**Department of Health and Human Services**
**DEPARTMENTAL APPEALS BOARD**
**Appellate Division**

Golden Oaks Medical Care Facility
Docket No. A-12-46
Decision No. 2470
July 18, 2012

# FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Golden Oaks Medical Care Facility (Golden Oaks or Petitioner) appeals the December 7, 2011 decision of Administrative Law Judge (ALJ) Keith W. Sickendick upholding a determination by the Centers for Medicare & Medicaid Services (CMS), based on an October 8, 2009 complaint survey conducted by the State survey agency, that Golden Oaks was not in substantial compliance with the requirements for Medicare participation at 42 C.F.R. § 483.25(h). *Golden Oaks Medical Care Facility*, DAB CR2468 (2011). The ALJ also upheld a CMP of $700 per day for the period October 8 through October 21, 2009 imposed by CMS on Golden Oaks for that noncompliance.

Golden Oaks argues on appeal that it complied with section 483.25(h) and that the amount of the CMP was unreasonable. Request for Review (RR) at 14, 25. For the reasons explained below, we affirm the ALJ Decision.

## Case Background[1]

Golden Oaks participates in the Medicare program as a skilled nursing facility and the Michigan Medicaid program as a nursing facility. To participate in Medicare, a long-term care facility must at all times be in "substantial compliance" with the requirements in 42 C.F.R. Part 483.

On October 8, 2009, Michigan Department of Community Health (MDCH) surveyor Denise Young-Bean, R.N. conducted a complaint survey at Golden Oaks and found that the facility was not in substantial compliance with section 483.25(h), at the scope and severity level G (isolated actual harm that is not immediate jeopardy). CMS Ex. 3; 59 Fed. Reg. 56,116, 56,183 (Nov. 10, 1984)(scope and severity grid).

[1] The statutory and regulatory background is set out in detail on pages 2-5 of the ALJ Decision. The factual information in this section, unless otherwise indicated, is drawn from undisputed findings of fact in the ALJ Decision at pages 7-8 and undisputed facts in the record before him and is presented to provide a context for the discussion of the issues raised on appeal. Nothing in this section is intended to replace, modify, or supplement the ALJ's findings of fact or conclusions of law.

Section 483.25(h) is part of the quality of care regulation at section 483.25, which states that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." Section 483.25(h) imposes specific obligations upon a facility related to accident hazards and accidents, as follows:

> 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.

MDCH's Statement of Deficiencies (SOD) stated that Golden Oaks "failed to provide adequate supervision to prevent accidents" in the case of two sampled residents, identified as Resident 101 and Resident 102. CMS Ex. 3, at 1. However, before the ALJ, CMS relied only on the findings relating to Resident 102. ALJ Decision at 5. These findings involved falls by Resident 102 on June 16 and 22, 2009.

Resident 102 was an 83-year-old male who was readmitted to the facility on June 13, 2009. On June 13, 2009, the facility assessed Resident 102 to be at high risk for falls. Resident 102's Minimum Data Set (MDS) completed on June 18, 2009, shows that he had fallen in the last 30 days and in the last 31 to 80 days. ALJ Decision at 6; CMS Ex. 13, at 6, 9. Resident 102 was also assessed as being totally dependent on staff for all activities of daily living, including bed mobility (he required a one person assist) and transfers (he required a two person assist). In addition, Resident 102 was assessed as being in unstable condition, and he suffered from cognitive loss, confusion or dementia, contractures, and pain secondary to the contractures. ALJ Decision at 6.

At 10:30 a.m. on June 16, Resident 102 "roll[ed] out of bed into the floor mat" but sustained no injuries. ALJ Decision at 6; CMS Ex. 15, at 1. The Incident and Accident Report signed by facility staff on June 16 and 18 lists as interventions, or corrective measures, that were taken after the June 16 fall that staff "tied the mattress down, got bed alarm, contact[ed] [physical therapy] for safety."[2] ALJ Decision at 7; CMS Ex. 15, at 1.

Resident 102's care plan dated June 14 identifies as a problem "Potential for fall" due to "Disease Process, "Poor Safety Awareness," and "Cognitive Deficit." CMS Ex. 13, at 16. The plan contains check boxes showing as interventions to address this problem "Falls assessment upon admission" and "PT/OT to screen resident." *Id*. Several other

[2] It is unclear from the record what type of "bed alarm" or "bed sensor" was provided. *See, e.g.*, CMS Ex. 9, at 16, 48; CMS Ex. 13, at 55. Inasmuch as either type of alarm was designed to alert staff when the resident moved, it is immaterial which type was provided.

interventions to address this problem are added by hand, but Golden Oaks acknowledges that it is unclear "which interventions were added to the care plan on which days" and that one of the handwritten interventions, a bed sensor, was not implemented until after the June 16 fall. RR at 5; *see also* RR at 6-7. Resident 102's care plan dated June 16 (which was apparently added after his fall on that date) lists as a "problem" the resident's history of falls and states that "resident is always throwing lower extremities over the mattress of his bed due to poor safety awareness." ALJ Decision at 7; CMS Ex. 13, at 17. The "approach" section of the care plan also cautions staff to "be mindful that resident will throw lower extremities over the mattress." *Id.* The care plan also lists the following interventions: assist resident with turns and repositioning every two hours; assess for orthostatic hypotension; check for incontinence and change every two hours and as necessary; observe Foley catheter for placement to avoid discomfort; mechanical lift for all transfers; floor mats on both sides of bed; bilateral heel protectors while in bed; geriatric chair with a tab alarm while up; hi-low bed with bed in lowest position except when giving care; and low air mattress. *Id.*

On June 22, 2009, at 8:00 p.m., an aide heard Resident 102's bed alarm sounding and found Resident 102 on the floor next to the left side of his bed with his head on the floor and his body on the floor mat. The resident suffered a laceration on the right side of the back of his head that required stitches. ALJ Decision at 6-7. Following the June 22 fall, the facility gave the resident a different mattress, added bolsters on both sides of the bed, and conducted in-service training of staff regarding fall prevention equipment, interventions, safety, and positioning. *Id.* at 8. A physician's order dated June 23 required bed bolsters, a low air mattress, and the discontinuation of the vinyl mattress overlay wings that the facility implemented immediately after the June 22 fall. *Id.* A handwritten entry in the resident's care plan, dated June 23, 2009, indicates that "bilateral bolsters" were added as an intervention. CMS Ex. 13, at 17.

CMS accepted the recommendation of MDCH and imposed a CMP of $700 per day from October 8 through October 21, 2009. CMS Ex. 1, at 1. Golden Oaks timely requested a hearing before an ALJ but later waived its right to an in-person hearing, and the case was decided on the written record. On December 7, 2011, the ALJ issued a decision in favor of CMS, upholding the finding of noncompliance under section 483.25(h) and the CMP of $700 per day. On February 10, 2012, Golden Oaks filed an appeal with the Departmental Appeals Board (Board).

## The ALJ Decision

The ALJ concluded that CMS made a prima facie showing of noncompliance with section 483.25(h), noting the undisputed facts that Resident 102 "fell from bed on June 16, 2009 and again on June 22, 2009" and that the resident "suffered actual harm as a result of the June 22 fall[.]" ALJ Decision at 10. The ALJ further concluded that Golden Oaks "failed to rebut the prima facie showing or to establish an affirmative defense." *Id.*

The ALJ first noted that the facility assessed the resident as being at risk for falls when he was readmitted on June 13 and it was thus "clearly foreseeable that the resident could fall from bed or his wheelchair." *Id*. at 10-11. The ALJ found that the evidence shows that Golden Oaks recognized the resident's behavior of throwing his legs over the side of his mattress "as contributing to the risk of the resident falling from bed." *Id.* at 11. The ALJ also noted that Golden Oaks "presented no evidence that there was an attempt to identify the cause for the behavior or to control the behavior to reduce the risk for falls from bed." *Id*. The ALJ also rejected Golden Oaks' arguments that "it should be found in compliance or . . . its noncompliance should be excused" on the grounds that the resident's history of falls and high risk of falls may not have involved falls from bed; that the bed sensor alarm was adequate under the circumstances; and that it reasonably waited to use bed bolsters until it tried less restrictive interventions. *Id*. at 11-12. The ALJ thus concluded that Golden Oaks "failed to show that it took all reasonable steps to ensure that Resident 102 received supervision and assistance devices to meet his assessed need for prevention of falls and to mitigate the foreseeable risks of harm to him secondary to accidental falls from his bed or wheelchair." *Id*. at 13.

In addition, the ALJ concluded that the $700 per-day CMP was reasonable, stating that the noncompliance "was serious, as it caused actual harm to Resident 102," that "Petitioner has not alleged an inability to pay the CMP[,]" and that "[t]he evidence supports a conclusion that Petitioner was culpable[.]" ALJ Decision at 14. The ALJ also considered the fact that Golden Oaks had a prior history of noncompliance since it had been cited for noncompliance under Tag F323 (accidents and hazards) in two survey cycles occurring within the ten months prior to the survey at issue. *Id*. The ALJ further noted that "the CMP is at the low end of the range of authorized CMPs." *Id*.

**Standard of Review**

The Board's standard of review on a disputed finding of fact is whether the decision is supported by substantial evidence on the record as a whole. *Guidelines for Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs* (Board Guidelines), available at http://www.hhs.gov/dab/divisions/appellate/guidelines/prov.html. The Board's standard of review on a disputed conclusion of law is whether the ALJ's decision is erroneous. *Id*.

"Substantial evidence" is "more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971), *quoting Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938). Under the substantial evidence standard, the reviewer must examine the record as a whole and take into account whatever in the record fairly detracts from the weight of the evidence relied on in the decision below. *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 488 (1951).

## Analysis[3]

The ALJ concluded that: 1) Golden Oaks violated section 483.25(h); 2) Golden Oaks' violation of section 483.25(h) caused actual harm; 3) Golden Oaks was not in substantial compliance due to its violation of 42 C.F.R. § 483.25(h) from October 8 through 21, 2009; and, 4) there is a basis for the imposition of an enforcement remedy. ALJ Decision at 6. On appeal, Golden Oaks primarily contends that it implemented adequate interventions for Resident 102 and that the amount of the CMP was unreasonable.[4] RR at 14-23, 25. For the reasons discussed below, we find these arguments unpersuasive and conclude that the ALJ's conclusions of law are not erroneous.

### 1. The ALJ's conclusion that Golden Oaks was not in substantial compliance with section 483.25(h) is supported by substantial evidence and is free of legal error.

Section 483.25(h)(2) requires that a facility take all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents. *Woodstock Care Ctr.*, DAB No. 1726 (2000), *aff'd, Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 (6th Cir. 2003). As the Board has explained, this requires that facilities take all "practicable" measures to achieve that regulatory end. *Josephine Sunset Home*, DAB No. 1908, at 14 (2004). Although a facility is permitted the flexibility to choose the methods it uses to prevent accidents and injuries, the chosen methods must be adequate under the circumstances. *Guardian Health Care*, DAB No. 1943 (2004). Whether the supervision and assistance devices provided are "adequate" depends on the resident's ability to protect himself from harm. *Id*. at 17-18.

The ALJ found that, even before Resident 102 first fell at the facility on June 16, it was "clearly foreseeable that the resident could fall from bed," and that both before the June 16 fall and before the resident's fall on June 22, Golden Oaks failed to provide adequate supervision and assistance devices to mitigate the risks of harm from a fall. ALJ

[3] Although we do not specifically discuss all of the evidence and arguments presented, we have fully considered all arguments raised by Golden Oaks on appeal and reviewed the entire record.

[4] Golden Oaks also takes exception to five statements by the ALJ that the facility characterizes as "Findings of Fact[.]" RR at 5-11 (citing ALJ Decision at 7-8). In each instance, Golden Oaks does not actually challenge the content of ALJ's statements nor does it contend that the ALJ failed to consider other evidence that would compel a contrary finding. Rather, the facility simply contends that it "disagrees" with the ALJ's statements and goes on to make other arguments that we address later.

Decision at 10-11. Golden Oaks does not dispute that it was foreseeable that Resident 102 might fall.[5] As discussed below, we conclude there is substantial evidence in the record to support the ALJ's finding that after Resident 102 fell on June 16, Golden Oaks failed to provide adequate supervision and assistance devices to mitigate the risk of harm from another fall. A single incident that establishes a failure to provide the requisite care may be a sufficient basis for finding that a facility was not in substantial compliance with a participation requirement. *See, e.g., Ridge Terrace*, DAB No. 1834, at 16 (2002) (single observation by surveyor of inappropriate peri-care was sufficient to support deficiency finding). Accordingly, we need not consider whether Golden Oaks also failed to provide adequate supervision and assistance devices before the June 16 fall in order to affirm the ALJ's conclusion that Golden Oaks was not in substantial compliance with section 483.25(h).[6]

Before us, Golden Oaks "suggests that its choices of interventions were adequate" under the circumstances to mitigate the risk of falls by Resident 102. RR at 14. In support of this argument, the facility points out that it had assessed the resident as being at high risk for falls upon his readmission. The facility also points to the fact that its initial care plan included, among other things, bilateral floor mats, a high-low bed, and repositioning of the resident every two hours. *Id*. at 15, citing CMS Ex. 13, at 17. However, the facility also clearly recognized that these measures were not adequate by themselves to mitigate the risk of Resident 102's falling from his bed because it added the bed alarm as an intervention immediately after the June 16 fall. Thus, the question becomes whether the facility's sole addition of the bed alarm as an intervention was adequate under the circumstances to eliminate or reduce Resident 102's risk of falling out of bed based on what the facility knew after the June 16 fall.

Regarding this question, Golden Oaks contends that the "addition of the bed alarm is evidence that the [f]acility was tailoring the interventions specifically to [Resident] 102." RR at 17. Golden Oaks also argues that Resident 102 was "totally dependent on staff for bed mobility" and "was not a resident who would be expected to move about or out of his bed quickly." *Id*. Golden Oaks then submits, "It is with this thought, that the Facility asserts that the bed alarm was a reasonable intervention and adequate based on the resident's assessed needs." *Id*.

[5] Golden Oaks appears to argue that neither the resident's falls assessment nor the history of falls noted on the resident's MDS alerted the facility that the resident was specifically at risk of falling from bed. *See* RR at 15-16. After Resident 102 fell from his bed on June 16, it was of course clear that he was at risk of such falls. Thus, even if the risk of his falling from bed were not foreseeable upon readmission, it was clearly foreseeable after June 16.

[6] Similarly, we do not address in this decision the arguments Golden Oaks made that pertain only to whether it was in substantial compliance before the June 16 fall.

While it may be true that the facility implemented the bed alarm as an intervention "tailored" for Resident 102, that does not mean that the use of the bed alarm after the June 16 fall as an additional intervention was adequate under the circumstances to eliminate or reduce the risk of future falls from bed. Indeed, the ALJ rejected the facility's argument, finding:

> [T]he alarm did not prevent the [June 22] fall or the injury [laceration to the back of the head]. There is no evidence that Petitioner assessed whether the alarm might be more effective if the resident was in a different room where staff could respond more quickly, or whether he required closer supervision to permit a quicker response to prevent a fall from his bed or wheelchair.

ALJ Decision at 11. The ALJ also concluded:

> [I]t was clearly foreseeable that the resident could fall from bed or his wheelchair. The resident's care planning team planned multiple interventions to address the fall-risk. The evidence shows that the resident also had the behavior of throwing his legs over the side of his mattress. The evidence shows that the behavior was recognized as contributing to the risk of the resident falling from bed. Petitioner has presented no evidence that there was an attempt to identify the cause for the behavior or to control the behavior to reduce the risk for falls from bed.

*Id*. at 10-11.

In reaching this conclusion, the ALJ relied upon evidence that is undisputed and consists primarily of the facility's own documents, such as the plan of care and incident reports (CMS Exhibits 8; 13; 15), and the affidavit testimony of Surveyor Young-Bean (CMS Exhibit 21). For example, the facility's documents show that upon readmission, the resident was assessed as a high risk for falls and the MDS indicated that the resident had fallen within the last 30 days and again in the past 31-180 days, although the MDS does not provide any details surrounding those events (CMS Ex. 13, at 9). Indeed, the facility concedes that it was aware that knew Resident 102 was at high risk for falls even prior to the June 16 fall. RR at 14 ("From the time that R102 was readmitted to the Facility on June 13, 2009, the Facility had identified that he was a risk for falls and had implemented interventions to address that risk.").

The facility further concedes that "[a]s of June 16, 2009," it was aware Resident 102 was "always throwing his legs over the mattress of his bed due to poor safety awareness." RR at 17(citing CMS Ex. 13, at 17). The fact that the resident's updated care plan following the June 16 fall specifically instructs the facility's staff

to "be mindful" of the resident's leg throwing behavior as an approach to reducing the likelihood of falls shows that the facility believed this behavior was a possible cause of that fall. CMS Ex. 13, at 17; *see also* CMS Exs. 3, at 5; 9, at 16; 21, at 5.

Although the facility undertook some interventions that address the general risk of falls that Resident 102 presented, these measures focused on minimizing the impact of a fall rather than preventing falls due to the resident's leg throwing behavior from occurring in the first place. Although a bed sensor alarm would alert the facility's staff of Resident 102's movement after the fact if a fall occurred, it would not prevent or otherwise reduce the risk of falling from his bed, especially given that the resident was "always" throwing his legs over the mattress. The fact that Golden Oaks identified the resident's "leg throwing" as a possible cause of his June 16 fall also undercuts Golden Oaks' argument that the bed sensor was an adequate intervention because the resident had very limited mobility. Having identified a specific behavior that presented an increased risk that Resident 102 could fall out of his bed--throwing his legs over the mattress, the facility should have care-planned to address that specific behavior in order to eliminate or reduce the risk of future falls. As the ALJ found, Golden Oaks failed to present any documents or witness testimony that showed it attempted to identify the cause for the leg throwing behavior or to control that behavior to reduce the risk for falls from bed. ALJ Decision at 11. As the ALJ also found, there is nothing in the record indicating that the facility considered or undertook interventions, such as side rails or bed bolsters, that were tailored to address Resident 102's leg throwing behavior. *Id.*

The ALJ also relied on the written testimony of Surveyor Young-Bean. ALJ Decision at 10, citing CMS Ex. 21. Surveyor Young-Bean testified that "[g]iven [Resident] 102's history of falls, his high risk for falls, his instability of conditions, and his known behavior of throwing his legs over the mattress, the Facility's interventions prior to June 22, 2009 – specifically, floor mats, a hi-low bed, repositioning every 2 hours, and a bed sensor alarm (added after June 16, 2009) – were inadequate approaches to prevent accidents for this resident relating to falls from his bed." CMS Ex. 21, at 5-6. In particular, Surveyor Young-Bean testified that "there were no documents to show that an investigation was conducted to determine why [Resident] 102 was throwing his legs over the mattress." *Id*. at 6. She also testified that the "Facility did not increase the supervision for this resident" even though the facility "could have placed him on 15 or 30 minute checks, moved him closer to the nurses' station, moved him to a more readily accessible location, or implemented a sitter program." *Id*.

Golden Oaks chose not to cross-examine Surveyor Young-Bean's testimony and did not otherwise attempt to rebut her testimony by calling any witnesses or presenting other evidence. The facility also does not point to any evidence that the ALJ failed to address that would compel a different finding here. Instead, Golden Oaks contends that the ALJ's conclusions of law are erroneous because he "utilizes the affidavit of the Surveyor as expert testimony with no foundation." RR at 23 (emphasis omitted). We disagree.

First, Golden Oaks mischaracterizes the nature of Surveyor Young-Bean's opinion. Her opinion was that there were other intervention options that the facility could have reasonably considered or implemented, not that the care provided was inadequate because the facility failed to implement those specific measures. CMS Ex. 21, at 6. Second, Golden Oaks fails to explain the basis for its contention that there is "no foundation given for this opinion." RR at 23. The curriculum vitae and declaration of Surveyor Young-Bean (CMS Exhibits 19; 21) clearly establish that she is a registered nurse who is familiar with the standards of care at nursing homes and, therefore, has the knowledge and experience to opine on what were other possible interventions that the facility could have explored but did not. The ALJ could reasonably rely upon that testimony.[7] Finally, we note that this argument is untimely because the facility could have either challenged the credentials or testimony of Surveyor Young-Bean on cross-examination at a hearing or through its briefing before the ALJ but chose not to do so. *See* Board Guidelines ("The Board will not consider issues . . . which could have been presented to the ALJ but were not."); *see also Columbus Park Nursing and Rehab. Ctr.*, DAB No. 2316, at 11 (2010) ("Columbus Park, however, waived its opportunity to make this argument since it failed to raise it below.").

Golden Oaks also notes that the ALJ acknowledged the facility had assessed Resident 102 as being a risk for falls and care planned multiple interventions to address that risk and then argues that because the ALJ made "findings" as to what the care plan listed, it was "incongruous" for the ALJ to then find the facility presented no evidence that it had attempted to identify the cause for the behavior or to control the behavior to reduce the risk of falls by Resident 102 due to that behavior. RR at 22 (citing ALJ Decision at 11). Golden Oaks further argues that this alleged incongruity similarly discredits the testimony of Surveyor Young-Bean. RR at 7. We disagree.

There is nothing "incongruous" about the ALJ's finding that the facility had identified a specific fall risk due to the resident's leg throwing behavior and yet concluding that the facility presented no evidence that it took reasonable steps to reduce that specifically identified risk. Even though the resident's care plan states that he "is always" throwing his lower extremities over the mattress of his bed, none of the interventions or approaches in Resident 102's care plan show that Golden Oaks attempted to identify the cause of the leg throwing behavior or to control the behavior that he was "always" doing. The chosen interventions plainly do not address the cause or otherwise address Resident 102's constant leg throwing behavior. *Id.*

[7] Regardless of whether the witness is accepted as an expert, the ALJ is free to determine the credibility of the witness's testimony and give it whatever weight he considers appropriate. Absent a compelling reason to do so, and Golden Oaks has not provided one here, the Board defers to ALJ findings on the weight and credibility of testimony. *Woodland Oaks Healthcare Facility*, DAB No. 2355, at 7 (2010); *Gateway Nursing Ctr.*, DAB No. 2283, at 7 (2009), citing *Koester Pavilion*, DAB No. 1750, at 15, 21 (2000).

Golden Oaks also contends that the ALJ erred by suggesting that "the facility should have considered the use of restrictive interventions," which Golden Oaks argues "flies in the face of the standards with regard to restraints that CMS has worked toward since OBRA was passed." RR at 19. More specifically, Golden Oaks contends that using bed bolsters to prevent Resident 102 from falling out of bed would be considered a restraint and appears to argue that the facility was attempting to utilize the "least restrictive device" by using a bed alarm after the first fall.[8] RR at 19-20. This argument is without merit.

As the ALJ correctly observed, "[w]hether or not the bed bolster is a restraint not the issue."[9] ALJ Decision at 12. The ALJ also correctly observed that Golden Oaks "has not presented any evidence that bolsters, side rails, or other restraints were considered by the care planning team prior to either fall, despite the fact that Petitioner was clearly on notice that Resident 102 threw his legs over the mattress and recognized that such behavior could result in a fall." *Id*. There is also no indication in the resident's plan of care, or in any other facility document in the record, that Golden Oaks considered and rejected the use of bed bolsters after the June 16 fall as being "overly restrictive." Indeed, there is no indication in the record that the facility even considered using bed bolsters as an intervention prior to the June 22 fall. After the June 22 fall, however, the facility implemented the use of bed bolsters to reduce the risk of the resident falling from the bed.[10] This fact is consistent with the ALJ's conclusion because it demonstrates that there was another option the facility could have implemented prior to the second fall but did not even consider.

The facility's argument is also undercut by its own written guidelines for incident and accident interventions for staff, which list bed bolsters as a device used to assist to create boundaries in the bed. CMS Ex. 16, at 73; CMS Ex. 21, at 7. Those guidelines do not identify bed bolsters as a restraint, unlike other devices – such as assist bars, lap buddies, pommel cushions, self releasing seatbelts, and tilt back wheelchairs – which are specifically identified as restraints in the guidelines. *Id*. Golden Oaks also argues that under the guidelines contained in the State Operations Manual (SOM), "certainly bed bolsters used to prevent R102 from voluntarily getting out of bed would be considered a restraint." RR at 20 (citing SOM, Appendix PP, at 56-57). However, the SOM provisions to which Golden Oaks cites do not specifically include or otherwise list bed bolsters as a type of restraint.

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[8] Bed bolsters are "soft, tubular-shape[d] devices like a pillow that are applied to the bed and [are] not strapped to the resident." CMS Ex. 21, at 7. "They are typically placed along or next to the trunk of the body, such as shoulders to knees . . . ." *Id.*

[9] Golden Oaks also does not cite any authority that defines a bed bolster as a restraint. However, even if a bed bolster can be properly categorized as a "restraint," the ALJ also correctly stated that "the use of restraints is clearly permissible under statutory and regulatory participation requirements so long as criteria are met." ALJ Decision at 12, citing sections 1819(c)(1)(A)(ii) and 1919(c)(1)(A)(ii) of the Act; 42 C.F.R. § 483.13(a).

Even if Golden Oaks could have shown that it had determined bed bolsters were an inappropriate intervention after the June 16 fall, the facility would be still required to demonstrate that it provided adequate supervision and/or assistance devices to prevent Resident 102 from falling from his bed, especially given the facility's recognition that his leg throwing behavior could have caused the June 22 fall. However, as discussed above, the facility did not do so.

Golden Oaks also argues that the ALJ erred in concluding that CMS made a prima facie showing of noncompliance with section 483.25(h) because he improperly applied a "strict liability" standard. RR at 13. Golden Oaks points to the following language in the ALJ Decision:

> There is no dispute that Petitioner assessed Resident 102 as at risk for falls on June 13, 2009, and implemented some interventions to address that risk. There is no dispute that Resident 102 fell from bed on June 16, 2009 and again on June 22, 2009. There is no dispute that Resident 102 suffered actual harm as a result of the June 22, 2009 falls when his head hit the floor . . . . I conclude that CMS made a prima facie showing of noncompliance due to a violation of 42 C.F.R. § 483.25(h).

*Id*., quoting ALJ Decision at 10. However, Golden Oaks takes this language out of context. The language follows a lengthy description of the declaration of Surveyor Young-Bean, which alleges that Golden Oaks "failed to provide Resident 102 adequate supervision and assistance devices prior to the June 16 fall to prevent Resident 102 from falling from bed" and that Golden Oaks' "interventions were also inadequate prior to the fall from bed on June 22, 2009." ALJ Decision at 10, citing CMS Ex. 21, at 4-6. Thus, contrary to what Golden Oaks suggests, the ALJ did not conclude merely from the fact that Resident 102 fell twice after being assessed as a fall risk that CMS made a prima facie case of noncompliance, but instead relied on the surveyor's opinion that, prior to each fall, Golden Oaks failed to provide adequate supervision and assistance devices to address the risk that the resident might fall, as required by section 483.25(h).

In summary, the ALJ's conclusion that Golden Oaks was not in substantial compliance due to its violation of section 483.25(h) is supported by substantial evidence in the record and is free from legal error.

**2. The ALJ did not err in concluding that the CMP amount was reasonable.**

Golden Oaks challenges the ALJ's conclusion that the $700 per-day CMP was reasonable. Under the applicable regulations, the range of per-day CMPs that may be imposed for noncompliance that does not pose immediate jeopardy but either causes actual harm or has the potential for causing more than minimal harm is $50-$3,000 per day. 42 C.F.R. §§ 488.408(d)(1)(iii) and (d)(2), 488.438(a)(1)(ii). In determining the

amount of the CMP, CMS "take[s] into account" the following factors: (1) the facility's history of noncompliance (in general and specifically with reference to the cited deficiencies); (2) the facility's financial condition – that is, its ability to pay a CMP; (3) the seriousness, i.e., the severity and scope, of the noncompliance, and the relationship of the deficiencies; and (4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. 42 C.F.R. §§ 488.438(f), 488.404(b), (c).

Golden Oaks argues that the CMP amount was not reasonable because CMS's notice of imposition of remedies "does not indicate that CMS considered the Facility's degree of culpability as required by 42 C.F.R. § 488.438(f)." RR at 25 (emphasis omitted). This argument reflects a misunderstanding of the burden of proof regarding the factors specified in section 488.438(f). The Board has consistently held that "an ALJ or the Board properly presumes that CMS considered the regulatory factors and that those factors support the amount imposed." *Pinecrest Nursing and Rehabilitation Center*, DAB No. 2446, at 23 (2012) (emphasis in original). Hence, "'the burden is not on CMS to present evidence bearing on each regulatory factor' – or to explain its decision-making process and how it weighed each regulatory factor (though CMS is not prohibited from doing so if it wishes) –'but on the SNF to demonstrate, through argument and the submission of evidence addressing the regulatory factors, that a reduction is necessary to make the CMP amount reasonable.'" *Id*., quoting *Oaks of Mid City Nursing and Rehabilitation Center*, DAB No. 2375, at 26-27 (2011). In any case, the Board has long recognized that an ALJ is not permitted to review CMS's method or motive used in calculating the amount of the CMP. *See Capitol Hill Community Rehabilitation and Specialty Care Center*, DAB No. 1629, at 5 (1997). Indeed, as the Board recently stated: "How CMS calculated the amount of the CMP is not relevant because the ALJ conducts a de novo review of the reasonableness of the amount of the CMP based on the facts and evidence contained in the appeal record." *Jewish Home of Eastern Pennsylvania*, DAB No. 2451, at 13 (2012) (citations omitted).

Golden Oaks also argues that, contrary to what the ALJ found, it was not culpable for Resident 102's accidents. RR at 25. This argument is unavailing. The regulation specifically provides that "[t]he absence of culpability is not a mitigating circumstance in reducing the amount of the penalty." Section 488.438(f)(4). For the reasons discussed in the first part of our analysis, we agree with the ALJ's conclusion that Golden Oaks was culpable "because the evidence does not show that the care planning team assessed the need for interventions, whether interventions were implemented, and whether interventions implemented were effective." ALJ Decision at 14. The ALJ also relied upon his finding that the facility had "failed to assess Resident 102's leg throwing behavior and to adopt interventions to limit or prevent the behavior, even though Petitioner was clearly aware of this behavior." *Id*.

Furthermore, in concluding that the CMP amount was reasonable, the ALJ relied on three regulatory factors in addition to the degree of culpability, noting that Golden Oaks was cited for noncompliance with section 483.25(h) in two prior surveys within the 10 months preceding the survey at issue here; that the noncompliance with this requirement in the latter survey "was serious, as it caused actual harm to Resident 102"; and that Golden Oaks "has not alleged an inability to pay the CMP imposed or presented evidence to support such an allegation." ALJ Decision at 14. Golden Oaks does not dispute that the regulatory factors to which the ALJ refers were present here.

Thus, we conclude that these three factors, together with Golden Oaks' culpability, are a more than sufficient basis for concluding that a $700 per-day CMP – which, as the ALJ noted, is at the low end of the range of authorized CMPs – was reasonable.

**Conclusion**

For all of the foregoing reasons, we affirm the ALJ Decision.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Stephen M. Godek
Presiding Board Member