Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
Mitchell Village Care Center, (CCN: 16-5264),	)	Date: April 20, 2007
Petitioner,	)	Docket No. C-04-264
	)	Decision No. CR1589
v.	)	
Centers for Medicare & Medicaid Services.	)	

DECISION

Petitioner, Mitchell Village, violated 42 C.F.R. § 483.25(h)(2) on January 2, 2004. There is a basis for the imposition of an enforcement remedy. A per-instance civil money penalty (PICMP) of $3000 is a reasonable remedy.

I. Background

Mitchell Village Care Center, Petitioner, is a long-term care facility located in Mitchellville, Iowa. Petitioner participates in the Medicare and Medicaid programs. From January 5 through 7, 2004, the Iowa Department of Inspections & Appeals (the state agency) conducted a complaint survey of Petitioner and found that Petitioner was not in substantial compliance with Medicare and Medicaid participation requirements. The state agency cited Petitioner for violation of 42 C.F.R. § 483.25(h)(2) (Tag F 324)[1] and alleged that the deficiency presented immediate jeopardy for Petitioner's residents.

[1] All references are to the revision of the Code of Federal Regulations (C.F.R.) in effect at the time of the survey, unless otherwise indicated. The "Tag" designation refers to the part of the State Operations Manual (SOM), Appendix PP, "Survey Protocol for Long Term Care Facilities," "Guidance to Surveyors" that pertains to the specific regulatory provision allegedly violated.

The Centers for Medicare and Medicaid Services (CMS) notified Petitioner by letter dated January 28, 2004, that it concurred with the state agency finding that Petitioner was not in substantial compliance and that that condition posed immediate jeopardy for Petitioner's residents. Request for Hearing, Exhibit A. CMS acknowledged in its January 28 letter that the state agency found that Petitioner had removed immediate jeopardy before the state agency exited the facility. However, CMS indicates that Petitioner continued to be out of substantial compliance and the continued noncompliance posed the possibility of actual harm to residents. CMS advised Petitioner that it was imposing a $3000 PICMP, as recommended by the state agency. CMS advised Petitioner that if substantial compliance was not achieved by April 16, 2004, a denial of payments for new admissions would also be imposed and that its provider agreement would be terminated if substantial compliance was not achieved by July 16, 2004. The denial of payment and termination remedies were not imposed as Petitioner returned to substantial compliance.

Petitioner filed a request for a hearing on March 26, 2004. The case was assigned to me for hearing and decision. I conducted a two-day hearing in this case on February 28 and March 1, 2005 and a transcript (Tr.) of the proceeding has been prepared. CMS offered and I admitted CMS exhibits (CMS Exs.) 1 through 4. Petitioner offered and I admitted Petitioner Exhibits (P. Exs.) 1 through 6. Petitioner filed a post-hearing brief (P. Br.) and reply (P. Reply). CMS filed its post-hearing brief (CMS Br.) and reply (CMS Reply).

II. Discussion

A. Findings of Fact

The following findings of fact are based upon the exhibits admitted. Citations to exhibit numbers related to each finding of fact may be found in the analysis section of this decision if not indicated here.

1. Resident 1 is an 83-year-old, five-foot, one-inch, 105-pound female with diagnoses of dementia, progressive Alzheimer's disease, delusional behavior and chronic anxiety. Joint Statement of Undisputed Facts (Jt. Statement); CMS Ex. 2, at 67-68, 88-107; P. Ex. 3.

2. Resident 1 was not to be outside Petitioner's facility, unless accompanied by staff or family. Jt. Statement.

3. Resident 1's records reflect that she could ambulate independently in her room and required limited assistance outside her room, on and off the unit. Jt. Statement; CMS Ex. 2, at 104-05.

4. Resident 1 had verbalized an intention to leave the facility prior to being discovered alone outside the facility on January 2, 2004. Jt. Statement; CMS Ex. 2, at 58-59.

5. On December 31, 2003, two days prior to eloping on January 2, 2004, Resident 1 attempted to leave the facility by opening an exit door but an alarm sounded and she was immediately redirected by staff. Jt. Statement; CMS Ex. 2, at 59.

6. On January 2, 2004, at approximately 7:00 a.m., Resident 1 was discovered on the front lawn of a neighboring house by a neighbor, who notified Petitioner. CMS Ex. 2, at 59-60; Jt. Statement.

7. An ambulance was summoned and when the crew arrived at 7:12 a.m. on January 2, 2004, they noted that Resident 1: had pale skin, shallow breathing, was cold to the touch, and shaking; she was wearing shirt, pants, shoes, socks, and a coat had been placed over her by a bystander; she had abrasions on her left and right knees; the heat in the ambulance was turned-up to warm the resident; oxygen was administered by nasal cannula due to the resident's shallow breathing; and the crew started a warm saline drip. CMS Ex. 2, at 114, 116, 118, 141-49; Jt. Statement.

8. Resident 1 was taken by ambulance to the local hospital and treated for moderate hypothermia. CMS Ex. 2, at 71-80, 118; Tr. 47.

9. Prior to being discovered outside the facility at approximately 7:00 a.m. on January 2, 2004, Petitioner's staff last observed Resident 1 at approximately 5:30 a.m. in the facility dining room not far from the front door. P. Ex. 1 at 2; CMS Ex. 2, at 12, 18.

10. Until a neighbor entered the facility and indicated that Resident 1 was "down the road on the ground," no one in the facility was aware that Resident 1 was missing. P. Ex. 2, at 15.

11. The doors of Petitioner's facility had alarms: the front door had an alarm that sounded if the door was open from the outside without pushing a button or from the inside without entering a code on a key-pad and, if the exterior button was pushed or the code entered, the alarm would not sound for ten seconds to permit entry or exit; the front door also had a WanderGuard™ alarm system that was triggered whenever a resident wearing a WanderGuard™ bracelet approached the door too closely; and the emergency exit doors at the end of each of three corridors had an alarm that immediately sounded when the door was opened; and all the alarms except the WanderGuard™ were controlled by a reset button and on and off switches on a panel at the nurses' station near the front door. Tr. 25-27, 139-42.

12. There was no report in facility records of an alarm sounding the morning of January 2, 2004, between the time Resident 1 was observed at 5:30 a.m. and 7:00 a.m. when she was found outside. Jt. Statement.

13. Petitioner investigated but never determined how Resident 1 eloped from the facility without notice; Petitioner could not determine whether the alarm was turned off; the alarm failed; or whether Resident 1 eloped during the alarm delay which occurred when employees were arriving or leaving the morning of January 2, 2004.

B. Conclusions of Law

1. Petitioner's request for hearing was timely and I have jurisdiction.

2. Petitioner violated 42 C.F.R. § 483.25(h)(2) (Tag F 324) on January 2, 2004.

3. Petitioner has failed to rebut the CMS *prima facie* showing of a violation of 42 C.F.R. § 483.25(h)(2) on January 2, 2004.

4. There is a basis for the imposition of a PICMP.

5. A PICMP of $3000 is reasonable considering the regulatory factors at 42 C.F.R. § 488.438(e).

C. Issues

The general issues are:

1. Whether there is a basis for the imposition of an enforcement remedy; and,

2. Whether the remedy imposed is reasonable.

D. Applicable Law

Petitioner is a long-term care facility participating in the federal Medicare program as a skilled nursing facility (SNF) and in the state Medicaid program as a nursing facility (NF). The statutory and regulatory requirements for participation by a long-term care facility are found at sections 1819 and 1919 of the Social Security Act (Act) and at 42 C.F.R. Part 483. Sections 1819 and 1919 of the Act vest the Secretary of Health and Human Services with authority to impose civil money penalties against a long-term care facility for failure to comply substantially with federal participation requirements.

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, 488.300-488.335. Pursuant to 42 C.F.R. Part 488, CMS may impose a per-instance or per day 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; 488.430. The regulations in 42 C.F.R. Part 488 also give CMS a number of other remedies that can be imposed if a facility is not in compliance with Medicare requirements.

The regulations specify that a CMP that is imposed against a facility on a per day basis will fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP, from $3050 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)(i), (d)(2). The lower range of CMP, from $50 per day to $3000 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). There is only a single range of $1000 to $10,000 for a PICMP that applies whether or not immediate jeopardy is present. 42 C.F.R. §§ 488.408(d)(1)(iv); 488.438(a)(2).

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

When a penalty is proposed and appealed, CMS must make a *prima facie* case that the facility has failed to comply substantially with federal participation requirements. "*Prima facie*" means that the evidence is "(s)ufficient to establish a fact or raise a presumption unless disproved or rebutted. *Black's Law Dictionary* 1228 (8th ed. 2004), *see also*, *Hillman Rehabilitation Center*, DAB No. 1611, at 8 (1997), *aff'd Hillman Rehabilitation Center v. U.S. Dept. of Health and Human Services*, No. 98-3789 (D.N.J. May 13, 1999). To prevail, a long-term care facility must overcome CMS's showing by a preponderance of the evidence. *Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004); *Batavia Nursing and Convalescent Inn*, DAB No. 1911 (2004); *Emerald Oaks*, DAB No. 1800 (2001); *Cross Creek Health Care Center*, DAB No. 1665 (1998); *Evergreene Nursing Care Center*, DAB No. 2069, at 7-8 (2007).

E. Analysis

1. Petitioner violated 42 C.F.R. § 483.25(h)(2) (Tag F 324) and there is a basis for imposing a CMP.

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). 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 mitigate 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.* Based on the regulation and the cases in this area, CMS meets its burden to show a *prima facie* case if the evidence demonstrates that the facility failed to provide adequate supervision and assistance devices to prevent accidents, given what was reasonably foreseeable. *Alden Town Manor Rehabilitation & HCC*, DAB No. 2054 (2006), at 5-6, 7-12. 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).

Resident 1 was an 83-year old female resident at Petitioner's facility. Her Minimum Data Set Quarterly Assessment (MDS), assessment reference date of October 10, 2003, reflects that she was moderately impaired for daily decision-making, *i.e.*, she made poor decisions and required cues and/or supervision; she had short and long-term memory deficits; she had indicators of delirium or periodic disordered thinking and/or awareness; a depressed mood that was not easily altered; she had a history of falls within the past 180 days; and she received both antipsychotic and antidepressant medication. Resident 1 was independent for ambulation in her room but needed limited assistance with ambulation outside her room, on and off the unit. CMS Ex. 2, at 104-06. Resident 1 was assessed at "high risk for injury related to impaired cognition manifested by need for assistance at

times with ambulation/locomotion" and her care plan dated October 14, 2003, specified "utilize door alarms." CMS Ex. 2, at 98. According to the resident's clinical record, she suffered from progressive Alzheimer's disease, chronic anxiety, delusional behavior, and depression, among other things. CMS Ex. 2, at 67, 88-107; P. Ex. 3.

The parties stipulated that at approximately 7:04 a.m. on Friday, January 2, 2004, Resident 1 was discovered by a neighbor outside the facility lying on the front lawn of a nearby residence. Emergency medical services personnel were called and the resident was transported to the hospital where she was treated for hypothermia and abrasions to her knees and subsequently returned to Petitioner on January 4, 2004. CMS Ex. 2, at 60, 71-80. The parties agree that Resident 1 was not supposed to be outside Petitioner's facility unless accompanied by facility staff or a family member. Jt. Statement. The parties also stipulated that prior to the elopement that caused the deficiency citation, Resident 1 had verbalized an intention to the leave the facility and, late on December 31, 2003, she opened a door with an alarm that sounded alerting staff to redirect her before she escaped. Jt. Statement; CMS Ex. 2, at 59. On January 2, 2004, Resident 1 was last seen by staff around 5:30 a.m. in the dining room of the facility near the front door. The parties agree that no facility record reflects that a door alarm sounded between 5:30 a.m. when Resident 1 was last seen by staff and roughly 7:00 a.m. when the neighbor triggered the front door alarm when he entered the building to report he found Resident 1 on the ground outside. Staff did report that the front door alarm sounded three times between midnight and 7:00 a.m. on January 2, 2004. The first two instances of the alarm sounding occurred between 4:40 a.m. and 4:45 a.m. when the paper boy arrived and then exited the building.[2] The third alarm sounded when the neighbor entered around 7:00 a.m. to report finding Resident 1. P. Ex. 1, at 2; Petitioner's Proposed Findings of Fact No. 22; CMS's Proposed Findings of Fact Nos. 41 and 54. The facility report of investigation related to Resident 1's elopement reflects that several staff entered and exited the front door between 5:40 a.m. and 6:20 a.m. on January 2, 2004. Staff entered and exited the front door without triggering the door alarm, apparently, by pushing the outside button or entering the correct code on the inside door keypad. When either the exterior button is

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[2] LPN Janita Lansman testified that she had worked for Petitioner for over a year and during that time the newspaper boy regularly set off the alarm around 4:40 a.m. Tr. 246, 255. Ms. Lansman agreed with my conclusion that, given earlier testimony regarding the purported volume of the alarms, the alarm sounding at 4:40 a.m. must be disturbing for the residents. Although this evidence supports Petitioner's theory that its alarms worked, it also suggests that the alarms may not have been particularly effective, *i.e.*, if after a year no one came up with a solution for the paper boy triggering the alarm nearly every morning how loud or bothersome were the alarms. Also, if the alarms were being constantly triggered, one must question how effective they were to provoke an appropriate staff response.

pushed or the code is correctly entered on the interior keypad, there is a 10 second delay before the alarm resets and is active. P. Ex. 1, at 2-3; Tr. 25-27, 139-42, 225-28. During its investigation, Petitioner's staff was able to show that a person could slip out of the facility from the dining room during the ten second delay without being seen. P. Ex. 1, at 3; Tr. 225-28.

The evidence establishes a *prima facie* showing of a violation of 42 C.F.R. § 483.25(h)(2) in this case, *i.e.,* CMS has produced sufficient evidence that, absent conflicting evidence, shows a violation occurred. *Meadow Wood Nursing Home*, DAB No. 1841, at 7 (2002); *Emerald Oaks*, DAB No. 1800, at 16 (2001). Resident 1 was outside the facility without knowledge of the staff and without supervision. Thus, the burden is upon Petitioner to either rebut the *prima facie* case or to show affirmatively, that more likely than not, it was in substantial compliance. *Emerald Oaks*, at 16.

Petitioner argues that it appropriately assessed Resident 1 and that reliance upon its door alarms was a reasonable intervention to address the foreseeable risk to the resident. Petitioner asserts that it provided appropriate and adequate supervision to Resident 1. Petitioner further contends that the fact that Resident 1 exited the building undetected does not mean that it did not provide adequate supervision. P. Br. at 18-19; P. Reply at 9-11. I conclude, however, that Petitioner has not rebutted the *prima facie* showing by CMS or shown that it took all reasonable steps to ensure that Resident 1 received supervision and assistance devices necessary to meet her assessed needs and mitigate foreseeable risks of harm from accidents.

The evidence shows that Resident 1 left Petitioner's facility without supervision sometime between 5:30 a.m. and 7:00 a.m. on January 2, 2004. There is no question that as a result of eloping, Resident 1 suffered abrasions and hypothermia, which is actual harm. There is no question that Petitioner's staff was unaware that Resident 1 left the facility until a Good Samaritan found her and reported the discovery. Petitioner could not determine through its investigation how Resident 1 exited the building; whether she left through the front door or another door is unclear. P. Ex. 1. Petitioner contends that since no unaccounted for door alarms were heard and all systems were in operating order and not deactivated, it did all that it was required to do to ensure that Resident 1 remained inside. Petitioner also argues that it was not foreseeable that any resident could elope given its alarm system, the maintenance and inspections of that system, and the fact that no other resident had ever exited unsupervised by staff. P. Reply at 9. Petitioner's significant reliance on one mechanical means of supervising its residents who might seek to exit its facility is troubling, even though I accept as fact Petitioner's assertion that no resident escaped in many years. No system, mechanical, electrical, or human is fool proof and Resident 1 proved that point. It is not reasonable for a facility to rely upon a single system or intervention to provide necessary supervision for its residents. Rather the

facility should be able to show that there are redundancies of protection or multiple interventions that take into consideration the possibility of failure of a single intervention or system and that also take into consideration the unique condition and needs of its residents.

It was clearly foreseeable that Resident 1 was an elopement risk who required some intervention in addition to reliance upon the door alarms to address that risk and the related risk of accidental injury. On December 31, 2003, Resident 1 attempted to elope but was caught when a door alarm sounded. There is no question that the resident also verbalized an intent to leave the facility. Jt. Statement. The evidence does not show that Petitioner took any action or made any intervention based upon the December 31, 2003 attempted elopement and the resident's verbalization. A nursing noted related to that incident shows Resident 1 was redirected, a facsimile was sent to her physician, but no other interventions are noted. CMS Ex. 2, at 59. Testimony at hearing by Tina Steffen, Petitioner's Administrator, shows that only one staff member made the decision not to make other interventions after the attempted elopement on December 31, 2003. Tr. 138, 236-37.

Petitioner points to the intervention on Resident 1's care plan to "utilize door alarms" (CMS Ex. 2 at 98), however Petitioner acknowledges that that intervention was based upon an October 2003 assessment related to a goal for the resident to be free of injuries from falls. P. Brief at 3. Petitioner has relied upon door alarms for years (P. Reply at 9) apparently with success. However, Petitioner cannot argue that the intervention to use door alarms was tailored particularly to provide necessary care and services to Resident 1. Rather, it was the policy of Petitioner that doors be locked and/or alarmed. It is clear, that the intervention on Resident 1's care plan was not intended to address her attempted elopement on December 31. Petitioner does not point to any intervention that was adopted following the December 31 elopement attempt or the resident's verbalizations. Petitioner only added a WanderGuard® to the resident's care plan after the January 2, 2004 elopement (CMS Ex. 2, at 97; P. Ex. 1, at 1). Following the December 31 attempted elopement, no intervention was added to Resident 1's care plan that required staff to do regular or intermittent checks on her whereabouts despite her prior exit seeking behavior barely two days earlier, her verbalizations, and the fact she normally liked to sit in the dining area not far from the front door in the early morning (which is exactly where she was last observed at 5:30 a.m. on January 2, 2004) (P. Ex. 1, at 2-3). Petitioner has not produced evidence that its front door and dining area were subject to regular or constant direct observation by staff in the early morning when this elopement apparently occurred, despite the fact that the evidence shows much traffic through that door in the early morning. Petitioner takes the unreasonable position that it is "unreasonable" to have some member of its staff monitor who is coming and going from its facility. P. Brief at 8.

Petitioner's theory that if CMS or the state agency cannot explain how Resident 1 exited the building, then CMS cannot find that Petitioner was deficient, is ill-founded. P. Brief at 12-18, P. Reply at 4-7. Petitioner cannot so easily avoid its obligation and its burden as a provider to show it did all it reasonably could to protect Resident 1 from accidents. The exact means or route by which Resident 1 exited the facility undetected is not a necessary element of the CMS *prima facie* case. Rather, the burden is on Petitioner to rebut the CMS showing that Resident 1 was outside the facility and unsupervised or that it did all it reasonably could to prevent that accident.

I conclude that Petitioner failed to do all it reasonably could to provide adequate supervision to this resident: she was able to leave the facility undetected, no staff were even aware that she was missing, and, as a consequence of this lack of supervision, she suffered actual harm. To prevail, Petitioner must show that it took reasonable measures to protect Resident 1 from accidents. Whatever system Petitioner chooses to use – whether it is an alarm, one-to-one supervision, or someone stationed at the front door to supervise entry and exit – must be adequate and appropriate to supervise the residents so to minimize or prevent risks of accidents. Here Petitioner has not rebutted CMS's prima facie showing or shown affirmatively that it was in substantial compliance with the regulatory requirement to provide adequate supervision and assistance devices. Petitioner has not shown that it did all that it reasonably could do to protect Resident 1 from being outside alone and unsupervised.

2. A PICMP of $3000 is reasonable on the facts of this case.

If a facility is not in substantial compliance with program requirements, CMS has the authority to impose one or more of the enforcement remedies listed in 42 C.F.R. § 488.406, including a CMP. CMS may impose a CMP for the number of days that the facility is not in compliance or for each instance that a facility is not in substantial compliance. 42 C.F.R. § 488.430(a). The minimum amount for a PICMP is $1000 and the maximum is $10,000. CMS imposed a per instance penalty here of $3000 – the low end of the range. I must consider whether the proposed PICMP is reasonable.

In determining whether the amount of the per instance 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. § 488.404; and (4) the facility's degree of culpability.

Petitioner has not argued that the proposed PICMP is unreasonable but focused upon whether or not there is a basis for imposing such a remedy. The PICMP amount is at the low-end of the range. Petitioner has not argued or submitted any evidence that it is unable to pay the PICMP. CMS has offered no evidence of past noncompliance for me to consider. The deficiency is serious and supports the PICMP proposed. It was merely fortuitous that the resident was discovered before she suffered more significant injury or death. Respondent 1 did suffer actual harm, hypothermia and abrasions, and she was hospitalized. Petitioner is culpable in this case for failure to assess and intervene to address Resident 1's attempted elopement and verbalizations and to adequately monitor ingress and egress from its facility. Therefore, I conclude that given all the factors, a PICMP of $3000 is reasonable.

III. Conclusion

For the foregoing reasons, I conclude that Petitioner violated 42 C.F.R. § 483.25(h)(2) and that a PICMP of $3000.00 is reasonable.

/s/

Keith W. Sickendick
Administrative Law Judge