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

Pearsall Nursing and Rehabilitation Center – North
Docket No. A-16-19
Decision No. 2692
May 12, 2016

# FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Pearsall Nursing and Rehabilitation Center – North (Pearsall) requests review of the Administrative Law Judge (ALJ) decision upholding the Centers for Medicare & Medicaid Services' (CMS) imposition of an $8,750 per-instance civil money penalty (CMP) on Pearsall for failure to be in substantial compliance with the requirements for long-term care facilities participating in the Medicare program. *Pearsall Nursing and Rehabilitation Ctr. – North*, DAB CR4197 (September 10, 2015). Based on a complaint survey conducted at Pearsall and concluded on February 27, 2014, CMS found Pearsall not in substantial compliance with the Medicare quality of care requirement at 42 C.F.R. § 483.25 that facilities must provide for each resident "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." The ALJ granted CMS's motion for summary judgment after finding no dispute about any fact material to concluding that Pearsall was not in substantial compliance with that regulation. The ALJ also concluded that CMS's determination that the noncompliance posed immediate jeopardy to resident health and safety was not subject to review in this case and that the amount of the per-instance CMP ($8,750) was reasonable. For reasons explained below, we affirm the ALJ Decision.

## Legal Background

To participate in the Medicare program, a long-term care facility, including a skilled nursing facility, must be in "substantial compliance" with the requirements in 42 C.F.R. Part 483. 42 C.F.R. §§ 483.1, 488.400. Under agreements with the Secretary of Health and Human Services, state survey agencies conduct onsite surveys of facilities to verify compliance with the Medicare participation requirements. *Id*. §§ 488.10(a), 488.11; *see also* Social Security Act (Act) §§ 1819(g)(1)(A), 1864(a).

A state survey agency reports any "deficiencies" it finds in a Statement of Deficiencies (SOD), which identifies each deficiency under its regulatory requirement and the corresponding "tag" number. A "deficiency" is any failure to comply with a Medicare

participation requirement, and "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 causing minimal harm." 42 C.F.R. § 488.301 (also defining "noncompliance" as "any deficiency that causes a facility to not be in substantial compliance").

CMS may impose one or more remedies on noncompliant facilities, including per-day and/or per-instance CMPs. *Id.* §§ 488.402(b)-(c), 488.406, 488.408(d)(1)(iii)-(iv), 488.408(e)(1)(iii)-(iv), 488.430(a). When CMS imposes a per-instance CMP, it chooses an amount within the $1,000-$10,000 range designated for per-instance CMPs. *Id.* §§ 488.408(d)(1)(iv), 488.408(e)(1)(iv), 488.438(a)(2). This range applies to a per-instance CMP regardless of the level of noncompliance found by CMS. *Id.*; *compare* 42 C.F.R. §§ 488.408(d)(1)(iii), 488.408(e)(1)(iii) and 488.438 (a)(1) (providing for per-day CMPs in an upper range ($3,050-$10,000) for noncompliance that CMS determines constitutes immediate jeopardy and a lower range ($50-$3,000) for levels of noncompliance less than immediate jeopardy).

## Case Background[1]

Facts regarding Resident 1[2]

At issue here is Pearsall's alleged failure to provide timely care and treatment of a known acute hip fracture sustained by Resident 1, a 47-year-old female resident of Pearsall. Resident 1 was admitted to Pearsall on May 17, 2013 with diagnoses that included, among others, Alzheimer's-type dementia, Type 1 (insulin-dependent) diabetes, end-stage renal disease, hypertension and hypokalemia (low potassium levels). ALJ Decision at 7, *citing* CMS Ex. 7, at 12-16. Resident 1 was wheelchair bound and required staff assistance for nearly all activities of daily living. *Id.*, *citing* CMS Ex. 7, at 48-49. Pearsall's plan of care for this resident noted that she was "at risk for misunderstanding" and "usually understands/comprehends most of conversation but may miss part or intent of message." *Id., citing* CMS Ex. 7, at 52. Resident 1's care plan also stated that she was "at risk for unrelieved pain," and that she should receive acetaminophen as needed for relief of pain or fever. *Id., citing* CMS Ex. 7, at 63. The care plan also instructed staff to "monitor for [complaints of] pain or increased [signs and symptoms] of pain: increased tearfulness, agitation, facial grimacing/moaning." *Id.*

[1] The facts stated here are taken from the ALJ Decision and/or the record and are not intended to replace any findings by the ALJ. The facts are undisputed unless we indicate otherwise.

[2] "Resident 1" is the identifier used on the SOD and in the appeal proceedings to refer to the resident whose care, or lack thereof, is at issue here.

In early January 2014, Resident 1's physician ordered an x-ray after Resident 1 complained of hip pain. *Id*., *citing* CMS Ex. 7, at 20, 30. A January 11, 2014 x-ray showed an acute intertrochanteric fracture (a type of hip fracture) of her left proximal femur. *Id.*, *citing* CMS Ex. 7, at 20; CMS Ex. 8, at 3; ALJ Decision at 2 and n.1. A "24-hour report" done by staff the same day as the x-ray stated Resident 1 needed a medical appointment to address her fractured femur. CMS Ex. 7, at 85. The next day (January 12, 2014), staff wrote that Resident 1 "needs apt [with orthopedic surgeon] the sooner the better." CMS Ex. 7, at 86; ALJ Decision at 2, *citing* CMS Ex. 3, at 55. The same notation appeared the following day (January 13, 2014) along with a note that the resident "NEEDS PRIOR." ALJ Decision at 7, *citing* CM Ex. 7, at 87 (capitalization in original). "NEEDS PRIOR" means that she needed prior insurance authorization to see the orthopedic surgeon. *Id*., *citing* P. Br. at 7; CMS Ex. 7, at 88. The next day (January 14, 2014), staff again wrote that Resident 1 "Needs prior auth[orization] . . . to be seen by [orthopedic surgeon] . . . ." *Id.*, *citing* CMS Ex. 7, at 88. The 24-hour reports from January 15 through January 22, 2014 each contained the same or a very similar notation. *Id*., *citing* CMS Ex. 7 at 89-92, 100-103. The record contains no evidence (and Pearsall does not allege) that during the period January 11-January 22, 2014, staff conducted any follow-up on the status of the prior authorization or consulted with Resident 1's physician about different treatment options to address the fracture. *Id*. at 7-8.

On January 21, 2014, Resident 1 had a nephrology evaluation at a dialysis center, and a nurse there noted that Resident 1 complained of "pain to [left] groin/hip." *Id*. at 8, *citing* CMS Ex. 7, at 93. The nurse also noted Resident 1 complained of "losing mobility/function/unable to bear [weight]." *Id*. Resident 1's nephrologist evaluated Resident 1 on that date, and his evaluation addressed Resident 1's hip pain and ordered a referral to an orthopedic surgeon. *Id*. On January 22, 2014, Pearsall staff noted in Resident 1's records that her physician was "aware" that prior authorization was needed. *Id*., *citing* CMS Ex. 7, at 103. On January 23, 2014, Pearsall staff noted that Resident 1's physician was expected "to send referral to see [orthopedic surgeon]." *Id*., *citing* CMS Ex. 7, at 104. As of January 24 and 25, 2014, that referral had not come; instead, the same notation about expecting the referral appeared for each date. *Id*., *citing* CMS Ex. 7, at 105-106.

Resident 1's nephrologist evaluated Resident 1 again on January 28, 2014 and noted a follow-up with an orthopedic surgeon for her femur fracture was "pending"; a nurse at the dialysis center called an orthopedic surgeon's office which declined to schedule an appointment because the "office does not accept [Resident 1's] insurance." *Id*., *citing* CMS Ex. 7, at 93.

On February 7, 2014, Resident 1 again complained of hip pain at the dialysis center. *Id*., *citing* CMS Ex. 7, at 10. A nursing note at the dialysis center stated that an appointment had been scheduled – apparently by center staff – for Resident 1 to see a different orthopedic surgeon. *Id*. That orthopedic surgeon's office asked for the report from

Resident 1's January 11, 2014 x-ray, and dialysis center staff faxed the report to the surgeon's office. *Id*., *citing* CMS Ex. 7, at 94. The surgeon's office then requested "STAT" a more recent x-ray. *Id*. After making Pearsall aware of the appointment with the surgeon and his request for a new x-ray, dialysis center staff ordered the x-ray which was taken on February 7, 2014 and again showed a left femoral neck intertrochanteric fracture. *Id*. at 8-9, *citing* CMS Ex. 7, at 94, 21. Pearsall staff did "[n]o follow-up" with regard to this new x-ray until February 10, 2014, when staff faxed the x-ray report to the new orthopedic surgeon's office. *Id*. at 9, *citing* CMS Ex. 7, at 10 (Pearsall incident report). The surgeon immediately ordered that Resident 1 be directly admitted to the hospital for treatment. *Id*., *citing* CMS Ex. 7 at 10, 94.

The ALJ Decision

The ALJ concluded that summary judgment for CMS was appropriate because the material facts, set forth above, were undisputed and supported a conclusion that Pearsall was not in substantial compliance with section 483.25 because its "staff did not take reasonable steps to provide Resident 1 timely treatment and care after an X-ray showed that she had an acute [hip fracture]."[3] ALJ Decision at 7. The ALJ determined that the documentary evidence, "consist[ing] of, among other things, Petitioner's facility records, partial medical records for Resident 1, Petitioner's investigation documents, and survey documents[,]" was sufficient to establish all the material facts. *Id.* at 6. The ALJ found that Pearsall's citation to other evidence (medication administration records, facility job descriptions and facility policies) as showing that "Petitioner 'reasonably assessed the necessary care and services' for Resident 1" only raised "a legal question" which he was "able to decide based on undisputed facts." *Id.*, *citing* P. Br. at 6. The ALJ also concluded that Pearsall cited no evidentiary support for its assertion that it reasonably assessed Resident 1's care and treatment needs following discovery of her fractured hip and that the undisputed evidence of record did not support the assertion. The ALJ stated:

> There are no documented assessments of Resident 1's hip or pain levels by Petitioner's nursing staff, there were no changes to Resident 1's care plan between the time her hip fracture was first shown on an X-ray and the time she was finally admitted to the hospital, and there are no documented occasions where staff determined Resident 1's comfort level.

*Id*. at 11. The ALJ accepted as true statements cited by Pearsall in which three employees who provided care to Resident 1 averred that she did not complain to them about pain. *Id.* at 6, 11. The ALJ found, however, that this evidence did not contradict the undisputed documented complaints of hip pain on which the surveyor relied. *Id*. The ALJ also found that whether Resident 1 complained of pain at all was ultimately

[3] Hereafter, we use the phrase "hip fracture" as a shorter way to refer to the acute intertrochanteric fracture of Resident 1's left proximal femur.

immaterial since Pearsall did not dispute either that it knew Resident 1 had a hip fracture or that it failed to obtain the care and treatment needed to address the fracture for 30 days after discovering it. *Id*. at 9-11.

**Standard of Review**

We review an ALJ's grant of summary judgment de novo, construing the facts in the light most favorable to the petitioner and giving the petitioner the benefit of all reasonable inferences. *See Livingston Care Ctr.*, DAB No. 1871, at 5 (2003), *aff'd, Livingston Care Ctr. v. U.S. Dept. of Health & Human Servs*., 388 F.3d 168, 172-73 (6th Cir. 2004). Summary judgment is appropriate when there is no genuine dispute about a fact or facts material to the outcome of the case and the moving party is entitled to judgment as a matter of law. *Id*.; *Celotex Corp. v Catrett*, 477 U.S. 317, 322-25 (1986). The party moving for summary judgment (here, CMS) has the initial burden of demonstrating that there is no genuine issue of material fact for trial and that it is entitled to judgment as a matter of law. *Celotex*, 477 U.S. at 323. If the moving party carries that burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial.'" *Matsushita Elec. Industrial Co. v. Zenith Radio Corp*., 475 U.S. 574, 587 (1986) (*quoting* Rule 56(e) of the Federal Rules of Civil Procedure).

"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), *aff'd, Senior Rehab. & Skilled Nursing Ctr. v. Health & Human Servs.*, 405 F. App'x 820 (5th Cir. 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. Regional Med. Ctr*., DAB No. 2459, at 5 (2012) (*quoting Matsushita*, 475 U.S. at 587), *aff'd, Mission Hosp. Regional Med. Ctr. v. Sebelius*, No. SACV 12-01171 AG (MLGx), 2013 WL 7219511 (C.D. Cal. 2013). In examining the evidence to determine the appropriateness of summary judgment, an ALJ 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 Nursing Home*, DAB No. 2344, at 7 (2010); *Brightview* at 10 (entry of summary judgment upheld where inferences and views of non-moving party are not reasonable). Drawing factual inferences in the light most favorable to the non-moving party does not require that an ALJ accept the non-moving party's legal conclusions. *Cedar Lake Nursing Home* at 7.

Our standard of review on a disputed conclusion of law is whether the ALJ Decision is erroneous. *See Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs* at http://www.hhs.gov/dab/divisions/appellate/guidelines/prov.html.

**Discussion**

A. Summary judgment for CMS is appropriate since no material fact is disputed.

CMS found Pearsall out of compliance with section 483.25, a regulation that provides the quality of care requirements for long-term care facilities participating in the Medicare program. The lead-in language of the regulation provides as follows:

> Each 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.

42 C.F.R. § 483.25.[4] The Board has explained that section 483.25, as the lead-in language signifies, "imposes on facilities an affirmative duty designed to achieve favorable outcomes to the highest practicable degree." *Windsor Health Care Ctr.*, DAB No. 1902, at 16-17 (2003), *aff'd, Windsor Health Ctr. v. Leavitt*, 127 F. App'x 843 (6th Cir. 2005). Facilities "must take 'reasonable steps' and 'practicable measures to achieve that regulatory end.'" *Golden Living Ctr. – Foley*, DAB No. 2520, at 23 (2013), *quoting Clermont Nursing & Convalescent Ctr.*, DAB No. 1923, at 21 (2004), *aff'd, Clermont Nursing & Convalescent Ctr. v. Leavitt*, 142 F. App'x 900 (6th Cir. 2005). The regulation "implicitly imposes on a facility the duty to provide care and services that, "at a minimum, meet accepted professional standards of quality 'since the regulations elsewhere require that the services provided or arranged by the facility must meet such standards.'" *Id.*, *quoting Spring Meadows Health Care Ctr.*, DAB No. 1966, at 17 (2005). Compliance with the regulation also means that a facility must furnish the care and services set forth in its residents' care plans, implement physician orders, monitor and document residents' conditions and follow its own policies. *See Life Care Ctr. of Bardstown*, DAB No. 2479, at 22 (2012), *aff'd, Life Care Ctr. of Bardstown v. U.S. Dept. of Health & Human Servs.*, 535 F. App'x 468 (6th Cir. 2013).

In its request for review (RR), Pearsall does not dispute the legal requirements of section 483.25 as discussed above and in the ALJ Decision. *See* ALJ Decision at 9. Pearsall's argument on appeal is that the ALJ improperly granted summary judgment because, Pearsall claims, it did raise disputes about facts material to concluding whether it was in substantial compliance with the regulation. RR at 7, 9-10. Pearsall cites no specific facts

[4] This lead-in language applies to section 483.25 generally and to the multiple requirements addressing specific areas of care identified in subsections of the regulation, such as the requirements, among others, for preserving a resident's abilities in activities of daily living, preventing accidents, and preventing development of pressure sores. *See* 42 C.F.R. § 483.25(a)-(n).

that are material and disputed, and we find none based on our de novo review of the record.[5]

Pearsall refers broadly to "the evidence presented in Pearsall's Response [to CMS's Motion for Summary Judgment]." RR at 7. However, Pearsall identifies no specific evidence relevant to the material facts that Pearsall staff did not timely implement the order from Resident 1's physician to refer Resident 1 to an orthopedic surgeon, with the result that Resident 1 received no treatment for a known hip fracture for 30 days. Pearsall points to absolutely no evidence capable of raising any dispute about these material facts. Instead, Pearsall sets forth what it characterizes as the ALJ's findings that Pearsall violated section 483.25 by "not (1) assessing [Resident 1's] hip pain (2) not timely making an appointment with an orthopedic surgeon pursuant to physician orders resulting [sic] and (3) assessing and intervening to prevent Resident 1 from having hip pain." RR at 9. Pearsall then states:

> Pearsall identifies, relying on CMS's submitted evidence, contested fact disputes on each of the three deficiencies and establishes the need for examination of witnesses, live testimony, exhibits and consideration of other relevant evidence through an evidentiary hearing. The survey findings and alleged deficiencies forming the basis of CMS's Motion are contradicted by CMS's own summary judgment evidence namely, the 110 pages of contemporaneously created care plans and physician medical records and the 60 page Provider Investigation Report and its supporting documentation. This evidence contradicts, or at the very least disputes, the survey findings made by CMS and the opinions of CMS declarants [the surveyor and a CMS registered nurse consultant].

RR at 9-10 (footnotes omitted).

Merely referring to the record without identifying any specific evidence in that record to support its assertion is not sufficient to raise a factual dispute precluding summary judgment. Moreover, we have conducted a de novo review of the record and find absolutely no evidence in either CMS's ten exhibits or Pearsall's two exhibits that even tends to undercut the material facts discussed above.

Pearsall also asserts that the ALJ based his decision on findings about failures of assessment or intervention, issues which Pearsall claims are in dispute. This is a

[5] Pearsall's reliance on *Kingsville Nursing and Rehabilitation Center*, DAB No. 2234 (2009) and *Madison Health Care, Inc*., DAB No. 1927 (2004) is misplaced because in each of those cases, unlike this one, the Board concluded that there were disputes of material fact that precluded summary judgment. We discuss *Madison Health Care* again later in our decision when we address Pearsall's arguments about alleged material disputes of fact regarding the reasonableness of the CMP amount.

misstatement of the basis for the ALJ's decision. The ALJ did discuss the evidence of record regarding Resident 1's pain and any actions Pearsall took with regard to that pain. He found undisputed evidence documenting Pearsall's complaints of hip pain even if she did not make such complaints to the three Pearsall staff members whose statements Pearsall cited as evidence of no complaints, statements the ALJ accepted as true for purposes of summary judgment. ALJ Decision at 6, 11. The ALJ also noted that none of the staff member statements Pearsall relied on stated that these staff members had actually assessed Resident 1 for pain. *Id*. at 11. The ALJ also found "no documented assessments of Resident 1's hip or pain levels by Petitioner's nursing staff, . . . no changes to [her] care plan between the time her hip fracture was first shown on an X-ray and the time she was finally admitted to the hospital, and . . . no documented occasions where staff determined Resident 1's comfort level." *Id.* However, contrary to Pearsall's assertion, the ALJ did not base his finding of noncompliance with section 483.25 on a failure to assess Resident 1's hip pain or to intervene to prevent such pain. The ALJ concluded it was not material whether Resident 1 complained of hip pain to anyone because regardless of whether the resident complained of hip pain she had a known hip fracture for which Pearsall staff did not seek timely treatment:

> It is undisputed that Petitioner's staff knew that Resident 1 had a fractured hip, and her complaints of pain (or lack thereof) should have made no difference in whether Petitioner sought to obtain further treatment for her fracture. Even if she were not in pain (or could not verbalize her pain), staff could not ignore or unreasonably delay treatment for a known acute fracture and still maintain the resident's highest overall well-being.

*Id*.

We find no error in the ALJ's conclusion that Pearsall violated section 483.25 by not timely seeking treatment for Resident 1's hip fracture regardless of whether Resident 1 complained of pain to anyone or whether Pearsall staff did any assessment of her pain. Whether the resident complained of pain or not is immaterial to the undisputed facts that she had a hip fracture and that Pearsall staff knew of the hip fracture as of January 11, 2014; yet, Pearsall did not set up an appointment with an orthopedic surgeon, and the resident was not treated by an orthopedic surgeon for 30 days even though her treating physician had ordered such treatment "the sooner the better." CMS Exs. 3, at 55; CMS Ex. 7, at 86, 87.

Pearsall argued before the ALJ that its staff attempted to set up an appointment with an orthopedic surgeon but the surgeon "'refused to see Resident 1 because he did not accept her insurance.'" ALJ Decision at 11, *citing* P. Br. at 13. The ALJ had noted earlier in his decision that the record showed it "ultimately was Resident 1's nephrologist and the dialysis center nursing staff, not Petitioner, who located an orthopedic surgeon willing to treat Resident 1 and scheduled an appointment for Resident 1 to see that surgeon." *Id*. at

10. Nonetheless, for purposes of summary judgment, the ALJ inferred that Pearsall's staff had attempted to obtain an appointment with an orthopedic surgeon but was stymied by that surgeon's refusal to accept the resident's insurance. *Id*. at 11. The ALJ, however, concluded that was not enough to establish substantial compliance:

> [I]t is unreasonable to claim that Petitioner did not have to follow up or arrange for any further care for Resident 1's acute hip fracture simply because one surgeon refused to operate based on Resident 1's insurance. Petitioner had an obligation to provide the necessary care and services to Resident 1 so that she could maintain her highest practicable well-being, which most certainly included not suffering from a known hip fracture for 30 days without treatment. Indeed, the dialysis facility that treated Resident 1 did not have the same difficulty consulting with and arranging for treatment from an orthopedic surgeon. *See* CMS Ex. 7, at 93-94. By not ensuring that Resident 1 received the care and services necessary to treat her hip fracture, Petitioner did not substantially comply with 42 C.F.R. § 483.25.

*Id*. at 11-12 (footnote omitted). Pearsall does not challenge this conclusion on appeal, and we find no error in the ALJ's conclusion that merely attempting to arrange an appointment and then, when the surgeon contacted refused to see the resident, doing nothing more for the resident's acute fracture for a significant period of time did not amount to substantial compliance with section 483.25. Although Pearsall claims that the delay in obtaining prior authorization was due to circumstances beyond its control, RR at 11, it offers no evidence to support that claim and, in particular, no evidence that it made efforts either to obtain the prior authorization or to find a doctor who would not require prior authorization.

B. The ALJ did not err in declining to review CMS's immediate jeopardy determination or in determining that $8,750 is a reasonable amount for the per-instance CMP.

CMS determined that Pearsall's noncompliance with section 483.25 was at a level posing immediate jeopardy to Resident 1. Immediate jeopardy is "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS determined that Pearsall's noncompliance with section 483.25 posed immediate jeopardy for Resident 1 when she received no treatment for an acute hip fracture for 30 days, and the ALJ correctly stated that this determination was not subject to review. ALJ Decision at 3-4. As the ALJ noted, CMS's immediate jeopardy determination is subject to review only if a successful challenge would affect the range of the CMP amount or CMS has made a finding of substandard quality of care that caused the facility to lose its approval to offer or conduct nurse aide training. 42 C.F.R.

§§ 498.3(b)(14), 498.3(d)(10). In this case, a successful challenge to the immediate jeopardy could not affect the CMP range because CMS imposed a per-instance CMP which has a single range ($1,000-$10,000) regardless of the level of noncompliance. 42 C.F.R. §488.438(a)(2); *compare* 42 C.F.R. § 488.438(a)(1) (providing for per-day CMPs in an upper range ($3,050-$10,000 per day) and lower range ($50-$3,000 per day) depending on the level of noncompliance). The Board has long held that because a per-instance CMP has a single range, a successful challenge to a per-instance CMP could not affect the range of the CMP. *See, e.g.*, *NMS Healthcare of Hagerstown*, DAB No. 2603, at 7 (2014). In addition, although Pearsall's violation of section 483.25 at the immediate jeopardy level met the definition of substandard quality of care, *see* 42 C.F.R. § 488.301, the ALJ correctly concluded that he could not review the immediate jeopardy for that reason because even if Pearsall had a nurse aide training program (and the ALJ found no evidence it did), the amount of the CMP ($8,750) here is more than the $5,000 amount that automatically results in loss of a nurse aide training program. ALJ Decision at 3-4, *citing* 42 U.S.C. § 1395i-3(f)(2)(B); 42 C.F.R. § 483.151(b)(2)(iv); *White Sulphur Springs Ctr*., DAB No. 2520, at 17 (2013).

On appeal, Pearsall acknowledges that the immediate jeopardy determination made by CMS here is not subject to review. RR at 13 n.40. Pearsall nonetheless presents argument opposing the immediate jeopardy determination "for purposes of addressing the excessive nature of the CMP." *Id*. Pearsall is not entitled to challenge the immediate jeopardy determination for that purpose or any other purpose. Since CMS's immediate jeopardy determination was not subject to review, as a matter of law it was final and the ALJ lawfully factored that determination of scope and severity into his determination that the $8,750 CMP amount was reasonable. *White Sulphur Springs Ctr*. at 17-18.

Pearsall argues that $8,750 is an unreasonable and excessive amount for the per-instance CMP under the factors the regulations require CMS to evaluate in determining a CMP amount. RR at 14-20. These factors require CMS to consider the facility's compliance history, financial condition and culpability[6] as well as the seriousness of the deficiencies, that is, the scope and severity of the noncompliance. 42 C.F.R. §§ 488.438(f), 488.404 (incorporated by section 488.438(f)(3)). An ALJ, in turn, must review the reasonableness of the CMP de novo based on the facts and evidence of record. *Emerald Oaks*, DAB No. 1800, at 11-13 (2001). Pearsall claims that "[t]here is no evidence that the penalty assessment in this case is based on the requisite factors . . . ." RR at 14. As discussed below, that is not correct.

CMS stated in its notice letter that it had considered the factors, and the ALJ applied the factors to the undisputed facts material to the factors. CMS Ex. 2, at 8; ALJ Decision at 12. With respect to compliance history, *see* 42 C.F.R. § 488.438(f)(1), the ALJ noted the

[6] We note, as did the ALJ, the regulatory provision stating that "absence of culpability is not a mitigating circumstance in reducing the amount of the penalty." 42 C.F.R. § 488.438(f)(4), *cited in* ALJ Decision at 12.

absence of any dispute (which Pearsall confirms here) that Pearsall had no recent prior enforcement actions. *Id*. With respect to financial condition, *see* 42 C.F.R. § 488.438(f)(2), Pearsall argues that there is no evidence CMS considered this factor. RR at 16. That argument is clearly rebutted by CMS's statement to the contrary in its notice letter and by CMS's informing Pearsall in the same letter of its opportunity to submit any "pertinent financial information" for CMS's consideration in determining the amount of the CMP. CMS Ex. 2, at 8. In any event, "[t]he Board has repeatedly held that in a proceeding to challenge CMS's determination of noncompliance and imposition of a CMP, an ALJ or the Board properly presumes that CMS considered the regulatory factors and that those factors support the amount imposed." *Pinecrest Nursing & Rehab. Ctr*., DAB No. 2446, at 23 (2012). Accordingly, it is not CMS's burden to present evidence on each factor or to explain either how it weighed the factors or made its decision as to the amount of the CMP; instead, the nursing facility has the burden "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*. (citation omitted). Here, the ALJ found, "Petitioner has not alleged or offered evidence that its financial condition affects its ability to pay the CMP." ALJ Decision at 12. Pearsall does not dispute this finding, and, as the Board cases cited above indicate, the ALJ correctly allocated to Pearsall the responsibility for coming forward with such evidence. As the Board stated in *Coquina Center*, "[u]nless a facility contends that a particular regulatory factor does not support that CMP amount, the ALJ must sustain it." DAB No. 1860, at 32 (2002), *cited in* ALJ Decision at 12.

The ALJ found the $8,750 CMP amount "well-supported by the record before me." ALJ Decision at 13. That record, as discussed above, included undisputed evidence that Pearsall did not give Resident 1 care or treatment for a known hip fracture for 30 days. Section 488.438(f)(3) required the ALJ to factor into his determination of a reasonable CMP amount the scope and severity of this noncompliance with section 483.25. He did so, and found the noncompliance to be very serious:

> Once Petitioner's staff knew of Resident 1's acute femur fracture and the refusal of one orthopedic surgeon to see Resident 1 based on her insurance, Petitioner did not take any other steps to provide the necessary care and services to Resident 1, which left her with an untreated fracture for nearly one month. It is impermissible for Petitioner to shift blame to the orthopedic surgeon's office or Medicaid, or to downplay its culpability in this case. Petitioner's staff allowed Resident 1's fracture to go untreated for a month and did not ensure she received care during that time. In fact, but for the dialysis center's nursing staff – not Petitioner – making arrangements for Resident 1 to see a surgeon, it may have been even longer while the fracture went untreated.

*Id*. at 12.

We conclude that the ALJ properly applied the factors in section 488.438(f) and determined that the $8,750 CMP amount was reasonable.[7] The facts on which the ALJ based that determination are undisputed, and Pearsall has pointed to no other evidence material to that determination or offered any argument that would lead us to conclude that the ALJ erred in finding the CMP amount reasonable. Pearsall cites *Madison Health Care, Inc.*, DAB No. 1927 (2004) as purportedly holding that "where '. . . the reasonableness of the amount' of a CMP is 'at issue, an ALJ may not dispose of the case entirely on a summary judgment motion.'" RR at 14 (citation omitted). Since Pearsall has not raised a genuine factual dispute affecting this ALJ's noncompliance determination or his determination of the reasonableness of the per-instance CMP amount, *Madison Health Care* would not apply even if Pearsall's statement of the holding were accurate and the case were factually on point, neither of which is true. The Board held in *Madison Health Care* that "even where summary judgment properly lies against a facility as to the existence of a basis sufficient to authorize CMS to impose remedies, a factual dispute material to the factors justifying the reasonableness of the amount of a CMP may preclude summary judgment on this issue." DAB No. 1927, at 21. The basis for that holding was the Board's finding that there were factual disputes about the seriousness of Madison Health Care's noncompliance – a factor in determining the reasonableness of a CMP amount under section 488.438(f) – because the ALJ based his noncompliance determination on only one of the seven deficiencies on which CMS's motion for summary judgment rested and, unlike the ALJ here, did not draw all factual inferences in Madison Health Care's favor. Here there are no factual disputes affecting the ALJ's determination of either Pearsall's noncompliance or the seriousness of that noncompliance. Moreover, the Board in *Madison Health Care* did not rule out an ultimate conclusion that the CMP amount was reasonable but found summary judgment improper because the ALJ "did not explain how he arrived at a judgment that the same amount of CMP remained reasonable in the absence of any findings about the validity of the other deficiency findings."[8] DAB No. 1927, at 22. Here, there is only one deficiency finding at issue, and the ALJ clearly explained why he found the CMP amount reasonable in light of the seriousness of that deficiency. Thus, *Madison Health Care* is factually distinguishable, legally not on point and offers no support for Pearsall. We conclude that the ALJ did not err in finding $8,750 a reasonable per-instance CMP amount.

[7] "The determination of whether a CMP amount is reasonable is a conclusion of law, not a finding of fact." *Cedar Lake Nursing Home* at 12.

[8] On remand, the ALJ held a hearing and issued a decision upholding CMS's finding of noncompliance and the $450 per day CMP amount based on the same single deficiency citation, and the Board affirmed the decision. *See Madison Health Care, Inc*., DAB CR1325 (2005), *aff'd*, *Madison Health Care, Inc.*, DAB No. 2049 (2006).

**Conclusion**

For the reasons stated above, we affirm the ALJ Decision.

/s/
Leslie A. Sussan

/s/
Susan S. Yim

/s/
Sheila Ann Hegy
Presiding Board Member