Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Autumn Care Center
(CCN: 36-5481),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-907

Decision No. CR4304

Date: October 9, 2015

DECISION

In an annual health survey completed January 3, 2014, the Ohio Department of Health (state agency) determined that Autumn Care Center (Petitioner or facility), was not in substantial compliance with the requirements of a Medicare-participating long-term care facility. The state agency cited seven separate deficiencies that resulted in Petitioner's overall noncompliance. Based on the state agency's findings, the Centers for Medicare & Medicaid Services (CMS) imposed a $3,510 per-instance civil money penalty (CMP) based only on one of the cited deficiencies, specifically the determination that Petitioner violated 42 C.F.R. § 483.25(h) because it did not provide adequate supervision to prevent accidents. Petitioner requested a hearing before an administrative law judge to challenge the noncompliance determination and enforcement remedy. CMS now moves for summary judgment, which Petitioner opposes.

For the reasons set forth below, I find that the undisputed material facts of this case show Petitioner was not in substantial compliance with Medicare participation requirements because it did not provide adequate supervision to prevent future falls of a resident assessed to be at high risk for falls. I also find that the per-instance CMP is reasonable. Therefore, I grant summary judgment in favor of CMS.

I. Background and Procedural History

Petitioner is a long-term care facility in Newark, Ohio, that participates in the Medicare and Medicaid programs. Following an annual health survey that ended January 3, 2014, the state agency determined that Petitioner was not in substantial compliance with Medicare participation requirements for a long-term care facility based on seven separate deficiencies. *See* CMS Exhibit (Ex.) 7. The most serious deficiency, which is the only deficiency for which CMS later imposed an enforcement remedy, was cited as the failure to comply with 42 C.F.R. § 483.25(h), cited as Tag F-323. CMS Ex. 7 at 10-19. That participation standard generally requires a facility to ensure that a resident's environment remains free from accident hazards and the resident receives adequate supervision and protective devices to prevent accidents. 42 C.F.R. § 483.25(h). The state agency found that Petitioner's noncompliance with section 483.25(h) was at a scope and severity level of "G," meaning that there was isolated actual harm that was not immediate jeopardy. CMS Ex. 7 at 10.

In reaching its conclusion regarding Petitioner's noncompliance with section 483.25(h), the state agency found that Petitioner did not provide adequate supervision to three residents, referred to in the survey documents and this proceeding as "Resident 61," "Resident 63," and "Resident 86." According to the state agency: Petitioner did not provide adequate supervision to Resident 61 to prevent her repeated falls despite assessing her as being at high risk for falls; Petitioner did not provide adequate supervision to Resident 86 to prevent physical encounters with other residents as well as the resident's repeated falls; and Petitioner did not provide adequate supervision to Resident 63 to prevent her elopement from the facility. CMS Ex. 7 at 10-19.

By letter dated February 7, 2014, CMS accepted the state agency's findings and imposed a per-instance CMP of $3,510 for the noncompliance cited under Tag F-323 (42 C.F.R. § 483.25(h)), as well as a mandatory denial of payment for new admissions (DPNA) effective April 3, 2014, if Petitioner did not achieve substantial compliance by that time. CMS Ex. 4 at 2. A revisit survey on March 4, 2014, determined that Petitioner had returned to substantial compliance effective February 10, 2014. CMS Ex. 5 at 2. As a result, in a letter dated April 14, 2014, CMS rescinded the mandatory DPNA, leaving the per-instance CMP for noncompliance with 42 C.F.R. § 483.25(h) as the only enforcement remedy against Petitioner. CMS Ex. 6 at 1.

Petitioner then requested independent, informal dispute resolution. CMS Ex. 17. The Michigan Peer Review Organization recommended to the state agency that the survey findings related to Resident 86 be removed as a basis for noncompliance with 42 C.F.R. § 483.25(h) but otherwise recommended that the noncompliance determination be affirmed. CMS Ex. 23 at 1. The state agency affirmed Petitioner's noncompliance

without modification.[1] CMS Ex. 22. Petitioner then filed a request for hearing.[2] CMS timely filed its prehearing exchange, consisting of a prehearing brief (CMS Br.), witness and exhibit lists, and 24 proposed exhibits (CMS Exs. 1-24). Petitioner also timely filed its prehearing exchange, which included its prehearing brief (P. Br.) and nine proposed exhibits (P. Exs. 1-9). CMS subsequently filed a motion for summary judgment (CMS Mot. Summ. J.), and Petitioner filed an opposition (P. Opp.). CMS argues in its motion for summary judgment that the material facts regarding Petitioner's care of Resident 61 are undisputed and that those undisputed facts establish that Petitioner did not provide the resident with adequate supervision to prevent her falls. CMS Mot. Summ. J. at 2-4. Petitioner does not argue that there are facts in dispute regarding Resident 61 but instead claims that it provided adequate supervision to Resident 61 to the maximum extent Petitioner was authorized to do so. P. Opp. at 1-4. Petitioner contends that the noncompliance determination should be reversed and therefore opposes summary judgment in favor of CMS. P. Opp. at 5.

The parties have not submitted new evidence with the motion for summary judgment and opposition but instead relied on the proposed exhibits already submitted as part of their prehearing exchanges. Neither party filed objections to the admission of the proposed exhibits. In the absence of any objections, I admit CMS Exs. 1-24 and P. Exs. 1-9 into the record for consideration.

II. Statutory and Regulatory Framework

The Social Security Act (Act) establishes the minimum standards of resident care that a long-term care facility must meet in order to participate in the Medicare and Medicaid programs and authorizes the Secretary of Health and Human Services (Secretary) to issue regulations implementing those statutory requirements. 42 U.S.C. §§ 1395i-3, 1396r. Specific Medicare participation requirements for long-term care facilities are in 42 C.F.R. Part 483. A long-term care facility must remain in substantial compliance with program

[1] The state agency's letter that notified Petitioner it was affirming the noncompliance determination after independent review was dated February 6, 2014, which is clearly an error. *See* CMS Ex. 22. Petitioner requested review on February 13, 2014. CMS Ex. 17 at 1. The independent review body returned its recommendations to the state agency on March 6, 2014. CMS Ex. 23.

[2] Petitioner requested a hearing based on the February 7, 2014 notice letter. Req. for Hrg. at 1; CMS Ex. 4. Petitioner did not file a hearing request based on the final notice letter dated April 14, 2014. However, the April 14 notice letter did not change the overall noncompliance determination or CMP that CMS imposed on Petitioner in the February 7 notice letter. Therefore, the request for hearing based on the February 7 notice letter effectively preserved Petitioner's challenge to the noncompliance determination and CMS's enforcement remedy.

requirements to participate in Medicare. 42 C.F.R. § 483.1(b). "Substantial compliance" means "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for minimal harm. *Id.* § 488.301. "Noncompliance" means "any deficiency that causes a facility not to be in substantial compliance." *Id.*

The Act authorizes the Secretary to impose enforcement remedies against a long-term care facility if it does not comply substantially with federal participation requirements. 42 U.S.C. § 1395i-3(h)(2). The Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility that is not in substantial compliance with participation requirements. State agencies survey facilities on behalf of CMS to determine whether the facilities comply with federal participation requirements. 42 C.F.R. §§ 488.10-.28, 488.300-.335. Standard surveys must occur at least every 15 months, and complaints of abuse or neglect of residents in a long-term care facility may trigger a survey sooner than a standard survey. *See* 42 U.S.C. § 1395i-3(g)(1)(C), (g)(2)(A)(iii). The regulations specify the enforcement remedies that CMS may impose if a facility is not in substantial compliance with Medicare requirements. 42 C.F.R. § 488.406. These remedies include: termination of a facility's participation in the Medicare program, closure of the facility, temporary management, denial of certain Medicare payments, transfer of residents, state monitoring, directed plans of correction, and various CMPs. *Id.* § 488.408.

CMS may impose a per-day CMP for the number of days a facility is not in substantial compliance or a per-instance CMP for each instance of the facility's noncompliance. *Id.* § 488.430(a). A per-instance CMP, which CMS imposed in this case, may range from $1,000 to $10,000. *Id.* § 488.438(a)(2). When establishing the amount of a per-instance CMP, CMS must consider, among other things, the seriousness of the deficiencies, which includes whether the deficiencies posed no actual harm with the potential for more than minimal harm that is not immediate jeopardy, actual harm that is not immediate jeopardy, or immediate jeopardy to resident health and safety. *Id.* §§ 488.438(f), 488.404(b).

If CMS imposes an enforcement remedy against a long-term care facility based on a noncompliance determination, the facility may request a hearing before an administrative law judge to challenge the noncompliance finding and enforcement remedies. 42 U.S.C. §§ 1320a-7a(c)(2), 1395cc(h); 42 C.F.R. §§ 488.408(g), 498.3(b)(13).

III. Issues

This case presents the following issues:

1. Whether summary judgment is appropriate;

2. Whether Petitioner was in substantial compliance with the Medicare participation requirement in 42 C.F.R. § 483.25(h) at the time cited; and

3. If Petitioner was not in substantial compliance, whether the $3,510 per-instance CMP imposed is reasonable.

The scope and severity determination is not reviewable in this case. An administrative law judge may review CMS's scope and severity findings only if a successful challenge would affect the range of the CMP, or if 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 9-10 (2010); *Aase Haugen Homes*, DAB No. 2013, at 17-19 (2006). For a per-instance penalty, the regulations provide only one range of possible penalty ($1,000 to $10,000), so the scope and severity of any noncompliance does not affect the range of the possible CMP. *See* 42 C.F.R. § 488.438(a)(2). Further, CMS's G-level finding here does not constitute a substandard quality of care finding.[3]

For purposes of summary judgment in this case, my review is limited to Petitioner's care of Resident 61. As mentioned above, the state agency cited facts involving the care of two other residents to support the noncompliance citation, but CMS moved for summary judgment in this case based only on Petitioner's care of Resident 61. *See* CMS Mot. Summ. J. at 2-4. Therefore, I do not make any conclusions about Petitioner's care of other residents that the state agency originally included as part of the factual basis for the citation under Tag F-323 (42 C.F.R. § 483.25(h)). As explained below, Petitioner's care of Resident 61 is sufficient to support the deficiency cited as well as the reasonableness of the enforcement remedy imposed.

IV. Findings of Fact and Conclusions of Law

1. Summary judgment is appropriate.

Summary judgment is appropriate if there is "no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law." *Mission Hosp. Reg'l Med. Ctr.*, DAB No. 2459, at 5 (2012) (citations omitted). The moving party must show that there is no genuine dispute of material fact requiring an evidentiary hearing and that

[3] Substandard quality of care means one or more deficiencies related to participation requirements under 42 C.F.R. § 483.13, resident behavior and facility practices, 42 C.F.R. § 483.15, quality of life, or 42 C.F.R. § 483.25, quality of care, that constitute either immediate jeopardy to resident health or safety (level J, K, or L); a pattern of or widespread actual harm that is not immediate jeopardy (level H or I); or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm (level F). *See* 42 C.F.R. § 488.301.

it is entitled to judgment as a matter of law. *Id.* If the moving party meets its initial burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial . . . .'" *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986). "To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact — a fact that, if proven, would affect the outcome of the case under governing law." *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010). A party "must do more than show that there is 'some metaphysical doubt as to the material facts . . . . Where the record taken as a whole could not lead a rational trier of fact to find for the nonmoving party, there is no genuine issue for trial.'" *Mission Hosp.*, DAB No. 2459, at 5 (quoting *Matsushita*, 475 U.S. at 586).

In examining the evidence to determine the appropriateness of summary judgment, I must draw all reasonable inferences in the light most favorable to the non-moving party. *See Brightview Care Ctr.*, DAB No. 2132, at 2, 9 (2007); *but see Cedar Lake*, DAB No. 2344, at 7 (2010); *Brightview*, DAB No. 2132, at 10 (upholding summary judgment where inferences and views of non-moving party are not reasonable). However, drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions. *Cedar Lake*, DAB No. 2344, at 7.

There is no genuine dispute of any material fact in this case. CMS has presented facility-created and otherwise unchallenged evidence that Petitioner's staff assessed Resident 61, an 81-year-old female resident, as needing assistance from two or more persons for walking between locations in her room as well as for walking in the corridor of the facility. CMS Ex. 10 at 4. Staff also assessed Resident 61 as being at high risk for falls in November 2013 and twice in December 2013, each time noting that Resident 61 had three or more falls in the three months prior to the assessment. CMS Ex. 10 at 5. It is undisputed that Resident 61 fell three times between July 10, 2013 and December 17, 2013, and was found on the ground one additional time on September 23, 2013, although there is no clear evidence whether she fell in the September 23 incident. CMS Ex. 10 at 14-17, 21. The responses of Petitioner's staff to these falls are also undisputed. On July 10, 2013, staff decided to keep Resident 61 in an area where they could monitor her and updated her care plan to reflect that new requirement. CMS Ex. 10 at 7, 14. On October 1, 2013, Resident 61's physician ordered staff to place a pressure alarm around her bed and bedside chair. CMS Ex. 10 at 11, 15. On December 17, 2013, Petitioner's staff requested a medication review. CMS Ex. 10, at 17.

On December 31, 2013, during the annual survey giving rise to this case, the surveyor observed Resident 61 walking without assistance to the day lounge in the facility. None of Petitioner's staff was around Resident 61 to supervise her while she was walking. CMS Ex. 20 at 5.

Petitioner has not come forward with any evidence that conflicts with CMS's evidence or that raises a dispute of any facts relevant to Resident 61. Petitioner also has not come forward with any testimony from an individual present at the time of the survey, or otherwise come forward with any documentation, to refute the surveyor's observations. Indeed, Petitioner has not disputed the surveyor's observations at all in its opposition to summary judgment. Instead, Petitioner argues that it took all of the steps that Resident 61's family authorized facility staff to take, and in doing so, Petitioner complied substantially with Medicare participation requirements. *See* P. Opp. at 1. Whether the undisputed facts support CMS's noncompliance determination and enforcement remedy or not is a legal issue to decide. I find there are no issues of material fact to decide, and I do not need to weigh any of the evidence. My decision in this case is based on undisputed evidence, drawing all reasonable inferences in favor of Petitioner. Accordingly, summary judgment is appropriate.

2. *The undisputed evidence establishes Petitioner's staff did not adequately supervise Resident 61, contrary to her plan of care and her assessments, while she walked in the facility.*

The quality of care regulation set forth in 42 C.F.R. § 483.25 generally requires that a facility ensures each resident receives the necessary care and services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being in accordance with the resident's comprehensive assessment and plan of care. The regulation imposes specific obligations upon a facility related to accident hazards and accidents. It states in relevant part:

> (h) *Accidents*. The facility must ensure that –
>
> (1) The resident environment remains as free of accident hazards as is possible; and
>
> (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

42 C.F.R. § 483.25(h). In this case, the state agency and CMS based the noncompliance determination primarily on subsection 483.25(h)(2). Regarding that subsection, the Board has explained that a facility must 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." *Briarwood Nursing Ctr.*, DAB No. 2115, at 11 (2007) (citing *Woodstock Care Ctr. v. Thompson*, 363 F.3d 583, 590 (6th Cir. 2003)). The Board has also determined that accident precautions contained in a resident's plan of care represent a facility's judgment about what measures are necessary to keep the resident safe, and failure to implement such precautions supports a conclusion that a facility did not meet its obligation under section 483.25(h)(2) to provide adequate

supervision. *See Cedar Lake Nursing Home*, DAB No. 2288, at 6-11 (2009), *aff'd*, *Cedar Lake Nursing Home v. U.S. Dep't of Health* & *Human Servs.*, 619 F.3d 453 (5th Cir. 2010); *see also St. Catherine's Care Ctr. of Findlay, Inc.*, DAB No. 1964, at 13 n.9 (2005) ("If a facility concedes that it identified a risk in the resident assessment and that it either failed to plan for the risk or failed to follow its own plan, summary judgment may be appropriate."). An accident "does not, in itself, prove that the supervision or devices provided must have been inadequate to prevent it." *Josephine Sunset Home*, DAB No. 1908, at 13 (2004). However, an accident is "relevant to the extent the surrounding circumstances shed light on the nature of the supervision being provided and its adequacy for the resident's condition." *St. Catherine's Care Ctr. of Findlay, Inc.*, DAB No. 1964, at 12.

Here, Petitioner's staff was well-aware of Resident 61's fall risk. Resident 61's care plan, in place since August 6, 2012, addressed her risk of falls and set a goal of "no fall related injuries." CMS Ex. 10 at 6. There is no dispute, nor can there be, that falls were a foreseeable risk of harm to Resident 61 and that she needed adequate supervision to prevent the foreseeable risk of harm from those falls. The plan of care that Petitioner's staff developed for Resident 61 recognized as much. CMS Ex. 10 at 6. After an incident on July 10, 2013, where another resident pushed Resident 61 and caused Resident 61 to fall and sustain an injury to the back of her head, staff updated her care plan to include keeping Resident 61 in an area "where staff can monitor [her]."[4] CMS Ex. 10 at 7, 14.

On September 23, 2013, Petitioner's staff observed Resident 61 sitting on the floor in another resident's room. CMS Ex. 10 at 21. The record does not make it clear whether Resident 61 fell or sat down. Staff happened to find Resident 61 in this position without knowing how Resident 61 ended up in another resident's room or documenting the cause of her being on the ground. Facility staff continued for several days to monitor Resident 61 for any injuries from the September 23 incident, although no injuries were ultimately found. CMS Ex. 10 at 21. Petitioner's staff requested that Resident 61 receive a physical therapy screen. *See* CMS Ex. 10 at 7; *see also* CMS Ex. 10 at 21 (noting that Resident 61's physician was notified but did not order anything new).

On October 1, 2013, at 1:45 A.M., Resident 61's roommate reported to facility staff that Resident 61 was on the floor of their room. CMS Ex. 10 at 15, 22. Staff observed a laceration on Resident 61's forehead. CMS Ex. 10 at 22. Resident 61 was unable to tell staff what happened, but her roommate believed that Resident 61 was trying to transfer

[4] While it was foreseeable that Resident 61 could fall and suffer injury as a result, *see* CMS Ex. 10 at 6, there is nothing in the record that suggests Petitioner's staff should have foreseen that another resident would push down Resident 61 and injure her. Therefore, the July 10 incident alone does not form a basis for noncompliance.

from her rocking chair to a reclining chair without assistance. CMS Ex. 10 at 22. Following the incident, Resident 61's physician ordered that facility staff place pressure alarms around Resident 61's bed and bedside chair, which staff did. CMS Ex. 10 at 11, 15.

An assessment worksheet dated November 4, 2013, noted that Resident 61 required supervision when walking in the hallway and for locomotion. CMS Ex. 15 at 3; P. Ex. 6 at 9. Staff reiterated that supervision requirement in a later assessment worksheet dated December 7, 2013. P. Ex. 6 at 15. Two nursing notes on November 6, 2013, indicate that Resident 61 ambulated unassisted, but she required at least one other person to assist with her activities of daily living. CMS Ex. 10 at 23. On November 8, 2013, staff assessed Resident 61 as requiring assistance from at least two people for, among other things, transfers, walking in her room, and walking in the corridor. CMS Ex. 10 at 4. On November 14, 2013, and again on December 14, 2013, staff assessed Resident 61 as being at high risk for falls. CMS Ex. 10 at 5.

On December 17, 2013, Petitioner's staff observed Resident 61 on the ground of the hallway. Staff determined that Resident 61 had "fallen and hit handrail in corridor . . . ." CMS Ex. 10 at 17. Resident 61 had bruising above and around her right eye. As a result of the fall, staff requested a medication review for Resident 61. CMS Ex. 10 at 17. Staff again assessed Resident 61 as being at high risk for falls. CMS Ex. 10 at 5.

On December 31, 2013, during the state agency's survey of Petitioner's facility, the surveyor observed Resident 61 "ambulate into the day lounge without assistance" and the surveyor also saw "that no staff members were present in the day lounge to supervise her." CMS Ex. 20 at 5. Petitioner does not dispute the surveyor's observations.

Resident 61's repeated falls and Petitioner's staff finding Resident 61 on the ground on at least three occasions demonstrate that the intended supervision and interventions in Resident 61's care plan were not adequately implemented, in violation of the regulatory requirement. *See* 42 C.F.R. § 483.25(h)(2). If Petitioner's staff had been providing the adequate supervision that Resident 61's updated care plan required, specifically to keep her in an area "where staff can monitor" her whereabouts, they would have known what caused Resident 61 to end up sitting on the ground in another resident's room on September 23, 2013, and possibly prevented it by diverting her away from the other resident's room. *See* CMS Ex. 10 at 6. The September 23 incident demonstrates that staff was not carrying out the type of supervision that Resident 61's care plan required in order to mitigate harm from her foreseeable risk of falls. It was certainly foreseeable that Resident 61 entering another resident's room could result in harm from a fall or altercation, or both. *See* CMS Ex. 10 at 14. Yet it is undisputed that staff did not keep Resident 61 in an area where they could monitor her as her care plan required and instead allowed her to enter another resident's room and end up on the ground in that room for unknown reasons.

Petitioner's lack of adequate supervision of Resident 61 was not limited to September 23rd. On December 17, 2013, after staff had put in place pressure alarms, assessed Resident 61 repeatedly as being at high risk for falls, noted that she needed supervision when ambulating in the hallway, and required that she be placed in an area where staff could monitor her, Petitioner's staff found Resident 61 unattended and unsupervised in the hallway after falling against a handrail and sustaining a head injury. CMS Ex. 10 at 17. If Petitioner's staff had actually implemented any of the supervision methods that it had included in Resident 61's medical records, then the supervision may have been adequate to prevent the foreseeable risk of harm to Resident 61 from her falls. *See Cedar Lake Nursing Home*, DAB No. 2288, at 6-7 (citations omitted). On December 17, 2013, the fact that Petitioner's staff found Resident 61 after she fell in the hallway, completely unsupervised and without any explanation of the events leading to the fall, sufficiently demonstrates that Petitioner did not provide Resident 61 with adequate supervision despite being fully aware that Resident 61 was at high risk of sustaining injury from falls. On December 31, 2013, the surveyor observed Resident 61 walking and sitting in the common area without any supervision, which represented yet another occasion where Petitioner's staff did not provide Resident 61 with any supervision, let alone adequate supervision, to prevent the foreseeable risk of harm from falls.

Petitioner argues that it did everything that it could to supervise Resident 61 and that the next step would have been to restrain the resident. P. Br. at 13; P. Opp. at 6. Petitioner goes on to assert that Resident 61's family did not authorize the use of physical restraints, so there was nothing more Petitioner's staff could have done to prevent Resident 61's falls. P. Opp at 9; *see also* P. Ex. 6 at 23. Under Petitioner's theory, it complied with the regulatory standard because it put in place all of the supervision methods for which it was permitted. But Petitioner's argument overlooks two key aspects of this case.

First, Petitioner's staff was not actually implementing the supervision that Resident 61's care plan and assessments called for because staff repeatedly did not have Resident 61 in an area where they could monitor her nor did they adequately supervise her when she walked in the hallway. *See* CMS Ex. 10 at 17, 21. The measures Petitioner had intended to implement were likely reasonable in light of the circumstances, but Petitioner's staff was not actually carrying them out and was therefore unable to provide the necessary adequate supervision to Resident 61. For example, on December 17, 2013, Petitioner's staff found Resident 61 on the floor of a hallway after she fell. CMS Ex. 10 at 17. Staff did not observe her in the hallway or monitor her movement before the fall. Staff did not witness the fall. Rather, staff found Resident 61, already on the ground and injured and then assessed and treated her.

Second, staff certainly did not need to restrain Resident 61 to a specific area in order to monitor her. Petitioner's assertion that restraints were its only remaining option is unreasonable and a misunderstanding of the regulatory requirement. Petitioner's staff did not need to prevent every future fall of Resident 61 by tying her to a bed or chair in order

to comply with the regulation. Instead, staff needed to provide adequate supervision by taking reasonable steps to mitigate the foreseeable risk of harm. *See Briarwood Nursing Ctr.*, DAB No. 2115, at 5, 11. In this case, staff should have actually carried out the supervision required in Resident 61's care plan and assessment as the facility determined those measures were reasonable to address Resident 61's high risk of falls.

I conclude that Petitioner was not in substantial compliance with the Medicare participation requirement in 42 C.F.R. § 483.25(h) because its staff did not carry out the steps in Resident 61's care plan and assessments, which recognized Resident 61's high risk for falls, and therefore did not provide the resident with adequate supervision to prevent the foreseeable risk of harm from falls.

3. *The $3,510 per-instance CMP is reasonable.*

Based on Petitioner's noncompliance, CMS imposed a $3,510 per-instance CMP against Petitioner. CMS Ex. 4 at 1. The factors listed in 42 C.F.R. § 488.438(f) guide whether the CMP imposed here is reasonable. Those factors include: (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, including neglect, indifference, or disregard for resident care, comfort or safety. Among the factors specified in section 488.404 are the scope and severity of noncompliance, the relationship of one deficiency to another deficiency resulting in noncompliance, and the facility's history of noncompliance generally as well as with reference to the cited deficiencies. 42 C.F.R. § 488.404(b)-(c). In addition, the "absence of culpability is not a mitigating circumstance in reducing the amount of the penalty." 42 C.F.R. § 488.438(f)(4). Unless a facility shows that a particular regulatory factor does not support the CMP amount, the ALJ must sustain it. *Coquina Ctr.*, DAB No. 1860 at 32 (2002).

The $3,510 per-instance CMP imposed in this case is in the low-to-middle range of available CMPs, which may range from $1,000 to $10,000 per instance. *See* 42 C.F.R. § 488.408. Petitioner was previously cited for noncompliance with the requirement in 42 C.F.R. § 483.25(h), cited as Tag F-323, once before in a May 2010 survey. *See* CMS Ex. 18 at 1. Petitioner has not alleged or offered evidence that its financial condition affects its ability to pay the CMP. CMS offered financial information that Petitioner submitted to CMS for 2012, which shows that it has adequate funding to pay the relatively low CMP imposed in this case. CMS Ex. 19 at 41.

This case involves more than one instance where the Petitioner did not meet Medicare participation standards with respect to Resident 61, and its staff is ultimately culpable for the noncompliance. Once Petitioner's staff knew of Resident 61's high risk of falls, it was required to plan for and carry out reasonable steps to supervise and prevent foreseeable harm from falls. On repeated occasions, staff did not monitor Resident 61's whereabouts and only discovered that Resident 61 had fallen when they happened to find

her injured on the floor, often requiring emergency medical services to treat her injuries. Staff documented reasonable measures to supervise Resident 61 in her care plan and medical records, but they did not implement all of those steps and allowed Resident 61 to walk down hallways unsupervised and at a greater risk for harm than if she was being adequately supervised in accordance with Petitioner's own directives. I find Petitioner's staff was ultimately responsible for the breakdown in providing Resident 61 with the adequate supervision that her care plan and assessments required. In light of these circumstances, I find that the $3,510 per-instance CMP imposed here is well-supported by the record before me.

V. Conclusion

I conclude that the undisputed facts show Petitioner was not in substantial compliance with Medicare participation requirements, and the CMP CMS imposed is reasonable. CMS, therefore, is entitled to summary judgment affirming the noncompliance determination and enforcement remedy of a $3,510 CMP.

/s/
Joseph Grow
Administrative Law Judge