Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: December 11, 2009
Cedar Lake Nursing Home,	
Petitioner,	Civil Remedies CR1967 App. Div. Docket No. A-09-119
	Decision No. 2288
- v. -	
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Cedar Lake Nursing Home (Cedar Lake, Petitioner) appeals the June 24, 2009 decision of Administrative Law Judge (ALJ) Carolyn Cozad Hughes in Cedar Lake Nursing Home, DAB CR1967 (2009) (ALJ Decision). On summary judgment, the ALJ upheld the imposition by the Centers for Medicare & Medicaid Services (CMS) of a $5,000 per-instance civil money penalty (CMP). The ALJ determined that the undisputed facts established that Cedar Lake was not in substantial compliance with the Medicare requirements governing accident prevention under 42 C.F.R. § 483.25(h). In addition, the ALJ concluded that the amount of the per-instance CMP was reasonable.

For the reasons discussed below, we uphold the ALJ Decision granting summary judgment in favor of CMS.

Standard of Board Review

Summary judgment is appropriate when the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. See Celotex Corp. v. Catrett, 477 U.S. 317, 322-25 (1986); Everett Rehabilitation and Medical Center, DAB No. 1628, at 3 (1997). Whether summary judgment is appropriate is a legal issue that we address de novo. Lebanon Nursing and Rehabilitation Center, DAB No. 1918 (2004). In reviewing whether there is a genuine dispute of material fact, we view proffered evidence in the light most favorable to the non-moving party. Kingsville Nursing and Rehabilitation Center, DAB No. 2234 (2009); Madison Health Care, Inc., DAB No. 1927 (2004), and cases cited therein. The standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. Departmental Appeals Board, Guidelines--Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs, http://www.hhs.gov/dab/guidelines/prov.html.

Case Background[1]

Cedar Lake is a long-term care facility in Malakoff, Texas that participates in the Medicare program. The State survey agency completed a survey of Cedar Lake on March 5, 2008. Based on the Statement of Deficiencies (SOD) issued by the State survey agency, CMS determined that Cedar Lake was not in substantial compliance with 42 C.F.R. § 483.25(h) and imposed a $5,000 per-instance CMP based on that noncompliance. (CMS also determined that Cedar Lake was not in substantial compliance with other Medicare participation requirements but imposed no remedy for those alleged deficiencies.) Section 483.25(h) is part of the quality of care requirements at section 483.25. The lead-in language for section 483.25 states:

> 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

[1] The applicable statutory and regulatory provisions are described in the ALJ Decision at pages 1-4 and in the text below.

well-being, in accordance with the comprehensive assessment and plan of care.

Section 483.25(h) provides:

> *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.

Cedar Lake filed a request for a hearing before an ALJ. The ALJ who was initially assigned to the case, Jose A. Anglada, issued a pre-hearing order permitting the parties to file motions for summary disposition pursuant to Rule 56 of the Federal Rules of Civil Procedure (also known as summary judgment). CMS moved for summary judgment, submitting 13 exhibits. Cedar Lake submitted a pre-hearing brief with 14 exhibits and subsequently submitted its response in opposition to CMS's motion with two affidavits as attachments. ALJ Anglada issued an order denying CMS's motion for summary judgment (MSJ), stating, without discussion, that "there are issues of fact in controversy, thus making this case inappropriate for summary judgment." Order dated 12/29/08, at 1. Shortly thereafter, ALJ Anglada left the agency, and the case was reassigned to ALJ Hughes. ALJ Decision at 2. On March 17, 2009, ALJ Hughes issued a ruling vacating the denial of summary judgment. After further briefing by the parties, ALJ Hughes issued the ALJ Decision finding that summary judgment was appropriate.

CMS's allegations of noncompliance with section 483.25(h) centered around the care that Cedar Lake provided to Resident 10 (R10). The ALJ Decision states that CMS had supported its allegations with evidence that was unchallenged by Cedar Lake and established that--

- R10 had a history of wandering, was at high risk for elopement, and repeatedly attempted to leave the facility.
- R10 had a history of falls, and fell multiple times in January 2008.
- The facility developed a care plan, dated September 19, 2007, to address the problem it identified as "resident occasionally wanders from facility." The plan required staff to place the resident in an area "where constant

observation is possible" and to "approach the resident warmly and positively."

- Plan amendments dated January 15 and January 27, 2008 added social services intervention, WanderGuard placement,[2] frequent observation, door alarm and administration of ordered medications as needed for insomnia and restlessness. The plan also directed staff to intervene when the resident ambulated up and down the halls, offering her a drink or snack, and assisting her back to her room.
- An additional plan, dated January 27, 2008 (and reviewed periodically thereafter) directed all staff to monitor the resident location every two hours, notify the interdisciplinary team of any attempts to leave the facility, monitor the resident's location every fifteen minutes if an attempt to leave occurs "until an action plan and protective measures are in place," redirect resident from wandering in and out of other residents' rooms, encourage participation in activities, and refer to the social worker if R10 has trouble coping with placement.
- R10's physician ordered a Wanderguard[.]
- Social services assessments dated January 7, January 31, and February 7, 2008, indicate that R10 became combative when staff attempted to redirect her as she tried to leave the facility.
- On February 20, 2008, a visitor reported that she saw R10 out of the facility, walking along the shoulder of Highway 31. Staff found her and returned her to the facility, tired and thirsty, but unharmed.
- Incident reports dated February 20, 2008, reiterate that a visitor "said there was an elderly woman in a pink sweat suit walking down the highway and wondered if she belonged here." Staff ran after her and returned her to the facility unharmed.
- According to the incident report, on the day of R10's elopement, new alarms were being installed and the previous alarms had been turned off for rewiring.

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[2] The ALJ Decision states that a "WanderGuard system attaches sensors to exit doors and/or windows, causing them either to lock or sound an alarm when approached by a resident wearing a corresponding bracelet/anklet." ALJ Decision at 5, n.3.

- Staff explained to surveyors that the door alarms had not sounded when R10 exited the facility because workers installing a new alarm system had turned off the existing system, and no workers were at the front door when she left.
- Following her safe return, the facility implemented one-on-one supervision of R10 pending completion of the new alarm system.
- At least three other facility residents were equipped with WanderGuard bracelets or anklets at the time of R10's elopement.

ALJ Decision at 5-6 (citations and footnote omitted). The ALJ concluded, "based on the undisputed facts," that Cedar Lake "failed to take all reasonable steps to prevent R10's elopement." Id. at 7. The ALJ observed that, in addition to requiring use of a WanderGuard, R10's care plan contained specific requirements for her supervision, but that "Petitioner has come forward with no evidence as to the frequency and means by which staff supervised R10 prior to the time her [February 20, 2008] elopement was discovered[.]" Id. at 9. The ALJ concluded: "Because the undisputed evidence establishes that the facility did not provide R10 with the supervision and assistance devices she needed, and did not take reasonable steps to ensure that her environment remained free of accident hazards, it was not in substantial compliance with 42 C.F.R. § 483.25(h), and CMS is entitled to summary judgment on that issue." Id. The ALJ further concluded that the $5,000 per-instance CMP imposed by CMS was reasonable in amount.

Analysis

On appeal, Cedar Lake does not dispute any of the facts that the ALJ identified in her decision as undisputed. According to Cedar Lake, "[t]he seminal issue in this case is whether Petitioner's actions with respect to Resident #10 were reasonable in terms of supervision and assistance to prevent an elopement." Request for review (RR) at 5. Cedar Lane argues that the ALJ erred in granting summary judgment for CMS on this issue as well as on the issue of whether the amount of the per-instance CMP was reasonable. We discuss below why we reject these arguments and uphold the ALJ Decision.[3]

[3] We have fully considered all arguments raised by Cedar (Continued. . .)

1. The ALJ did not err in concluding that the undisputed facts establish that Cedar Lake failed to substantially comply with section 483.25(h)(2).

We note preliminarily that Cedar Lake argued before the ALJ and on appeal that an elopement may not properly be considered an "accident hazard" within the meaning of section 483.25(h)(1). See ALJ Decision at 7; RR at 19-20. We need not determine whether Cedar Lake violated section 483.25(h)(1), however. As discussed below, we agree with the ALJ that, in failing to supervise R10 in accordance with her plan of care, Cedar Lake violated section 483.25(h)(2) and that its culpability for that violation was sufficient to justify the $5,000 per-instance CMP.

The Board has previously stated, and the ALJ here recognized, that section 483.25(h)(2) requires that a facility take "all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents." Briarwood Nursing Center, DAB No. 2115, at 11 (2007), citing Woodstock Care Ctr. v. Thompson, 363 F.3d 583, 590 (6th Cir. 2003) (facility must take "all reasonable precautions against residents' accidents"); ALJ Decision at 7. A facility is permitted the flexibility to choose the methods it uses to prevent accidents, but the chosen methods must constitute an "adequate" level of supervision under all the circumstances. Briarwood at 5. Furthermore, as the Board noted in Kenton Healthcare, LLC, DAB No. 2186 (2008):

> The Board has confirmed that the measures that a facility adopts to care for its residents are evidence of the facility's evaluation of what must be done to attain or maintain a resident's highest practicable physical, mental, and psychosocial well-being, as required by section 483.25. Woodland Village Nursing Center, DAB No. 2053, at 8-9, (2006), aff'd, Woodland Village Nursing Ctr. v. U.S. Dep't of Health & Human Servs., 239 Fed. Appx. 80 (5th Cir. 2007), citing Spring Meadows Health Care Center[, DAB No.

(Continued. . .)

Lake on appeal and reviewed the full record, regardless of whether we specifically address below particular assertions or documents.

> 1966] at 16-18 [(2005)](addressing facility failures to observe their own policies for resident care). Failure to fully employ those measures as intended may thus be . . . evidence that the facility failed to provide residents with needed care and supervision as required by the regulation.

Kenton at 22.

The ALJ concluded here that Cedar Lake did not take "all reasonable steps" to ensure that R10 did not elope because it did not follow the plan of care it developed to prevent her from eloping. In particular, after listing the interventions specified in R10's plan of care in addition to the WanderGuard, the ALJ stated: "Yet, notwithstanding the conclusory and imprecise claims that R10 was monitored 'on a regular basis,' and that 'the facility provided proper supervision," Petitioner has come forward with no evidence as the frequency and means by which staff supervised R10 prior to the time her elopement was discovered[.]" ALJ Decision at 8, citing P. MSJ Response, Ex. A, at 2; P. MSJ Response, Ex. B at 2, 4; CMS Ex. 9, at 17, 78, P. Ex. 5, at 1, P. Ex. 11, at 2.[4] Cedar Lake disputes this conclusion on appeal, stating that it "has demonstrated that the facility provided proper supervision to Resident #10[.]" RR at 8. As discussed below, we conclude that the evidence proffered by Cedar Lake, even read in the light most favorable to it, fails to demonstrate that it provided supervision in accordance with its plan of care for R10.

In response to the MSJ, Cedar Lake identified "whether the care plans . . . were followed" as a genuine issue of material fact. MSJ Supp. Response at 4. However, all but one of the documents relied on by Cedar Lake and cited by the ALJ address only the

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[4] Cedar Lake argues that ALJ's finding, in the caption on page 3 of the ALJ Decision, that "CMS is entitled to summary judgment because the undisputed evidence establishes that the facility did not follow its own elopement prevention policies . . ." (emphasis added), is erroneous because, inter alia, "Cedar Lake was not cited for deficient policy formulation or implementation." RR at 8. In context, however, it seems clear that the ALJ was referring only to Cedar Lake's failure to follow R10's plan of care, which was, in effect, Cedar Lake's policy for preventing her from eloping.

supervision Cedar Lake provided after R10 eloped and was returned to the facility. Exhibit B of Cedar Lake's response to the MSJ – the affidavit of C. Lynn Morgan – addresses, in part, the supervision Cedar Lake provided before R10 eloped, but states only that "Resident #10 was monitored on a regular basis" during that time. MSJ Response, Ex. B at 4, citing P. Exs. 3, 5, 11. (The affidavit also states on page 2 that "the facility provided proper supervision to each of the residents at issue in the survey report"; however, it is unclear what period of time this refers to.) As the ALJ Decision indicates, this general description of the supervision provided does not either directly or by inference answer the question whether Cedar Lake followed R10's plan of care, which required that R10's location be monitored every two hours, or every 15 minutes if she attempted to elope, in addition to requiring that R10 be placed in a location where constant observation was possible. Moreover, the affiant, who identified herself as a private consultant, stated that, in order to prepare the affidavit, she reviewed the SOD and Cedar Lake's request for hearing and all accompanying medical records, facility documents, and exhibits. Thus, she did not claim she had personal knowledge of what type of supervision Cedar Lake actually provided.

Furthermore, of the three exhibits cited in the affiant's statement about monitoring "on a regular basis," only Petitioner's Exhibit 3, on which Cedar Lake specifically relies on appeal, contains any information about the supervision Cedar Lake provided before R10 eloped. This exhibit consists of the Nurses' Records for the month of February 2008 and shows, next to the entry "rounds daily by LVN [licensed vocational nurse] for patient observation," initials in the boxes for each day of both the 6 to 2 and 10 to 6 nursing shifts and for all but a few days of the 2 to 10 nursing shift. P. Ex. 3, at 1. Cedar Lake argues that this "plainly shows scheduled monitoring each day and on each shift[.]" RR at 8. If this document had referred to the plan of care, it could have been read, in the light most favorable to Cedar Lake, as documenting that all of the supervision required by R10's plan of care had been provided during each shift. Cf. Kingsville at 8 (staff members' initials in spaces for each shift on ADL flow sheets that described the required action as repositioning every two hours support an inference that residents had been repositioned every two hours during the shift). In the absence of any reference to the plan of care, however, this document by itself cannot reasonably be read to indicate any regular monitoring by staff more often than

once per eight-hour shift. Clearly, this falls far short of the requirement in R10's care plan for monitoring her every two hours at a minimum.[5] Moreover, Cedar Lake does not point to any evidence that it placed R10 in a location where she could be constantly observed, as required by her care plan.

Cedar Lake also argues in effect that the supervision it provided was adequate because it was unforeseeable that the alarm would not sound when R10 attempted to leave the facility on February 20. According to Cedar Lake, R10's elopement "was completely beyond the facility's control" because the contractor installing the new alarm system never advised anyone at the facility that the old alarm system would be disconnected for a few hours while the new system was being connected. RR at 11. However, Cedar Lake had previously determined that it could not rely solely on the alarm sounding to prevent R10 from eloping inasmuch as its plan of care for R10 required, in addition to the use of a WanderGuard, that facility staff closely supervise R10. Accordingly, even if Cedar Lake could not anticipate the reason the alarm did not sound when R10 left the facility on February 20, its care plan belies its argument that it was unforeseeable that R10 could leave the facility without the alarm sounding.[6]

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[5] In the MSJ, CMS alleged that R10 had attempted to elope nine times prior to February 20 and cited nurse's notes documenting an attempt to leave on February 6 that arguably would have triggered the requirement in the care plan for monitoring every 15 minutes. MSJ at 6; CMS Ex. 9, at 17. However, it is immaterial whether, at the time R10 eloped, Cedar Lake was required to monitor her every two hours or every 15 minutes as Cedar Lake proffered no evidence of monitoring even every two hours.

[6] In response to the same argument below, the ALJ stated:

> Any reasonable person could anticipate the need for heightened supervision when strangers, who are neither familiar with resident behavior nor responsible for resident welfare, are working in and around the facility exit doors. That those strangers were working with the facility alarm systems makes even more foreseeable the increased risk to R10 and the facility's other elopement-prone residents.

(Continued. . .)

Thus, the undisputed facts regarding Cedar Lake's plan of care for R10, as well as the undisputed facts regarding the care Cedar Lake actually provided, justify the ALJ's determination on summary judgment that Cedar Lake failed to substantially comply with section 483.25(h)(2).[7]

Cedar Lake nevertheless argues that whether the "audible alarm system" that was being replaced at the time of R10's elopement "is acceptable under the licensing regulations" is a material factual dispute precluding summary judgment. RR at 20. According to Cedar Lake, although it replaced that system with one that had both an audible alarm and a locking mechanism, "there is no state or federal requirement for alarm systems to both lock and alarm." RR at 17-18. The nature of the alarm system is simply irrelevant to the basis on which the ALJ granted summary judgment. Nothing in the ALJ Decision suggests that the ALJ found Cedar Lake's existing alarm system inadequate. Instead, the ALJ concluded, without making any finding as to what type of alarm system was required, that Cedar Lake itself had planned not to rely solely on an alarm system, but on other interventions as well, and did not follow that plan.

Similarly, Cedar Lake appears to take the position that there is a material factual dispute as to whether Cedar Lake

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ALJ Decision at 8. We need not rely on this rationale because R10's care plan required close supervision of R10 under all circumstances.

[7] Cedar Lake argued before the ALJ that CMS's motion for summary judgment must be supported by affidavits--an argument which the ALJ rejected. ALJ Decision at 4-5. Cedar Lake now argues only that CMS did not produce affidavits or "other competent summary judgment evidence" in support of its motion for summary judgment. RR at 22 (emphasis in original). However, Cedar Lake does not explain why the evidence on which the ALJ relied is not "competent summary judgment evidence" nor explain why CMS was required to proffer any evidence with respect to facts found by the surveyors and relied on by CMS which Cedar Lake did not dispute.

"implement[ed] any new system to prevent recurrence after R10's elopement." RR at 17. What Cedar Lake did after the fact is not relevant to whether it was in substantial compliance before R10 eloped on February 20. The only reference in the ALJ Decision to actions Cedar Lake did or did not take following R10's elopement appears in the ALJ's list of undisputed facts, which states that following R10's elopement, "the facility implemented one-on-one supervision of R10 pending completion of the new alarm system." ALJ Decision at 6. The ALJ did not opine as to whether this was adequate to prevent R10 from eloping in the future. Instead, the ALJ specifically relied only on Cedar Lake's failure to take all reasonable steps to prevent R10's elopement as a basis for imposing the per-instance CMP. Although the surveyors found that the deficiency continued after R10 eloped on February 20, the ALJ could uphold the imposition of a per-instance CMP without making any finding as to the duration of the noncompliance because a per-instance CMP "may be imposed for each 'instance of noncompliance,' not for each day of noncompliance or each incident which evidenced noncompliance with one or more participation requirements." Columbus Nursing and Rehabilitation Center, DAB No. 2247, at 29 (2009) (citing 42 C.F.R. § 488.438(a)(2)).

Cedar Lane's other arguments have no merit.

Cedar Lake argues at considerable length, as it did before the ALJ, that CMS improperly relied on Quality Assurance (QA) committee documents in citing a deficiency under section 483.25(h). According to Cedar Lake, the surveyors "obtained confidential QA data and then cited deficiencies based upon the committee's activities and the committee documents' contents" in violation of Texas law and regulations as well as federal regulations which Cedar Lake says treat QA documents as privileged. See ALJ Decision at 9-10; RR at 11-15. Cedar Lake identifies as the QA documents a February 20, 2008 Incident/Accident Report regarding R10's elopement signed by its Assistant Director of Nursing and the February 22, 2008 QA committee minutes, which Cedar Lake submitted as its Exhibits 5 and 6. RR at 12. The ALJ Decision does not cite to the QA committee minutes at all. The ALJ Decision does cite to the incident report as support for facts relating to R10's elopement, including that the alarm system was being replaced and that the alarms had been temporarily disconnected. See ALJ Decision at 6. To the extent that these facts are undisputed, it is irrelevant whether the incident report was privileged

under state or federal law.[8] Moreover, we agree with the ALJ that since Cedar Lake was required to prepare an incident report for the State survey agency, "[t]hat the incident report is also reviewed by the QAC does not make it a privileged document" (ALJ Decision at 10). See Jewish Home of Eastern Pennsylvania, DAB No. 2254, at 11-12 (2009) (citing 42 C.F.R. § 483.13(c)(3)).

Cedar Lake also argues that the ALJ erred because she applied a "strict liability" standard in concluding that Cedar Lake violated section 483.25(h)(2), i.e., that the ALJ concluded from the mere fact that R10 eloped that Cedar Lake must not have been providing proper supervision. RR at 6. Cedar Lake is correct that section 483.25(h)(2) does not make a facility strictly liable for elopements. See, e.g., Tri-County Extended Care Center, DAB No. 1936, at 7 (2004) (the quality of care regulations under section 483.25 "hold facilities to meeting their commitments to provide care and services in accordance with the high standards to which they agreed but do not impose strict liability, i.e., they do not punish facilities for unavoidable negative outcomes or untoward events that could not reasonably have been foreseen and forestalled"). However, nothing in the ALJ Decision suggests that the ALJ applied a strict liability standard here. The ALJ expressly relied on Cedar Lake's failure to provide the type of supervision specified in its own plan of care for R10, not on the mere fact that R10 succeeded in eloping.

Cedar Lake argues in addition that, under Texas law, "a facility should not be cited [for] a deficiency or assessed a monetary fine if the perceived deficient practice stems from the actions of an independent contractor beyond the facility's control[.]" RR at 11, citing 40 Tex. Admin. Code § 19.2112(h). That section, captioned "Administrative Penalties," provides that "[n]o facility will be penalized because of a physician's or

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[8] The only such fact in dispute appears to be whether R10 was still on Cedar Lake's property when she was found after having eloped on February 20. See RR at 11; MSJ Response, Ex. B at 4, and Ex. A at 1. Cedar Lake does not dispute that R10 had exited the building and that this constituted an elopement, nor does Cedar Lake explain how, even if it established that R10 was still on facility property, this would be sufficient to show that its staff was supervising her in accordance with her plan of care.

consultant's nonperformance beyond the facility's control...." On its face, this provision applies only to administrative penalties imposed by the State survey agency and does not purport to preclude the imposition of penalties or other remedies that are available under federal law. Even if that were the intent of this provision, a state law cannot shield an entity against the imposition of an administrative remedy authorized by federal statute. In any event, as discussed above, the ALJ correctly rejected Cedar Lake's argument that R10's elopement was beyond its control because the contractor failed to tell it that the alarm would not sound for a few hours.

The ALJ's conclusion that the amount of the per-instance CMP is reasonable is not erroneous.

When a per-instance CMP is imposed based on a finding of noncompliance, the CMP must be in the range of $1,000 to $10,000. 42 C.F.R. § 488.438(a)(2). In determining the amount of a CMP, CMS and the ALJ must use the factors listed at 42 C.F.R. § 488.438(f). Those factors are: (1) the facility's history of noncompliance; (2) the facility's financial condition; (3) factors specified in 42 C.F.R. § 488.404; and (4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. 42 C.F.R. § 488.438(f). Section 488.438(f) also states: "The absence of culpability is not a mitigating circumstance in reducing the amount of the penalty." Section 488.404 includes as factors the seriousness of and relationship among the deficiencies and the facility's history of noncompliance in general and specifically as to the cited deficiencies. The Board has held that in assessing whether CMP amounts are within a reasonable range, the ALJ should not look into CMS's internal decision-making process but, rather, should make a de novo determination as to the whether the amounts are reasonable applying the regulatory criteria based on the record developed before the ALJ. See, e.g., Kingsville at 13, and cases cited therein.

The ALJ determined that the $5,000 per-instance CMP imposed by CMS was reasonable in amount. The ALJ Decision addresses the regulatory factors as follows:

> CMS does not contend that the facility history justifies a higher CMP. Petitioner has not argued that its financial

> condition affects its ability to pay the penalty. With respect to the remaining factors, I find that, although $5000 is at the mid-range for per instance penalties ($1000 -- $10000), it is nevertheless a relatively small amount of money; any lesser amount would be highly unlikely to induce corrective action. Moreover, the facility recognized R10's vulnerability, but disregarded her safety when it failed to provide the level of supervision that she needed, for which it is culpable.

ALJ Decision at 10. On appeal, Cedar Lake asserts that CMS "bears the burden of demonstrating that the [CMP] imposed is reasonable" but that CMS did not produce any evidence on that issue. RR at 22. Cedar Lake further asserts that, "[c]onversely," the affidavit of C. Lynn Morgan "explicitly stating why the proposed penalty is not warranted" "at a minimum . . . created a fact issue with respect to whether the penalty was warranted," making summary judgment improper. Id., citing MSJ Response, Ex. B. The affidavit opines that the $5,000 per-instance CMP is not reasonable for the following reasons:

> [T]here is no culpability on the part of Cedar Lake. The facility has taken all action within its control (before, during, and since the survey) to minimize elopements and to provide for resident safety. The facility has continuously strived to update its systems to ensure resident safety, and has re-evaluated following system changes to ensure that the new changes were working. Issues involving the wander guard system were thoroughly investigated by the QA committee, and the maintenance department monitors the system daily to ensure proper functioning. There is no pattern of noncompliance, and the facility has not received any enforcement action for a related matter in the last several years.

MSJ Response, Ex. B at 8.

Contrary to what Cedar Lake argues, whether the CMP amount is reasonable is a legal conclusion to be drawn from the application of regulatory criteria to the facts of the case. The ALJ determined in effect that Cedar Lake's degree of culpability was sufficient to warrant a $5,000 per-instance CMP. There is no genuine dispute about the facts on which the ALJ relied in concluding that Cedar Lake was culpable. Specifically, the ALJ found that Cedar Lake disregarded R10's

safety by not providing the level of supervision required by the plan of care that Cedar Lake developed for her. Cedar Lake's arguments disputing its culpability do not address its failure to provide adequate supervision for R10. Instead, its arguments go only to whether Cedar Lake did all it could to ensure that the alarm system was adequate and functioning properly. As previously discussed, in concluding that Cedar Lake failed to substantially comply with section 483.25(h)(2), the ALJ relied on Cedar Lake's failure to provide the supervision required by R10's care plan, not on any findings regarding the alarm system. Cedar Lake's culpability for failing to provide the requisite supervision is not diminished by Cedar Lake's alleged lack of culpability for the fact that the alarm system did not work on the day R10 eloped or by any other matters relating to the alarm system.

Moreover, we see no error in the ALJ's determination that Cedar Lake's degree of culpability for its noncompliance was sufficient to justify a $5,000 per-instance CMP. As the ALJ Decision indicates, $5,000 – although almost the mid-point of the range for a per-instance CMP – is a relatively small amount. Here, CMS might have imposed a CMP of $3,050 or more per day for noncompliance at the immediate-jeopardy level for a period of several days.

As indicated above, Cedar Lake also takes the position that the CMP amount is not warranted because Cedar Lake has no significant history of noncompliance. Nothing in the ALJ Decision indicates that the ALJ determined that a history of noncompliance was a factor justifying the CMP amount. Instead, the ALJ merely stated that CMS did not rely on "facility history" to justify a higher CMP. Moreover, the Board has held that although a history of noncompliance is one of the factors to be considered in assessing the reasonableness of a CMP, the absence of a history of noncompliance is not a mitigating factor. See, e.g., Western Care Management Corp., d/b/a Rehab Specialties Inn, DAB No. 1921, at 93 (2004) (citing Franklin Care Center, DAB No. 1900 (2003) and 42 C.F.R. § 488.438(f)).

Cedar Lake also disputes CMS's determination that its noncompliance posed immediate jeopardy, which could be viewed as an argument that the CMP amount was based on an erroneous finding as to the seriousness of the noncompliance. RR at 21; MSJ Response, Ex. B at 6-8. Although the ALJ stated that she had no authority here to review CMS's immediate jeopardy

determination (ALJ Decision at 3, citing 42 C.F.R. § 498.3(b)(14)), she was not precluded from considering the seriousness of the deficiency - one of the factors in section 488.404 - in determining the reasonableness of the CMP amount. Nonetheless, the seriousness of the noncompliance is immaterial here because the CMP amount was reasonable based solely on Cedar Lake's degree of culpability. Furthermore, any reasonable assessment of the noncompliance would conclude that it was sufficiently serious to warrant a $5,000 per-instance CMP.

Accordingly, we uphold the ALJ's determination that the amount of the CMP was reasonable.

Conclusion

Based on the foregoing, we affirm the ALJ Decision granting summary judgment for CMS and upholding the per-instance CMP.

/s/
Judith A. Ballard

/s/
Leslie A. Sussan

/s/
Stephen M. Godek
Presiding Board Member