Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Meadowbrook Manor – Naperville,
(CCN: 14-5874),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-619

Decision No. CR4872

Date: June 21, 2017

DECISION

In this case, Petitioner, a long-term-care facility, determined that one of its residents required extensive assistance in eating. Nevertheless, staff left him unsupervised as he attempted to eat a hot dog; he choked on it, suffered irreversible brain damage, and ultimately died.

The facility, Meadowbrook Manor – Naperville, is located in Naperville, Illinois. It participates in the Medicare program. Following a complaint investigation survey, completed on October 10, 2013, the Centers for Medicare & Medicaid Services (CMS) determined that the facility was not in substantial compliance with Medicare requirements and imposed a $7,550 per instance civil money penalty (CMP) for the deficiency cited under the quality-of-care regulation, 42 C.F.R. § 483.25. Petitioner appeals.

For the reasons set forth below, I find that the facility was not in substantial compliance with 42 C.F.R. § 483.25 and that the penalty imposed is reasonable.

Background

The Social Security Act (Act) sets forth requirements for nursing facilities to participate in the Medicare program and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act § 1819. The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to survey skilled nursing facilities in order to determine whether they are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. Each facility must be surveyed annually, with no more than fifteen months elapsing between surveys, and must be surveyed more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a); 488.308. The state agency must also investigate all complaints. Act § 1819(g)(4).

This consolidated case originally involved three surveys: the complaint investigation, completed October 10, 2013; the facility's annual health survey, completed December 12, 2013; and the facility's annual life safety code survey, completed December 17, 2013. Petitioner appealed the findings from all three surveys and I consolidated the appeals. Thereafter, the parties stipulated to the December 12 and 17 survey findings. CMS Exs. 20, 21; CMS Pre-hearing Brief (CMS Br.) at 2; P. Pre-hearing Brief (P. Br.) at 1. Petitioner's appeal of the October survey findings remains.

In October 2013, surveyors from the Illinois Department of Public Health (state agency) responded to a complaint and visited the facility. CMS Ex. 10 at 6. They determined that it was not in substantial compliance with two Medicare program requirements:

- 42 C.F.R. § 483.10(b)(11) (Tag F157) (resident rights – notification of changes) at scope and severity level G (isolated instance of substantial noncompliance that causes actual harm that is not immediate jeopardy); and

- 42 C.F.R. § 483.25 (Tag F309) (quality of care) at scope and severity level J (isolated instance of noncompliance that poses immediate jeopardy to resident health and safety).

CMS Ex. 7 at 1-11.

CMS has imposed against the facility one per instance CMP of $7,550 for the deficiency it cited under 42 C.F.R. § 483.25. CMS Ex. 2 at 3; CMS Ex. 3 at 1. Because CMS

imposed no remedy for the resident rights deficiency, I have no authority to review that finding. *Lutheran Home – Caledonia*, DAB No. 1753 (2000); *see* 42 C.F.R. §§ 498.3(a); 498.3(b)(13); 498.3(d).

On November 30, 2016, I convened a hearing, via video teleconference, from the offices of the Departmental Appeals Board in Washington, D.C. Counsel and witnesses appeared in Chicago, Illinois. Gina Rozman and Chung-Han Lee appeared on behalf of CMS; Jason Lundy and Sarah Pugh appeared on behalf of Petitioner. Transcript (Tr.) at 6-7.

I admitted into evidence CMS Exhibits (Exs.) 1-21 and Petitioner's Exhibits (P. Exs.) 1-20. Tr. 8; Order Following Pre-hearing Conference at 2 (September 9, 2016). The parties have filed pre-hearing briefs and post-hearing briefs (CMS Post-hrg. Br.; P. Post-hrg. Br.). CMS filed a reply (CMS Reply).

Issues

The issues before me are:

1. Was the facility in substantial compliance with 42 C.F.R. § 483.25?

2. If the facility was not in substantial compliance with section 483.25, is the penalty imposed ($7,550 per instance) reasonable?

I have no authority to review CMS's immediate jeopardy determination. I may review CMS's scope and severity findings (which include immediate jeopardy) only if: 1) a successful challenge would affect the range of the CMP; or 2) CMS has made a finding of substandard quality of care that results in the loss of approval of a facility's nurse aide training program. 42 C.F.R. §§ 498.3(b)(14), 498.3(d)(10); *Cedar Lake Nursing Home*, DAB No. 2344 at 9 (2010); *Evergreen Commons*, DAB No. 2175 (2008); *Aase Haugen Homes*, DAB No. 2013 (2006).

For a per-instance penalty, the regulations provide only one range ($1,000 to $10,000), so the level of noncompliance here does not affect the range of the CMP. 42 C.F.R. § 488.438(a)(2). If I approve a penalty of at least $5,000 or more, CMS's scope and severity finding will not affect approval of the facility's nurse aide training program. Under the statute and regulations, the state agency cannot approve the program if CMS imposes a penalty of $5,000 or more. The facility loses its approval without regard to the immediate jeopardy finding. Act § 1819(f)(2)(B); 42 C.F.R. § 483.151(b)(2)(iv).

Discussion

1. *The facility was not in substantial compliance with 42 C.F.R. § 483.25 because facility staff did not provide a vulnerable resident with the feeding assistance he needed*.[1]

Program requirements. Under the statute and the "quality of care" regulation, each resident must receive, and the facility must provide, the necessary care and services to allow him to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with his comprehensive assessment and plan of care. Act § 1819(b); 42 C.F.R. § 483.25.

Resident 1 (R1). R1 was a 45-year-old man, initially admitted to the facility on February 28, 2010. CMS Ex. 12 at 5. He suffered from multiple sclerosis and a long list of other impairments, including paraplegia, unspecified psychosis, depression, neurogenic bladder, anxiety, toxic encephalopathy, and muscle weakness. CMS Ex. 12 at 5, 8, 146, 192, 228. He had limited range of motion in both upper and lower extremities and required extensive assistance with most activities of daily living. He used a wheelchair and required a Hoyer lift for all transfers. CMS Ex. 12 at 16, 192. He was generally alert and oriented, but with occasional periods of confusion. CMS Ex. 12 at 229.

Assessments. The Medicare program requires that all residents be assessed using the MDS or Minimum Data Set assessment tool, which provides a comprehensive assessment of the resident's functional capabilities and health problems. *See* 42 C.F.R. § 483.20(b).

R1's MDS assessments consistently indicated that he required "extensive assistance" with eating, which meant "one person physical assist." P. Ex. 9 at 14 (January 27, 2012); P. Ex. 8 at 10 (February 1, 2012); P. Ex. 7 at 15 (April 21, 2012); P. Ex. 6 at 15 (July 16, 2012); P. Ex. 5 at 15 and CMS Ex. 12 at 20 (October 8, 2012); CMS Ex. 12 at 20, 82 (December 31, 2012); CMS Ex. 12 at 20 and P. Ex. 4 at 15 (March 25, 2013); CMS Ex. 12 at 20 and P. Ex. 3 at 15 (June 17, 2013); and CMS Ex. 12 at 18, 37 (September 9, 2013).

Other assessments confirm that R1 required at least this level of eating assistance.

- A functional ability assessment, dated October 8, 2012, indicates that R1 "continues to require extensive assistance with most of his activities of daily

[1] My findings of fact/conclusions of law are set forth, in bold and italics, as captions in the discussion section of this decision.

living" and, given his limited range of motion in his upper extremities, he requires assistance with eating. CMS Ex. 12 at 16.

- A functional assessment dated January 1, 2013, indicates that the resident continues to require extensive to total assistance with some activities of daily living, including extensive assistance for eating. CMS Ex. 12 at 120.

- A dietary assessment dated January 3, 2013, indicates that the resident "[e]ats meals in his room [with] total assist." CMS Ex. 12 at 224.

- According to a nursing assessment dated August 10, 2013 (when he was readmitted to the facility after a hospital stay), R1 was totally dependent on staff for eating and other activities of daily living. CMS Ex. 12 at 186-187.

- Social service progress notes, dated September 9, 2013, confirm that the resident needs "a lot of" physical assistance due to his severe physical impairments. CMS Ex. 12 at 229.

See also, CMS Ex. 12 at 226 (quarterly nutritional progress, notes dated July 30, 2012 and October 8, 2012, indicating that he needs assistance with meals); CMS Ex. 12 at 20 (assessment entries dated October 8, 2012, December 31, 2012, March 25, 2013, and June 17, 2013, all checking "extensive assist" with eating); CMS Ex. 12 at 18 (September 2013 assessment form checking "extensive assist" for eating); CMS Ex. 12 at 190, 222, (quarterly nutritional progress notes, dated March 25, 2013, and September 9, 2013, indicating "needs assist" and "total assist" with meals).

In January 2012, R1's physician ordered that R1 be evaluated for dysphagia (difficulty swallowing), specifically to determine whether the resident could safely use a straw. CMS Ex. 12 at 228. The facility's speech pathologist, Chandra Dachepalli, evaluated the resident in January 2012, assessing whether any of various food consistencies would put him at risk for aspiration. CMS Ex. 11 at 18; P. Ex. 16 at 2 (Dachepalli Decl. ¶ 3); Tr. 64. "Aspiration" means that food or liquid travels down the airway into the lungs; it is potentially life-threatening. Serious, but not as likely to be fatal, is "penetration," which occurs when food or liquid goes down the airway and up to or around the vocal cords. However, penetration can lead to aspiration. Tr. 75.

Based on his evaluation, Speech Pathologist Dachepalli determined that the resident was able to use a straw and could tolerate all consistencies of food. CMS Ex. 11 at 18; CMS Ex. 12 at 228; P. Ex. 16 at 2 (Dachepalli Decl. ¶¶ 4-5); Tr. 66. He concluded that R1 did not need *skilled* intervention, but that the resident should follow aspiration precautions and safe swallowing strategies, including:

- Maintaining an upright (90 degree) position during meals and 30 minutes afterwards;

- Taking small bites;

- Alternating food with sips of liquid;

- Double swallowing.

Speech Pathologist Dachepalli explained the techniques to R1, who understood and cooperated. CMS Ex. 11 at 18; CMS Ex. 12 at 228; P. Ex. 16 at 2 ¶ 5; Tr. 67-69; *see* Tr. 70, 76. The facility performed no additional swallowing evaluations.

R1's care plan. Consistent with the speech pathologist's recommendation and the bulk of his other assessments, R1's care plan, dated January 3, 2013, indicates that he was *at risk for aspiration* and needed assistance with meals. The plan directs staff to monitor for signs and symptoms of aspiration. CMS Ex. 12 at 150. Entries dated May 21, 2013 reiterate that the resident needs assistance with meals and direct staff to "monitor for aspiration risk." CMS Ex. 12 at 150.

A September 9, 2013 entry also indicates that R1 requires "extensive staff participation to eat" and directs staff to "ensure" that he is sitting upright during meals. CMS Ex. 12 at 143; *see* CMS Ex. 12 at 184 (Interdisciplinary Resident Care Plan entry dated September 9, 2013, indicating "total assist" with meals).

The incident. Notwithstanding R1's multiple assessments and his care plan, staff did not monitor him while he ate. Instead, someone simply put his tray down in front of him and left him on his own.

On September 21, 2013, Nurse Aide Lemuel Regacho deposited a meal tray on R1's table. As usual, no one was assigned to assist the resident with his meal; no one reminded him to follow aspiration precautions or safe swallowing strategies. CMS Ex. 11 at 10; P. Ex. 14 at 1 (Regacho Decl. ¶ 3); Tr. 37-38, 40, 52. In fact, Nurse Aide Regacho did not even know that R1's care plan directed staff to monitor his eating in order to prevent him from aspirating. Tr. 57.

The meal that day included a hot dog, which everyone agrees is a choking hazard. Tr. 43, 52, 56, 73. Nurse Aide Regacho "helped set up" R1's meal tray, which meant that he put the tray down and put ketchup on the hot dog. CMS Ex. 12 at 11; P. Ex. 14 at 1 (Regacho Decl. ¶ 3). He then left R1 on his own and attended to R1's roommate – whom he was assigned to feed – closing the privacy curtain between the residents. CMS Ex. 11

at 10; CMS Ex. 12 at 11; P. Ex. 14 at 1-2 (Regacho Decl. ¶¶ 3-4); Tr. 51-52, 57. Nurse Aide Regacho did not cut the hot dog; he did not watch R1 eat; he did not remind R1 of safe swallowing strategies. Tr. 57.

At about 5:58 p.m., Nurse Aide Regacho heard "sounds" coming from R1 and discovered that the resident was choking. The nurse aide left the room in order to summon a nurse. CMS Ex. 11 at 1, 10; CMS Ex. 12 at 10; P. Ex. 14 at 2 (Regacho Decl. ¶ 5); P. Ex. 20; Tr. 57-58. When the nurse entered the room, R1 was unresponsive, and she attempted the Heimlich maneuver. According to the facility's incident report, she removed a three-inch-long hot dog from R1's throat. At 6:05 p.m., staff called 911. The emergency medical team arrived at 6:10 and took R1 to the hospital where he was placed on a respirator. He had suffered an anoxic brain injury (lack of oxygen) and subsequently died. CMS Ex. 12 at 8, 10, 244; CMS Ex. 13 at 2, 6, 9; P. Ex. 20. The emergency department report indicates that R1 aspirated on a piece of hot dog. CMS Ex. 13 at 6.

Thereafter, the facility took Nurse Aide Regacho's statement, but otherwise conducted no investigation. CMS Ex. 12 at 11.

The evidence thus establishes that the facility did not provide R1 with the care and services he needed, in accordance with his comprehensive assessments and plan of care. His assessments consistently called for a one-person physical assist with eating. CMS Ex. 12 at 18, 20, 37, 82; P. Ex. 3 at 15; P. Ex. 4 at 15; P. Ex. 5 at 15; P. Ex. 6 at 15; P. Ex. 7 at 15; P. Ex. 8 at 10; P. Ex. 9 at 14. Based on his dysphagia evaluation, he needed to follow aspiration precautions and safe swallowing strategies, and, at the time of the evaluation, he demonstrated that he could do so if properly instructed. CMS Ex. 11 at 18; CMS Ex. 12 at 228; Tr. 67-68, 76, 78 (indicating that he needed to follow the speech pathologist's recommendations in order to be safe). Based on his assessments, the facility developed a care plan directing staff to assist him with meals and to monitor his eating for signs and symptoms of aspiration. CMS Ex. 12 at 150.

The facility did none of this. Staff put his food down and left him on his own, even when the meal included a known choking risk – an entire hotdog. The facility did not assign anyone to monitor R1 during mealtimes. Tr. 40. Assistant administrator and former food services director, Kanchana Karanth, described, with apparent approval, entering his room to find him eating a hamburger, alone and unsupervised. Tr. 37-38. Indeed, it seems that facility staff observed R1 eating his meals only when completing his MDS assessment. Based on the assessment, staff determined that he needed extensive assistance with eating; then they failed to provide it.

Facility staff had no idea what their responsibilities were with respect to keeping R1 safe while he ate. When asked whether he was "usually aware" that a resident required extensive eating assistance, Nurse Aide Regacho testified that he did not know. Tr. 54.

The Departmental Appeals Board has emphasized that a resident's care plan represents the facility's judgment about what care and services are needed to keep the resident safe. If facility staff fail to provide care and services in accordance with the resident's comprehensive assessment and plan of care, it violates section 483.25. *White Sulphur Springs Ctr.*, DAB No. 2520 at 7 (2013); *Deltona Health Care*, DAB No. 2511 at 7-8 (2013); *Venetian Gardens*, DAB No. 2286 at 5 (2009). Because staff did not follow R1's care plan – indeed, it seems they were largely unaware of it – the facility was not in substantial compliance with section 483.25.

Petitioner's arguments: R1's fatal incident was "unforeseen and unpreventable." Notwithstanding the plain language of R1's care plan, Petitioner maintains that the fatal incident was "unforeseen and unpreventable." P. Post-hrg. Br. at 2.

In support, Petitioner points to quarterly nutritional progress notes, dated April 28, 2012, July 30, 2012, October 8, 2012, and January 3, 2013. These reports mention that R1 has no chewing or swallowing problems. However, they also indicate that he is not able to feed himself and that he is "totally dependent while eating." CMS Ex. 12 at 224, 226. Petitioner also notes that R1's MDS assessments list no signs or symptoms of a swallowing disorder. CMS Ex. 12 at 45, 90; P. Ex. 3 at 23; P. Ex. 4 at 23; P. Ex. 5 at 23; P. Ex. 6 at 23; P. Ex. 7 at 23; P. Ex. 8 at 18; P. Ex. 9 at 22.

The facility's interdisciplinary team had all of this information when it developed R1's care plan. CMS Ex. 12 at 143, 150-51. The team obviously did not consider sufficient to override other considerations the brief nutritional progress note entries and the purported absence of a choking incident. This is understandable, given the significance of those other considerations. The resident's advanced multiple sclerosis could affect his ability to swallow, and, as the care plan reflects, in order to be safe, he required close supervision. As Speech Pathologist Dachepalli explained, he needed to follow safe swallowing strategies. Failing to do so would put him at risk for aspiration or penetration, and increasing his supervision and assistance during meals was an appropriate intervention. CMS Ex. 11 at 18, 19; Tr. 71, 72, 78.[2]

In any event, as the Departmental Appeals Board has explained, a "good historical safety record" does not excuse a facility's failure to provide the care and services required. *White Sulphur Springs* at 14.

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[2] Disturbing evidence suggests that the resident did not follow safe swallowing strategies, and staff knew it. CMS Ex. 11 at 19; Tr. 71. In fact, he engaged in seriously reckless eating behavior that is not reflected in any of his assessments or the staff notes. According to R1's treating physician, Dr. Johnson, the resident had been "force feeding" himself large amounts of food and was known to have as many as five jawbreakers in his mouth at one time. Dr. Johnson learned of these behaviors after R1's fatal choking incident. CMS Ex. 11 at 16.

Petitioner's argument: "Extensive assistance" does not mean that staff has to monitor the resident while he eats. Petitioner acknowledges, as it must, that R1's assessments call for "extensive assistance" with eating but argues that "extensive assistance" can mean little more than setting up the resident's tray. P. Post-hrg. Br. at 9-10. Former Food Service Director Karanth claimed that "extensive staff participation" means "anything from meal tray set-up, cutting food, opening food containers, to physically helping a resident bring food or drink to his or her mouth." P. Ex. 11 at 3 (Karanth Decl. ¶ 10). According to Director Karanth, "monitor" means that staff "check in" to ask the resident if he needs anything, has his head up, is sitting up straight. Tr. 40.

I reject this opinion. First, the assessment forms themselves define "extensive assistance" as requiring "one person physical assist." *See, e.g.*, CMS Ex. 12 at 37. Contrary to Director Karanth's assertion, the assessment forms describe four separate levels of assistance: "set up"; "limited assist"; "extensive assist"; and "total assist." *See, e.g.* CMS Ex. 12 at 20. Staff here were supposed to provide "extensive assist"; instead, they provided "set up."

Second, Director Karanth's definition of "extensive assistance" is so broad as to be meaningless. Care plans are supposed to tell staff what to do to provide appropriate care. Tr. 41; *see Del Rosa Villa*, DAB No. 2458 at 10 (2012) (holding that the facility must develop a care plan setting out the level of supervision the resident requires and must "communicate to the staff their role and responsibility to implement the care plan"); *see White Sulphur Springs* at 9. Director Karanth could not explain how staff would understand what "extensive" means if that term encompasses virtually every form of assistance possible, from putting down the tray – which they must do for everybody – to spoon-feeding the resident. Tr. 41-43.

Third, the Departmental Appeals Board has rejected the notion that staff can appropriately protect a resident from aspiration without observing him. In *White Sulphur Springs*, it affirmed that "supervision" requires staff to observe the resident while he eats and drinks, "in order to immediately assist [him] if he choke[s] or aspirate[s]." *White Sulphur Springs*, DAB No. 2520 at 9, *quoting* DAB CR2706 at 5 (2013).

I agree that R1 did not require "skilled care." But he required assistance and monitoring. Someone had to observe him to make sure that he was sitting up at a 90º angle. Someone had to be there to cut up his food and to remind him to take small bites. Someone had to be there to remind him to sip liquids between bites and to double swallow. *See* CMS Ex. 11 at 16-17 (in which R1's treating physician opines that the resident would not have been likely to choke if his hot dog had been cut into small pieces); Tr. 73 (in which the speech pathologist agrees that R1's hot dog should have been cut up and that a staff member should have assisted him). The facility did not provide this level of care and was thus out of substantial compliance with section 483.25.

Petitioner's argument: R1 rejected offers of assistance. Finally, Petitioner argues that R1 was too independent and refused all offers of assistance at mealtimes. There are problems with this claim. First, staff did not document such refusal, as required by professional nursing standards. CMS Ex. 19 at 2-3 (Martin Decl. ¶ 6). Indeed, on September 21, Nurse Aide Regacho was not assigned to assist R1, and nothing in this record suggests that he offered the resident any help beyond delivering his tray and putting ketchup on the hot dog.

Second, nothing in R1's care plan suggests that his refusing assistance was a problem. CMS Ex. 12 at 143, 150, 151. If, in fact, the resident refused to cooperate with the instructions in his care plan, the facility was required to record the refusal and to develop alternative interventions to insure that he was eating safely. CMS Ex. 19 at 3 (Martin Decl. ¶ 6); *See White Sulphur Springs* at 9.

Finally, to the extent that R1's treatment records mention the issue, they suggest that he was willing to accept assistance. A nutritional progress note dated June 20, 2012, reads "res[ident] says he needs assist[ance] [with] meals." CMS Ex. 12 at 227. An interdisciplinary care plan update, dated April 5, 2013, says that the resident requested that a female assist him with his meals. CMS Ex. 12 at 193. And R1 cooperated fully with the speech pathologist, who reported that the resident listened and followed his cues. CMS Ex. 11 at 18; CMS Ex. 12 at 228; Tr. 67-68, 78.

2. The penalty imposed is reasonable.

To determine whether a civil money penalty is reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f): (1) the facility's history of noncompliance; (2) the facility's financial condition; (3) factors specified in 42 C.F.R. § 488.404; and (4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort, or safety. The absence of culpability is not a mitigating factor. The factors in 42 C.F.R. § 488.404 include: (1) the scope and severity of the deficiency; (2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and (3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

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 section 488.438(f) factors. I am neither bound to defer to CMS's factual assertions nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Ctr.*, DAB No. 1848 at 21 (2002); *Cmty. Nursing Home*, DAB No. 1807 at 22 *et seq*. (2002); *Emerald Oaks*, DAB No. 1800 at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1638 at 8 (1999).

Here, CMS imposes a per-instance penalty of $7,550, which is in the mid-to-higher-end of the range for a per-instance CMP ($1,000-$10,000), but is modest considering what CMS might have imposed. 42 C.F.R. § 488.408(e)(1)(iv); *see Plum City Care Ctr.*, DAB No. 2272 at 18-19 (2009) (observing that even a $10,000 per-instance CMP can be "a modest penalty when compared to what CMS might have imposed").

Except to argue that it was in substantial compliance, so no penalty should be imposed, Petitioner has not challenged the amount of the CMP. In any event, with respect to the section 488.438(f) factors, the facility has a poor compliance history, particularly with respect to the quality-of-care regulation. The facility was consistently out of substantial compliance with section 483.25 (and its subsections), as well as other regulations, for six surveys from January 2006 through November 2012. Many of the deficiencies cited caused actual harm to resident health and safety. CMS Ex. 5 at 1-6. The facility's history alone justifies the relatively modest penalty imposed.

Petitioner does not claim that its financial condition affects its ability to pay the CMP.

Finally, the deficiency here was very serious, as the above discussion shows. R1's interdisciplinary team recognized that the resident was at risk and developed a care plan designed to keep him safe. But facility staff disregarded that plan, with devastating results, for which the facility is culpable.

Conclusion

The facility was not in substantial compliance with 42 C.F.R. § 483.25 and the penalty imposed – $7,550 per instance – is reasonable.

/s/
Carolyn Cozad Hughes
Administrative Law Judge