Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Franklin Care Center,	)	Date: November 20, 2007
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-03-414
	)	Decision No. CR1694
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

For the reasons set forth below, I find that Franklin Care Center (Petitioner), was not in substantial compliance with program participation requirements during the period from January 20, 2003 through January 22, 2003, at a level which posed immediate jeopardy to resident health and safety. I therefore affirm the imposition of a per day civil money penalty of $3,100 for that period. I also find that Petition was not in substantial compliance for the period from January 23, 2003, through February 24, 2003, and I affirm the $100 per day civil money penalty for that period of time.

I. Background

Petitioner is a skilled nursing facility located in Franklin Park, New Jersey, and is licensed to participate in the Medicare program. Its participation in that program is governed by sections 1866 and 1819 of the Social Security Act and by implementing regulations at 42 C.F.R. Parts 483 and 488.

A complaint survey conducted on January 28, 2003, by the New Jersey Department of Health and Senior Services (NJDOHSS) found several deficience relating to the quality of care provided to the residents at Franklin Care Center. By letter dated February 14, 2003, CMS notified Petitioner of its determination, based upon the NJDOHSS survey, to impose a CMP in the amount of $3,100 per day for the period January 20, 2003 to January 22, 2003, and $100 per day from January 23, 2003 until February 24, 2003. The total CMP imposed by CMS against Petitioner is $12,600.

The survey concluded that Franklin Care Center was out of compliance with the following three Medicare participation requirements:

42 C.F.R. § 483.13(b) (Tag F223) (Abuse)
42 C.F.R. § 483.13(c) (Tag F226) (Staff Treatment of Residents)
42 C.F.R. § 483.13(h)(2) (Tag F324) (Quality of Care)

Noncompliance with 42 C.F.R. § 483.13(b) and 42 C.F.R. § 483.13(c) were determined to be at the immediate jeopardy level "J," while 42 C.F.R. § 483.25(h)(2) was determined to be a level G deficiency.

Petitioner timely requested a hearing and the case was assigned to me for a hearing and a decision. I convened an in-person hearing in Newark, New Jersey. Mr. Joseph Gorrell appeared on behalf of Petitioner, and Mr. David Rawson appeared on behalf of CMS. CMS filed 29 exhibits which it designated as CMS Ex. 1 - CMS Ex. 29. Petitioner filed 34 exhibits which it designated as P. Ex. 1 - P. Ex. 34. Neither party objected to the opposing party's exhibits. I receive the exhibits filed by both parties into evidence. At hearing, CMS presented the testimony of Ann Yates, NJDOHSS Surveyor. Petitioner presented the testimony of Kathryn Maguire, Director of Social Services. Each party submitted post-hearing briefs.

II. Applicable Law

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

Facilities that participate in Medicare may be surveyed on behalf of CMS by state survey agencies in order to determine whether the facilities are complying with federal participation requirements. 42 C.F.R §§ 488.10- 488.28; 42 C.F.R. §§ 488.300 - 488.335. Pursuant to 42 C.F.R. Part 488, CMS may impose either a per day CMP or a per instance CMP against a long-term care facility when a state survey agency concludes that the facility is not complying substantially with federal participation requirements. 42 C.F.R. §§ 488.406, 488.408, and 488.430. The penalty may start accruing as early as the date that the facility was first out of compliance until the date substantial compliance is achieved or the provider agreement is terminated. 42 C.F.R. § 488.440.

The regulations specify that a per day CMP that is imposed against a facility will fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMPs, of from $3,050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents, and in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1), (d)(2). The lower range of CMPs, of from $50 per day to $3,000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438 (a)(1)(ii).

The regulations define the term “substantial compliance” to mean:

> [A] level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

42 C.F.R § 488.301.

“Immediate jeopardy” is defined to mean:

> a situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

42 C.F.R § 488.301.

The Act and regulations make a hearing available before an Administrative Law Judge (ALJ) to a long-term facility against whom CMS has determined to impose a CMP. But the scope of such hearings is limited to whether an *initial determination* made by CMS is correct. Act, section 1128A(c)(2); 42 C.F.R. §§ 488.408(g), 498.3(b)(12) and (13). The hearing before an administrative law judge is a de novo proceeding. *Anesthesiologists Affiliated, et al*, DAB CR65 (1990), aff'd 941 F2d. 678 (8th Cir. 1991).

In civil money penalty cases CMS's determination as to the level of noncompliance of a skilled nursing facility (SNF) must be upheld unless it is clearly erroneous. 42 C.F.R. § 498.60(c)(2). CMS bears the burden of coming forward with evidence sufficient to establish a prima facie case that Petitioner was not in substantial compliance with the participation requirements at issue. *See Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004). Once CMS has established a prima facie case, Petitioner has the ultimate burden of persuasion: to prevail, Petitioner must prove by a preponderance of the evidence that it was in substantial compliance with each participation requirement at issue. *See Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd.*, *Hillman Rehabilitation Center v. United States, Department of Health and Human Services, Health Care Financing Administration*, No. 98-3789 (GEB), slip op. at 25 (D.N.J. May 13, 1999).

III. Issues

A. Whether the facility was complying substantially with federal participation requirements on the dates CMS determined to impose a CMP.

B. Whether CMS's determination of immediate jeopardy was clearly erroneous.

C. Whether the amount of the penalty imposed by CMS is reasonable, if noncompliance is established.

IV. Findings and Discussion

I make findings of fact and conclusions of law (Findings) to support my decision in this case. I set forth each Finding below as a separate heading. I discuss each Finding in detail.

A. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.13(b) during a period from January 20 - January 22, 2003. (Tag F223).

A resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion as provided by 42 C.F.R. § 483.13(b).

Based on record review, resident, and staff interviews, Ann Yates, a state surveyor (Surveyor Yates) found that Petitioner failed to intervene and/or implement effective interventions to protect one of its residents, Resident 1 (R1), from inappropriate sexual contact (sexual abuse) by one of its certified nursing assistant's (CNA's). CMS Ex. 2, at 1. Transcript, (Tr.) at 26.

CMS specifically alleges that Petitioner was out of compliance with Tag F233 because R1 was sexually abused by CNA 1 and as the result of the abuse R1 suffered post-traumatic stress disorder. During the 11 p.m. - 7 a.m. shift, on January 19-20, 2003, CNA 1 entered the room of R1 under the guise of changing R1's diaper. CNA 1 apparently kissed the resident on the cheek and fondled her genitalia. CMS Ex. 8. CNA 1 pretended to wash the resident, but had no towel or water. CMS Ex. 2, at 1; Tr. at 30-31. CNA 1 entered the resident's room a second time, some time later, and did the same thing. When he entered the resident's room a third time, R1 told him to get out and CNA 1 left. CMS Ex. 9, at 1-2; Tr. at 30-32. R1 told two other CNA's, Kanta Alhawite (CNA 2) (7 a.m. - 3 p.m. shift) and Phyllis Henry (CNA 3)(3 p.m. -11 p.m. shift), about what happened during the night shift on January 19-20. Neither of the two CNAs reported what had occurred to the administration. Tr. at 32-33. CNA 3 told R1 not to tell anyone about what had occurred, and she would speak to CNA 1 herself. CMS Ex. 9, at 2. CNA 2 said she forgot to report the incident because she was so busy.

CNA 1 returned for his scheduled shift from 11 p.m. -7 a.m. on January 21-22. CNA 1 was assigned to care for R1, but upon entering R1's room she refused care and told him to get out of her room. R1 then reported the incident involving CNA 1 to a nurse (nurse 1) on the 11 a.m. - 7 a.m. shift at approximately 2:30 a.m. on January 23, 2003. Nurse 1 then reported the incident to the 7 a.m. - 3 p.m. nurse (Nurse 2). The 7 a.m. - 3 p.m. Nurse 2 then reported the abuse incident to the administration which immediately initiated an investigation. CNA 1 was interviewed and terminated on January 23, 2003 and the non reporting CNAs were placed on leave until an investigation could be completed. CNA 3 was subsequently terminated. CMS Exs. 22, 24, 25; Tr. at 36.

Petitioner does not dispute that the abuse occurred. Petitioner contends that it did all it could do under the circumstances. Petitioner contends that the abuse occurred on the 11:00 p.m. to 7:00 a.m. shift on January 21-22, the event was reported and CNA 1 was terminated the next day. It is clear from the record, Petitioner's own investigation and Petitioner's termination of CNA 1, that the sexual abuse occurred. The argument, that Petitioner terminated the offending CNA as soon as it learned of the abuse, while indicative of when the immediate jeopardy was corrected, does not, however, rebut CMS's *prima facie* showing of abuse.

The thrust of Petitioner's principle arguments rest on the premise that the surveyor and CMS are confused as to the dates of the alleged abuse. Petitioner argues that the abuse incident took place on the 11 p.m. -7 a.m. shift on January 21-22, 2003, and not as Ms. Yates testified, on the 11 p.m. - 7 a.m. shift on January 19-20. Petitioner maintains that the offending CNA was terminated the next day January 23, 2003, and did not return to work at the facility after the abuse occurred. According to Petitioner, all three incidents in which CNA 1 went into R1's room occurred on the same shift. Petitioner maintains that CNA 2, and CNA 3 reported that the incident occurred on January 21-22. Pet. Br. at 12. In addition, Petitioner argues that the memory of R1 is not reliable and, essentially, that R1 should not be believed due to her emotional state, poor short term memory and alleged disorientation as to time and date. Pet. Br. at 13.

I do not find the arguments advanced by Petitioner to be persuasive. I give little weight to the reports of the two CNAs who failed to report the sexual abuse. Both of the non-reporting CNAs would be highly motivated to limit the period of time they knew of an incident of sexual abuse and did not report it. Only one of the non-reporting CNAs, (CNA 3), was discharged after the incident. Petitioner did not call any other CNA, nurse, or any other employee to testify as to when the abuse occurred. As to alleged disorientation as to time and date, Petitioner cites no medical record which documents that R1 was disorientation as to time and date.

Surveyor Yates testified that she interviewed R1 and indicated that R1 was able to recall when the incident actually happened. Ms. Yates also testified that the medical record showed R1 as not having focal deficits and documenting her as alert, oriented and able to communicate her needs. CMS Br. at 14; Tr. at 28; CMS Ex. 2, at 1; CMS Ex. 9, at 4. Ms. Yates also testified that she relied on statements made by Franklin's staff as to when the sexual abuse was reported to them and compared them to time cards and schedules to determine when those employees involved in the matter worked. Tr. at 60, 83, 84. Furthermore, Petitioner's own report to the Ombudsman's Office from Petitioner's

Assistant Administrator documents the incident as taking place on January 20, 2003. CMS Br. at 15; CMS Ex. 8. Surveyor Yates also indicates that the sequence of events she described were prepared "according to" the Director of Nursing and the Assistant Administrator. CMS Ex. 9, at 5; CMS Br. at 15.

Based on the evidence before me, I find the time line argued by CMS to be the most persuasive and supported by the record in this case. In view of the foregoing, I find that CMS has established a *prima facie* case that Petitioner failed to intervene and/or implement effective interventions to protect one of its residents from inappropriate sexual contact (sexual abuse) by one of its CNA's. Petitioner has not overcome CMS's *prima facie* case by a preponderance of the evidence. Therefore I sustain CMS determination to impose a CMP in the amount of $3,100 for three days – from January 20 through January 22, 2003.

B. Petitioner's failure to comply substantially with the requirements of 42 C.F.R. § 483.13(b) continued at a Level "G" from January 23, 2003 - February 24, 2003.

While CMS determined that the immediate jeopardy was corrected on January 23, 2003, CMS also determined that the deficiency continued to be cited at a level G until February 24, 2003. The basis for the continuation of the deficiency was a therapist's diagnosis of R1 as suffering from post-traumatic stress disorder. Tr. at 38. Surveyor Yates also testified that the deficiency ended on February 24, 2003, because it was at that time that a revisit survey was conducted and Petitioner had conducted in-service training to address the issue of sexual abuse. Tr. at 94.

State Surveyor Yates interviewed R1 and found that the psychotherapy progress notes for January 24, 2003, indicated that the therapist diagnosed R1 with post-traumatic stress disorder. R1 was reported to have felt guilty for reporting the incident which resulted in adverse actions to the CNAs.

The state surveyor testified and noted in the statement of deficiencies that

- Resident 1 was tearful and frightened.
- Resident 1 required psychological intervention and psychoactive medication.
- Resident 1 expressed feeling of guilt because she "got staff in trouble."

> • When the surveyor interviewed Resident 1 on January 28, 2003, she continued to be tearful and frightened.

Tr. at 34, 36-37; CMS Ex. 2, at 3; CMS Ex. 9, at 2.

At hearing, Petitioner presented one witness, Kathryn Maguire, Director of Social Services. When asked on direct examination what she knew of R1, Ms. Maguire indicated that R1 was quite sociable and would often come into her office to chat. Ms. Maguire also indicated that when she interviewed R1 concerning the incident

> there was some tearfulness as she related exactly what had occurred. But there was – I did not get the sense of overall sadness, you know, complete break down or sadness. There was this immediate cheerfulness as she related the incident to me.

Tr. at 104-106.

Petitioner also argued in its post-hearing brief that

> Resident 1 had a tearful disposition prior to the incident, and therefore, was not necessarily suffering from post-traumatic stress disorder. Resident had a history of bipolar disorder. Also, prior to the sexual assault incident, Resident 1 was described as crying and feeling she was cheated and abandoned by her family. Also prior to the sexual assault incident, Resident was noted crying in her room several times. Thus, Resident 1 was upset and subject to tears even before the sexual assault incident. Resident 1 was diagnosed with adjustment disorder with anxious mood, which proves that she was an anxious person even before the sexual abuse . . . Thus, the severity of the level G deficiency is inappropriate because Resident 1 did not suffer the extreme emotional trauma from the incident that CMS alleges. In fact, after the sexual assault incident, Resident 1 never stopped operating her rolling store.

Petitioner's Post-hearing brief at 14-15; Tr. at 72.

Petitioner seems to imply that it was impossible to tell whether the resident was upset by the sexual assault because she suffered from an "adjustment disorder" and always cried about one thing or another. However, Petitioner failed to provide any expert testimony as to R1's mood, affect, or post-traumatic stress. Moreover, R1's diagnosis is based on the facility's own consulting therapist. The diagnosing therapist was not called by Petitioner to testify at hearing as to R1's post-traumatic stress disorder. Thus, while Petitioner does

not dispute that the sexual abuse occurred, it uses selected parts of the medical record to speculate that the victim was not affected by that sexual abuse. I do not find Petitioner's line of argument to be persuasive or credible.

Based upon my review of all of the evidence and testimony in this case, I find that CMS has established, *prima facie*, that the deficiency continued at a level "G" for 33 days – from January 23, 2003 until February 24, 2003. Petitioner has not overcome CMS's *prima facie* case by a preponderance of the evidence. Therefore, I sustain CMS determination to impose a CMP in the amount of $100 for 33-days for a total amount of $3,300.

C. *CMS established that the facility failed to report all violations involving mistreatment, neglect or abuse as required by 42 C.F.R. § 483.13(c)(Tag F226).*

The facts underlying this deficiency, Tag F226, are identical to the facts underlying Tag F 223. The focus of the citation of Tag 226 is on the failure of four members of Franklin's staff to report an allegation of sexual abuse for three days after the incident occurred. Tr. at 40.

Facility policy documented that employees who have knowledge of abuse will be interviewed and a statement of each interview will be written and signed by the person being interviewed. There were no written statements for CNA 2, CNA 3, or Nurse 1, who all had knowledge of the abuse incident. The facility's policy fails to indicate that the allegations of abuse should be reported to the Administrator.

Section 483.13(c)(2) of 42 C.F.R. provides that all alleged violations of mistreatment, neglect or abuse must be immediately reported to the facility administrator and to other officials in accordance with State law, including the State survey and certification agency. Based on record review and staff interviews, the surveyors found that the facility failed to follow federal regulations and its own policy on reporting and investigating allegations of inappropriate sexual contact between CNA 1 and R1.

Every facility is required to develop and implement policies and procedures that prohibit mistreatment, neglect, and abuse of residents. The facts of this case establish that the facility staff, CNA 2, CNA 3 and Nurse 1 were aware of particular events and allegations of abuse, but failed to immediately report them or to take appropriate action as required by the policies. *Cedar View Good Samaritan*, DAB CR997 (2003); *see also Beverly Health and Rehabilitation Center - Williamsburg*, DAB No. 1748 (2000). The preponderance of the evidence here demonstrates a failure by Petitioner's staff to appropriately and immediately report instances of abuse as required by federal regulations and its own policy.

There is certainly no question that CNAs 2 and 3 and Nurse 1 had a duty to report CNA 1's sexual abuse of R1. Yet they failed to immediately report the incident. CMS alleged that Petitioner's employees failed to report an allegation of sexual abuse for three days after the incident of sexual abuse occurred. Thus, CNA # 1 was able to return to work and was assigned to provide care for R1, the resident he sexually abused. CMS argues that this failure placed R1 and other residents at potential risk.

Petitioner's only defense to this Tag is that CMS has placed the abuse on the wrong date. As previously noted, I find that Petitioner's argument as to when the sexual abuse occurred not persuasive.

Based on record review and staff interviews, the surveyors found that the Petitioner failed to follow the facility's abuse policy and procedures related to immediately reporting such incidents to the administrator. In so doing, Petitioner failed to provide protection for one of its residents who was sexually abused. In view of the evidence and testimony at hearing, I find that CMS has established a *prima facie* case that the facility staff failed to notify its administrator of the existence of an allegation of abuse regarding R1. Petitioner has not overcome CMS's *prima facie* case by a preponderance of the evidence.

D. Petitioner violated 42 C.F.R. § 483.25(h)(2) (Tag F324) and there is a basis for imposing a CMP.

According to the statement of deficiencies the nursing staff failed to consistently implement new interventions and effective measures for 1 of 2 sampled residents to prevent falls and injury. As a result, Resident 5 sustained falls with injury on October 24, 2002, December 13, 2002, and December 23, 2002. Tr. at 42; CMS Ex. 2, at 6.

Resident 5 (R5) was admitted to the facility on February 19, 1999 with a diagnosis of hypertension, angina, senile dementia and atherosclerosis. Her Minimum Data Set dated December 1, 2002 documented long and short term memory impairment with moderately impaired decision making skills. R5 required supervision with transfers, was independent in bed mobility and had a history of falls within the last 31-190 days. Tr. at 44; CMS Ex. 2, at 6, CMS Ex. 10, at 1.

R5's nursing care plan dated December 5, 2001, and updated through December 2002, indicated that Resident 5 was at risk for falls due to an unsteady gait. CMS Ex. 2, at 6; CMS Ex. 29, at 12. Interventions included using a wheelchair as a rolling walker, checking for proper foot wear, the mandatory use of non-skid socks while in bed, as well as the use of a wheelchair. R5 also required a bed alarm, and required a low bed and crash mat. Tr. at 46; CMS Ex. 2, at 6; CMS Ex. 29, at 13-15.

A nurses note dated October 24, 2002 documented that R5 was found sitting on the bathroom floor on her buttocks yelling "help me." She sustained a deep laceration, approximately 8 cm in length, to the left side of her head. She was transferred to the emergency room for evaluation and returned to the facility the same day with eleven sutures. Tr. at 47; CMS Ex. 10, at 1. There was no documentation in the nurses notes or investigative report to indicate a bed alarm was in place or that the resident was wearing non-skid socks at the time of the fall. Tr. at 48; CMS Ex. 29, at 8-10.

A nurses note dated December 13, 2002, documented that R5 was found on the floor with a bed sheet wrapped around her leg. She was calling for help and she had a hematoma on her head. Tr. at 49; CMS Ex. 29, at 19-21. The was no documentation in the nurses notes of a fall investigation to indicate that the bed alarm was in place or that the crash mat was in place at the time of the fall. Tr. at 49; CMS Ex. 29, at 19-21.

A investigation report dated December 23, 2002, documented that R5 was heard screaming in her room. When a nurse arrived R5 was found on the bathroom floor with her right leg twisted – a fracture was suspected. The report documented that R5 was not wearing the appropriate footwear. Tr. at 50; CMS Ex. 29, at 3. The report recommended that the alarm should be turned on while the resident was in bed. Tr. at 50. There was no documentation in the nurses notes that the bed alarm was in place or the resident was wearing non-skid socks at the time of the fall. Tr. at 50; CMS Ex. 10, at 2; CMS Ex. 29, at 3. R5 was sent to the emergency room for evaluation and admitted with a right hip fracture. She was readmitted to the facility on December 30, 2002.

Petitioner admits that R5 needed assistance with ambulation, but suggest that there were times when R5 ignored requesting assistance. P. Brief at 21; Tr. at 76. Petitioner argues that it did all it could to comply with CMS requirements. For example, following R5's hospitalization, the facility's IDT met and immediately revised safety precautions to accommodate R5's change in condition; further assessments were performed by Physical and Occupational Therapy; and a bed alarm and wheel chair alarm, along with a self-releasing belt, were put into place and added to the care plan. In addition, R5 was maintained in supervised areas while awake. P. Brief at 20; P. Ex. 32, 34.

CMS argues that Petitioner presented no testimony at hearing relative to the surveyor's findings that there was no documentation indicating that the bed alarm or crash mat was in place or that the resident was wearing non-skid socks at the time of any of her falls. CMS Brief at 19. Petitioner alleges that it had care planed for R5's falls and just because the record does not indicate that the alarms or socks or crash pad were in place at the time of the falls does not mean the assistive devices were not in place. Tr. at 78-79; P. Brief at

22. Petitioner also argues that it did not present witnesses on this at hearing because the record is clear that the facility complied with the requirement. I do not find the record that the facility complied with the regulatory requirements to be clear. Nor do I find Petitioner's arguments to be persuasive.

Under the statute and the "quality of care" regulation, a facility must ensure that "[e]ach resident receives adequate supervision and assistance devices to prevent accidents." 42 C.F.R. § 483.25(h)(2). An "accident" is "an unexpected, unintended event that can cause a resident bodily injury," excluding "adverse outcomes associated as a direct consequence of treatment or care (e.g., drug side effects or reactions)." State Operations Manual (SOM), App. P, page PP-105, Guidance to Surveyors for Long Term Care Facilities, Part 2, F324, Quality of Care (Rev. 274, June 1995), *Woodstock Care Center*, DAB No. 1726, at 4 (2000). The Board has explained the requirements of 42 C.F.R. § 483.25(h)(2) in numerous decisions. *Golden Age Skilled Nursing & Rehabilitation Center*, DAB No. 2026 (2006); *Estes Nursing Facility Civic Center*, DAB No. 2000 (2005); *Northeastern Ohio Alzheimer's Research Center*, DAB No. 1935 (2004); *Woodstock Care Center*, DAB No. 1726, at 28 (2000), *aff'd*, *Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). Section 483.25(h)(2) does not make a facility strictly liable for accidents that occur, but it does require that a facility take all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigates foreseeable risks of harm from accidents. *Woodstock Care Center v. Thompson*, 363 F.3d at 590 (a SNF must take "all reasonable precautions against residents' accidents"). A facility is permitted the flexibility to choose the methods of supervision it uses to prevent accidents, but the chosen methods must be adequate under the circumstances. *Id*.

Whether supervision is "adequate" depends in part upon the resident's ability to protect himself or herself from harm. *Id*. R5 fell three times and required help ambulating. An investigation of each fall indicated that her care plan was not followed as to the devices required to prevent accidents. The evidence in this case demonstrates that the facility failed to provide adequate supervision and assistance devices to prevent accidents, given what was reasonably foreseeable. Therefore, I find that CMS has established a *prima facie* case that Petitioner was not in substantial compliance with federal requirements for skilled nursing facilities participating in Medicare/Medicaid. Petitioner has not overcome CMS's showing by a preponderance of the evidence.

E. CMS's finding of immediate jeopardy was not clearly erroneous.

The regulations define immediate jeopardy as a situation in which a provider's non-compliance 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 finding of immediate jeopardy does not require "a finding of present harm, but also encompasses a situation that is [likely to cause] harm." *Britthaven*, DAB No. CR1259 (quoting *Hermina Traeye Memorial Nursing Home*, DAB No. 1810 (2002)).

CMS's determination of immediate jeopardy must be upheld unless it is clearly erroneous. 42 C.F.R. § 498.60(c)(2). The burden rests on the provider to prove that CMS's determination of immediate jeopardy is clearly erroneous. Based on the evidence and arguments before me, I find that Petitioner has not met that burden here.

F. A per-day CMP of $3,100 for the three days of immediate jeopardy and a per-day CMP of $100 for a period of January 23 - February 24 is reasonable.

In determining whether the amount of the CMP is reasonable, the following factors specified at 42 C.F.R. § 488.438 (f) must be considered: (1) the facility's history of non-compliance, including repeated deficiencies; (2) the facility's financial condition; (3) the seriousness of the deficiencies as set forth at 42 C.F.R.§ 404; and (4) the facility's degree of culpability. Both the CMP amounts for the immediate jeopardy citation as well as the non-immediate jeopardy citation in this case are at the low-end of the applicable range. CMS has offered no evidence of past noncompliance for me to consider. Petitioner has not argued or submitted any evidence that it is unable to pay the CMP.

I have concluded that Petitioner has not met its burden of showing that CMS's determinations of immediate jeopardy were "clearly erroneous" for the period January 20 2003 through January 22, 2003. The imposition of a CMP of $3,100 per day for this period, imposed for noncompliance at the immediate jeopardy level is therefore supported by the evidence in this case.

CMS imposed a per day civil money penalty in the amount of $3,100 for three days to remedy the immediate jeopardy. Regulations provide that CMS may impose either a per-diem or per-instance civil money penalties to remedy a nursing facility's deficiencies. 42 C.F.R. § 488.438(a)(1), (2). Penalties in the range of $3,050 to $10,000 per day are imposed for deficiencies constituting immediate jeopardy. 42 C.F.R. § 488.438. The per-day CMP of $3,100 is at the lower end of the applicable range. Based on the evidence before me, I find that the per-day CMP of $3,100 for 3 days is supported by the evidence in this case and is reasonable.

CMS also imposed a $100 per day civil money penalty for the non-immediate jeopardy deficiency for the period from January 23, 2003 to February 24, 2003. The regulations at 42 C.F.R. § 488.438(a)(1)(ii) provide that the range for non-immediate jeopardy deficiencies is between $50.00 and $3,000 per day. I have found that CMS has established a *prima facie* case of noncompliance relative to the non-immediate jeopardy citation. Petitioner has not rebutted CMS's case by a preponderance of the evidence. The $100 per day CMP is also at the low end of the applicable range and I find that the amount is fully supported by the evidence in this case. Therefore, I find that the $100 per day imposed by CMS in this case is reasonable.

V. Conclusion

Based on the testimony offered at the hearing, the documentary evidence, the arguments of the parties, and the applicable law and regulations, I find that Petitioner was not in substantial compliance with medicare requirements at the immediate jeopardy level for the period of January 20, 2003 through January 22, 2003. I further find that the $3,100 per day CMP for the period of the immediate jeopardy is reasonable. I also find that Petitioner's non-compliance continued from January 23, 2003 through February 24, 2003 at a non-immediate jeopardy level. Therefore, I also sustain the CMP of $100 per day for the period of January 23, 2003 through February 24, 2003.

/s/
Alfonso J. Montano
Administrative Law Judge