident was going to be noncompliant setting off her alarms when she self-transferred. Her behaviors continued with no real change in her care plan and no evidence that the care planning team or IDT actually evaluated the effectiveness of existing interventions or considered others. She fell on November 15 and again on December 13, 2008, and there is no evidence that the care planning team recognized a need to do something different, despite evidence in Petitioner's records that the resident was actually defeating the alarms by detaching or disconnecting them. She fell again on December 27, 2008, and Petitioner's primary focus was to lock or bar the doors to the courtyard rather than address Resident 1's problem of being non-compliant with self-transfers. Tr. at 390-95. Based upon Petitioner's clinical records, there is a clear failure of the care planning team to implement necessary interventions, to evaluate the effectiveness of those interventions, and to implement new interventions as necessary to ensure that Resident 1 received necessary care and services, specifically adequate supervision to minimize the risk of her falling, inside or outside.

I also conclude based on this record that there is a derivative violation of 42 C.F.R. § 483.75 (Tag F490), as the failure of management and the IDT to act appropriately in this case is significant evidence that the facility was not being administered so to attain or maintain the highest practicable physical, mental, and psychological well-being of each resident.[4] Petitioner's administrator, Lori Moberly, testified that management delayed any action with respect to the safety of resident's in the courtyard until Resident 1's second fall on December 27, 2008. Tr. at 390. A single fall by a resident in the courtyard should have triggered an investigation of the cause of the fall and corrective action if necessary. Administrator Moberly's admission that the risk posed to Resident 1

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[4] The surveyors also charged a violation of 42 C.F.R. § 483.75(o)(1) related to the requirement that the facility have a quality assurance and assessment (QA) committee that meets quarterly. I find it unnecessary to address this deficiency, as the deficiencies discussed are a sufficient basis for the modest CMP imposed. However, I note that the allegations in the SOD establish that Petitioner had a QA committee that met as required. The theory advanced by the surveyors appears to be that the QA committee did not do its job well in assessing and ensuring the safety of the interior courtyard. The regulation cited, however, does not address the effectiveness of a QA committee. Rather, the effectiveness of the administration of a facility and its provision of care and services is more appropriately analyzed in the context of the other requirements for participation, as I have done in this case.

or other resident's by the courtyard was not evaluated until Resident 1's second fall is an admission that facility management was not appropriately administering and maintaining the facility for the benefit of all residents.

Petitioner argues that, if I find a violation of 42 C.F.R. § 483.25(h), it returned to substantial compliance within days by limiting access to the courtyard, changing policies and procedures regarding courtyard access, installing alarms, and reassessing residents. P. Brief at 28-29. This argument is not persuasive as these interventions, whether or not necessary and appropriate, do not address Resident 1's risk for falls. In fact, it was not until February 6, 2009, that the care planning team took some new action to address Resident 1's risk for falls by adding to the resident's falls care plan a requirement for a floor sensor alarm at bedside.[5] P. Ex. 11, at 6. I accept that action as reflecting that the care planning team finally did its job, evaluated the effectiveness of interventions in place since October 2008, and then took action to implement a new intervention to address Resident 1's continued risk for falls.[6] Accordingly, I will not disturb the CMS decision to stop accrual of the CMP on February 6, 2009.

I also conclude that the determination that Resident 1 was exposed to immediate jeopardy was not clearly erroneous. Immediate jeopardy exists if the facility's noncompliance has caused or is likely to cause "serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination as to the level of a facility's noncompliance ─ which includes an immediate jeopardy finding ─ must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board has previously held that the regulation imposes upon Petitioner the burden to show that the CMS determination is clearly erroneous, and the Board has commented that it is a heavy burden indeed. *Edgemont Healthcare*, DAB No. 2202, at 20 (2008) (and cases cited therein). The occurrence of

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[5] The clinical record shows that a floor sensor alarm was applied beside the bed as a safety intervention on December 30, 2008. CMS Ex. 9, at 10; P. Ex. 16, at 9. Who took the initiative to add that alarm is not reflected in the documentary evidence, but Carla Kaylor, LPN, appeared to concur with counsel that the floor alarm was initiated by nursing staff. Tr. at 293. There are references to the presence of the floor alarm in January 2009 and early February 2009. CMS Ex. 9, at 5; P. Ex. 15, at 28. The evidence does not indicate if and when the IDT assessed the need for the floor alarm other than the addition of that intervention on the care plan on February 6, 2009. P. Ex. 11, at 6. The Nurse's Notes entries for January and February show that Resident 1 continued to defeat or ignore her tab alarms and self-transfer and do not reflect that the floor sensor alarm was particularly effective, but it is some evidence of action by the IDT. CMS Ex. 9, at 1-10; P. Ex. 15, at 17-29.

[6] I also note that Petitioner alleged in its plan of correction for Tag F323 that it did not complete its corrections until February 13, 2009.

actual harm is not a prerequisite for a finding of immediate jeopardy (*Stone County Nursing & Rehab. Ctr.*, DAB No. 2276, at 19 (2009)), though the evidence in this case shows that Resident 1 suffered some actual harm in the form of bruising with each fall.

Petitioner argues that the CMS allegations of potential harm are speculative at best and approach the fanciful. P. Br. at 27-28. It is neither speculative nor fanciful that Resident 1 suffered severe osteoporosis with a history of pelvic fractures, and any fall was likely to cause serious injury, harm, or impairment. Petitioner has not met its burden of showing that the immediate jeopardy determination was clearly erroneous in the case of Resident 1.

6. A CMP of $4,250 per day from December 27, 2008 through February 6, 2009 is reasonable.

I have concluded that Petitioner did not violate 42 C.F.R. § 483.20 (g) through (j) or 483.20(d) and (k)(1) but that Petitioner did violate 42 C.F.R. §§ 483.25(h) and 483.75, and that the declaration of immediate jeopardy related to those violation is not clearly erroneous. Petitioner was not in substantial compliance with program participation requirements from at least December 27, 2008 through February 6, 2009, and there is a basis for the imposition of an enforcement remedy for that period.

If I conclude, as I have in this case, that there is a basis for the imposition of an enforcement remedy, and the remedy proposed is a CMP, my authority to review the reasonableness of the CMP is limited by 42 C.F.R. § 488.438(e). The limitations are: (1) I may not set the CMP at zero or reduce it to zero; (2) I may not review the exercise of discretion by CMS in selecting to impose a CMP (or the CMS selection of any other authorized remedy); and (3) I may only consider the factors specified by 42 C.F.R. § 488.438(f) when determining the reasonableness of the CMP amount. In determining whether the amount of a CMP is reasonable, 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 seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404(b), the same factors CMS and/or the state were to consider when setting the CMP amount; and (4) the facility's degree of culpability, including, but not limited to, the facility's neglect, indifference, or disregard for resident care, comfort, and safety, and the absence of culpability is not a mitigating factor. The factors that CMS and the state were required to consider when setting the CMP amount and that I am required to consider when assessing the reasonableness of the amount are set forth in 42 C.F.R. § 488.404(b): (1) whether the deficiencies caused (i) no actual harm but had the potential for minimal harm, (ii) no actual harm but had the potential for more than minimal harm, but not immediate jeopardy, (iii) actual harm that is not immediate jeopardy, or (iv) immediate jeopardy to resident health and safety; and (2) whether the deficiencies are isolated, constitute a pattern, or are widespread. My review of the reasonableness of the CMP is de novo and based upon the evidence in the

record before me. In reaching a decision on the reasonableness of the CMP, I consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found, and in light of the above factors. I am not bound to defer to the CMS determination of the reasonable amount of the CMP to impose, but my authority is limited by regulation as already explained. I am to determine whether the amount of any CMP proposed is within reasonable bounds, considering the purpose of the Act and regulations. *Emerald Oaks,* DAB No. 1800, at 10 (2001); *CarePlex of Silver Spring*, DAB No. 1683, at 14–16 (1999); *Capitol Hill Cmty. Rehab. & Specialty Care Ctr.*, DAB No. 1629 (1997).

The only enforcement remedy at issue is the CMP of $4,250 per day from December 27, 2008, through February 6, 2009. Because I have concluded that there was immediate jeopardy for the entire period of noncompliance, the minimum authorized CMP is $3,050 per day. 42 C.F.R. §§ 488.438(a)(1)(i) and (d)(2). I note that the CMP of $4,250 per day is in the bottom half of the authorized range. There is unrebutted evidence that Petitioner was previously found noncompliant with the requirement to provide adequate supervision, though that incident did not involve immediate jeopardy or actual harm. CMS Ex. 14. Petitioner has not argued or presented evidence to establish an inability to pay. I conclude that Petitioner was culpable for its failures. I conclude, based on the required factors, that a per day CMP of $4,250 is reasonable. I specifically decline to reduce the CMP amount, even though I concluded that Petitioner did not commit all the violations alleged by the surveyors.

6. Other issues raised by Petitioner are without merit or are not within my authority to decide.

Petitioner attempts to preserve additional issues for appeal. Petitioner argues that the allocation of the burden of persuasion in this case, according to the rationale of the Board in the prior decisions cited above, violates the Administrative Procedures Act, 5 U.S.C. § 551 *et. seq.*, specifically 5 U.S.C. § 556(d). Request for Hearing at 6; P. Br. at 18 n.9. Because the evidence is not in equipoise, the burden of persuasion did not affect my decision, and Petitioner suffered no prejudice.

Petitioner also argues that the Medicare Act is violated and Petitioner is deprived of due process if CMS is not required to submit evidence to prove it considered the regulatory criteria established by 42 C.F.R. §§ 488.404 and 488.438(f). Request for Hearing at 6. Here, however, CMS did provide evidence of the factors with its prehearing exchange and brief and post hearing brief. In any event, there is no prejudice to Petitioner because I conduct a de novo review, and Petitioner had ample opportunity to present any evidence for my consideration on the factors in this proceeding.

III. Conclusion

For the foregoing reasons, I conclude that Petitioner was not in substantial compliance with program participation requirements from December 27, 2008 through February 6, 2009 and that the imposition of a CMP of $4,250 per day is reasonable.

/s/
Keith W. Sickendick
Administrative Law Judge