Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Shorepointe Nursing Center,	)	Date: September 30, 2009
(CCN: 23-5443),	)	
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-08-690
	)	Decision No. CR2011
Centers for Medicare & Medicaid	)	
Services.	)	
	)	

DECISION

Petitioner, Shorepointe Nursing Center (Petitioner or facility), is a long term care facility located in St. Clair Shores, Michigan, that participates in the Medicare program. The Centers for Medicare and Medicaid Services (CMS) has determined that, from May 15 through July 10, 2008, the facility was not in substantial compliance with Medicare requirements. Although Petitioner concedes its substantial noncompliance with some requirements, it challenges CMS's determinations that, based on a May 2008 survey, it was not in substantial compliance with 42 C.F.R. § 483.25(h) (accident prevention) and, based on a June 2008 survey, it was not in substantial compliance with 42 C.F.R. § 483.25(c) (pressure sores). Petitioner also challenges the amount of the civil money penalty (CMP) imposed.

I conclude that, from May 15 through July 10, 2008, the facility was not in substantial compliance with the regulations cited. I also affirm as reasonable the civil money penalties (CMPs) imposed: $300 per day for 29 days (May 15-June 12, 2008) and $350 per day for 28 days (June 13 through July 10, 2008).

I. Background

The Social Security Act (Act) sets forth requirements for nursing facility participation in the Medicare program, and authorizes the Secretary of Health and Human Services to

promulgate regulations implementing those statutory provisions. Act § 1819. The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301. So long as CMS finds *one single deficiency at scope and severity level D* or higher, it may impose a remedy and I have no authority to review either its determination to impose a remedy or its selection of remedies. 42 C.F.R. §§ 488.408(g), 488.438(e), 498.3(d)(11).[1]

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. The regulations require that each facility be surveyed once every twelve months, and more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a), 488.308.

Here, following a survey completed May 15, 2008, CMS determined that the facility was not in substantial compliance with Medicare participation requirements, specifically:

- 42 C.F.R. § 483.12(a)(7) (Tag F204 – orientation for transfer or discharge) at a D level of scope and severity (isolated instance of noncompliance that causes no actual harm with the potential for more than minimal harm);

- 42 C.F.R. § 483.25(f)(1) (Tag F 319 – mental and psychosocial functioning) at a D level of scope and severity; and

- 42 C.F.R. § 483.25(h) (Tag F323 – accident prevention) at a G level of scope and severity (isolated instance of noncompliance that causes actual harm that is not immediate jeopardy).

CMS Ex. 1.

[1] In this regard the regulations are unambiguous and the law is well-settled. I therefore find puzzling CMS's gratuitous statement that "[b]ecause a [scope and severity] level G deficiency had been cited at this survey and on the previous standard survey of August 3, 2007, remedies could be imposed immediately." CMS Cl. Br. at 1. Nothing in the statute or regulations requires two surveys with G level deficiencies before remedies can be imposed. *See Gilroy Healthcare and Rehabilitation Center*, DAB CR1865, at 3 (2008).

After a second survey, completed June 13, 2008, CMS determined that the facility was still not in substantial compliance with participation requirements, citing deficiencies under the following regulations:

- 42 C.F.R. § 483.20(b)(2)(iii) (Tag F275 – resident assessment) at a D level of scope and severity;

- 42 C.F.R. § 483.20(c) (Tag F276 – quarterly review assessment) at a D level of scope and severity;

- 42 C.F.R. §§ 483.20(d), 483.20(k)(1) (Tag F279 – comprehensive care plans) at a D level of scope and severity;

- 42 C.F.R. § 483.25 (Tag F309 – quality of care) at a D level of scope and severity;

- 42 C.F.R. § 483.25(c) (Tag F314 – pressure sores) at a G level of scope and severity;

- 42 C.F.R. § 483.25(f)(2) (Tag F320 – mental and psychosocial functioning) at a D level of scope and severity;

- 42 C.F.R. § 483.25(l) (Tag F329 – unnecessary drugs) at a D level of scope and severity; and

- 42 C.F.R. § 483.65(a) (Tag F441 – infection control) at an F level of scope and severity (widespread noncompliance that causes no actual harm with the potential for more than minimal harm).

CMS Ex. 2. CMS subsequently determined that the facility returned to substantial compliance on July 11, 2008. CMS Ex. 8.

CMS has imposed against the facility a CMP of $300 per day from May 15 through June 12, 2008 (29 days x $300 = $8700) and $350 per day from June 13 through July 10, 2008 (28 days x $350 = $9800), for a total CMP of $18,500. CMS Ex. 3, at 2; CMS Ex. 8.

I held a hearing in Detroit, Michigan, on May 22, 2009. Ms. Rebecca Simkins appeared on behalf of Petitioner, and Ms. Juanita S. Temple appeared on behalf of CMS. I have admitted into evidence CMS Exhibits (CMS Exs.) 1-25, and Petitioner's Exhibits (P. Exs.) 1-8. Tr. 2; Order at 2 (March 26, 2009). The parties have filed pre-hearing briefs (CMS Br.; P. Br.), closing briefs (CMS Cl. Br.; P. Cl. Br.), and reply briefs (CMS Reply; P. Reply).

II. Issues

Petitioner limits its appeal to the two deficiencies cited at the G level of scope and severity. I therefore conclude that the facility was not in substantial compliance with Medicare program requirements and CMS has the authority to impose a CMP of at least $50 per day. *See* Order at 1 (March 26, 2009); Tr. 1-2; Act § 1819(h); 42 C.F.R. §§ 488.400, 488.402, 488.406, 488.408, 488.438, 498.20(b).

The remaining issues before me are: 1) Whether, from May 15 through July 10, 2008, the facility was in substantial compliance with 42 C.F.R. § 483.25(h) (accident prevention) and 42 C.F.R. § 483.25(c) (pressure sores); 2) If the facility was not then in substantial compliance, were the penalties imposed in excess of $50 per day – $300 per day for 29 days of noncompliance and $350 per day for 28 days of noncompliance (total $18,500) – reasonable?

III. Discussion

A. The facility was not in substantial compliance with 42 C.F.R. § 483.25(h) because staff did not follow the resident care plan instructions for preventing falls.[2]

Under the statute and the "quality of care" regulation, each resident must receive, and the facility must provide, the necessary care and services to allow a resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. Act § 1819(b); 42 C.F.R. § 483.25. The regulation also requires that the facility "take reasonable steps to ensure that a resident receives supervision and assistance devices designed to meet his or her assessed needs and to mitigate foreseeable risks of harm from accidents." *Windsor Health Care Center*, DAB No. 1902, at 5 (2003); *Briarwood Nursing Center*, DAB No. 2115, at 5 (2007); *Guardian Health Care Center*, DAB No. 1943, at 18 (2004) (citing 42 C.F.R. § 483.25(h)(2)). The facility must anticipate what accidents might befall a resident and take steps to prevent them. 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; *Windsor Health Care Center* at 5.

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

Resident 511 (R511). R511 was an 85-year-old woman, admitted to the facility on April 5, 2008, suffering from syncope and collapse, dementia, orthostatic hypotension, and other ailments. CMS Ex. 16, at 4; CMS Ex. 7, at 14. She required extensive assistance with all activities of daily living. CMS Ex. 7, at 8. She had a history of falls, and scored 20 on a fall risk assessment, where a score of 21 or greater put the resident at high risk for falls. CMS Ex. 7 at 5; CMS Ex. 16 at 23.

At the time of admission, R511's family warned staff that she would attempt to get out of bed and would ambulate, but would fall because of lower extremity weakness. CMS Ex. 7, at 14. Her April 5, 2008 care plan identified her as at risk for falls due to her history of falls and syncope.[3] To prevent falls, staff devised a care plan that called for bed and chair alarms "at all times to notify staff when resident is attempting to rise without assistance." The plan also directed that R511 be placed in a low bed with mats "to lessen the impact of falls." CMS Ex. 7, at 13.

R511 was not placed in a low bed with surrounding mats. In fact, staff did not even obtain an order for the bed and mats until after R511 had suffered two falls. CMS Ex. 7, at 16.

On April 19, 2008, R511 "rolled out of bed." Staff apparently found her on the floor, rolled up in her blankets, her alarm sounding. They speculated that she fell out of bed because her feet were tangled in the bed linens. CMS Ex. 16, at 9, 24, 30. She sustained a small skin tear and hematoma to her right elbow. Her care plan was amended to call for a pressure sensitive mattress alarm (when available) along with the tab alarm that was already in place.[4] CMS Ex. 16, at 30. A physician's telephone order, dated April 19, 2008, called for a "wheel chair and bed tab alarm." CMS Ex. 16, at 34.[5]

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[3] The care plan is somewhat confusing, because it characterizes her as "low risk." This does not mean that staff considered her unlikely to experience a fall, however. Rather, the facility's assessment tool presented options of "high risk" and "low risk." It had no "moderate risk" category. But facility staff obviously recognized that R511 was at risk of falling, and so incorporated fall prevention strategies into her care plan.

[4] The tab alarm clips to the resident and to either the resident's bed or chair. If the resident moves too far from his/her location in a chair or bed, it becomes unclipped and the alarm sounds. A pressure sensitive alarm, placed under a mattress or seat cushion, alerts staff to the resident's movement. Tr. 9.

[5] It seems that staff had applied the tab alarm without first obtaining a physician's order.

But staff did not order a pressure sensitive alarm, as called for in the April 19 amendment to R511's care plan. For reasons not fully explained, staff neither requested nor obtained a physician's order for such an alarm. And they still did not place R511 in a low bed with mats to cushion her falls, as called for in her initial care plan. Tr. 17

In the middle of the night of April 24-25, 2008, staff again found R511 lying on the floor next to her bed. Her bed tab alarm was still attached, although it had not sounded, apparently because the cord attaching the alarm to its tab was too long. R511 suffered hemotomas and a right orbital fracture. CMS Ex. 16, at 8, 9, 10, 11, 17, 31, 32; Tr. 16, 57. Following that accident, the facility finally ordered the bed sensor alarm called for in her care plan, as well as a low bed with mats. CMS Ex. 16, at 9, 18, 30.

Resident 506 (R506). R506 was a 98-year-old woman who had resided in the facility since August 30, 2004. CMS Ex. 15, at 11. She suffered multiple falls. On March 3, 2007, she slid out of her wheelchair onto the floor while attempting to close some blinds. CMS Ex. 15, at 24. On April 11, 2007, she slid out of her wheelchair while reaching for an item from a drawer. It seems that the breaks on her wheelchair had not been locked. CMS Ex. 15, at 24, 25.

According to her care plan, as of August 30, 2007, R506 was considered high risk for falls due to her arteriosclerotic heart disease, organic brain syndrome, and gouty arthritis. She had a history of falls, visual and auditory impairments, and was occasionally confused. The plan called for use of a chair alarm at all times, as well as a lowered bed with mats. CMS Ex. 15, at 28.

On September 1, 2007, R506 again slid out of her wheelchair onto the floor. This time staff cited the presence of a glossy magazine on the seat of the wheelchair as the cause for her fall. CMS Ex. 15, at 24, 26, 30. On January 30, 2008, she slipped out of her wheelchair while reaching for a blanket. CMS Ex. 15, at 24, 26, 30.

At 11:00 a.m. on March 16, 2008, R506 "was found" leaning forward out of her wheelchair, her hands and forehead on the floor. No staff witnessed the incident, but they surmised that she had been leaning forward to arrange flowers. She had bruising on her left wrist, and complained of pain. X-rays showed a fracture of the distal radius. CMS Ex. 15, at 6-10, 12, 15, 20-21. Her chair alarm was not in place because the nurse's aide responsible for R506's care had not attached it. CMS Ex. 15, at 10, 14, 18; Tr. 13, 20, 53-54.

Because facility staff included alarm use in the residents' care plans, I can reasonably infer that they considered them effective in preventing accidents. To hold otherwise would mean that the facility developed inadequate care plans, which would also put the facility out of substantial compliance with program requirements. Nevertheless, Petitioner now argues that alarms are ineffective. Citing the results of a study conducted

by Masspro, a "performance improvement organization" founded by the Massachusetts Medical Society, Petitioner argues that alarms alert staff to falls, but do not necessarily prevent them. P. Cl. Br. at 5-6; P. Ex. 7. I agree that, while an alarm is a tool that can assist staff in preventing accidents, it is not a substitute for adequate supervision, and a facility must also have in place sufficient staff, who are capable and willing to respond promptly when an alarm sounds.

Masspro's very interesting study underscores the importance of supervision. The study describes one facility's successful program to reduce falls while eliminating its use of alarms. But that facility did not just eliminate the use of alarms. Prior to implementing any changes, it trained its staff in falls prevention strategies. It designed a hall monitoring system which involved the presence on the units of high-level staff who were monitoring for safety. A resource aide focused specifically on high-risk residents. Staff increased their surveillance and added activities. Residents were toileted in advance of need; they were re-positioned and ambulated with greater frequency (which had the unintended but highly beneficial effect of reducing the incidents of pressure sores). The facility falls committee evaluated the program daily and weekly, making changes as appropriate. P. Ex. 7. With or without an alarm system, these are strategies Petitioner could have employed, but I see no evidence that it did so.

The facility recognized that R511 and R506 were at risk for falls, and devised plans to mitigate those foreseeable risks. But facility staff did not provide R511 or R506 with the assistance devices called for in their plans. Even when they provided R511 with a tab alarm, either its cord was too long or they attached it improperly, which rendered it ineffective. Because the facility failed to follow its own care plans, it did not insure that R511 and R506 received necessary care and services to allow them to maintain their highest practicable physical, mental, and psychosocial well-being in accordance with their assessments and plans of care. Nor did it take reasonable steps to ensure that they received supervision and assistance devices designed to meet their assessed needs and to mitigate foreseeable risks of harm from accidents. The facility was therefore not in substantial compliance with 42 C.F.R. § 483.25(h)(2).

B. Because its staff failed to take all necessary precautions to prevent pressure sores, the facility was not in substantial compliance with 42 C.F.R. § 483.25(c).

The quality of care regulation also requires that the facility ensure, based on the resident's comprehensive assessment, that a resident who enters the facility without pressure sores does not develop them unless his/her clinical condition shows that they were unavoidable. 42 C.F.R. § 483.25(c)(1). If the resident has pressure sores, the facility must ensure that he/she receives the treatment and services necessary to promote healing, prevent infection, and prevent new sores from developing. 42 C.F.R. § 483.25(c)(2). In assessing the facility's compliance with this requirement, the relevant question is: did the facility take all necessary precautions to prevent new sores from

developing. If it did so and the resident develops sores anyway, I could find no deficiency. But if the evidence establishes that the facility fell short of taking all necessary precautions, then the regulation is violated. *Koester Pavilion*, DAB 1750, at 32 (2000).

CMS's allegations of noncompliance with section 483.25(c) center around the care provided to Resident 415 (R415). Admitted to the facility on March 26, 2002, R415 had just turned 98-years-old at the time of the June 2008 survey. She suffered from arthritis and dementia, and had been admitted to hospice care. CMS Ex. 6, at 7, 9. She was "functionally chair bound" and completely dependent on staff for activities of daily living. CMS Ex. 14, at 8-9, 30. She was assessed as at moderate risk for pressure sores. CMS Ex. 6, at 12.

There has been some confusion as to which, if any, plans were in place to prevent pressure sores prior to R415's developing a sore in April 2008. According to Surveyor Melissa McKenny, she asked to see such a plan, but the facility's assessment nurse told her that she had inadvertently failed to develop one. Tr. 41-43. Petitioner has nevertheless produced a document, which it identifies as R415's care plan, in place prior to April 2008. CMS Ex. 14, at 20. The document is not dated but includes a 6/08 target date. Since care plan target dates are generally about 90 days from the date of a plan's inception, I can reasonably infer that the plan was developed in about March 2008. According to Petitioner, the document was not provided to the surveyor because it had been removed from the resident's file during a "period of transition," i.e. when the facility changed ownership. P. Ex. 5, at 3 (Hampton Decl. ¶ 8).

The plan is not very specific; it calls for a "pressure reducing device as needed for bed and chair" and reducing R415's time in her chair to less than two hours. No evidence suggests that these interventions were implemented. Moreover, it was R415's practice to sit with her right arm on her wheelchair's armrest (CMS Ex. 14, at 30), and, according to Director of Nursing, Deborah Hampton, a pressure ulcer had been reported on R415's right elbow as early as January 18, 2008. P. Ex. 5, at 3 (Hampton Decl. ¶ 9). Yet, not until April 13, 2008 were an elbow protector and right arm cushion added to R415's care plan. CMS Ex. 14, at 20.

A notation on the care plan dated April 13, 2008, describes a skin tear/decubitus found on R415's right elbow, and lists interventions of "treatment orders daily[,] elbow protector ordered by wound M.D." and cushioning the right arm of the resident's wheel chair. CMS Ex. 14, at 20. A physician telephone order dated April 14, 2008, called for staff to cleanse the right elbow ulcer with saline solution and to wrap the elbow, applying the medication Kerlix. CMS Ex. 14, at 3.

A weekly pressure ulcer record, dated April 15, 2008, describes a stage II ulcer on R415's right elbow, 1.4 cm x 2.2 cm in size, with shallow depth and a small amount of yellow drainage.[6] "Pressure relieving interventions" list "positioned with pillows for no pressure." CMS Ex. 14, at 11. A care plan dated April 15, 2008, notes the 1.4 cm x 2.2 cm wound, and lists 16 interventions, including keeping pressure off the affected site and repositioning every hour while in her chair. CMS Ex. 14, at 16. An order dated April 15, 2008 notes the open area on the resident's right elbow and recommends an assessment by the resident's attending physician. CMS Ex. 14, at 3.

In a consultation dated April 17, 2008, the attending physician describes R415 as "functionally chair-bound" and notes that her skin is "very thin and senile" and that she positions her right arm on the wheelchair armrest. As a result, a stage II pressure ulcer developed, which the physician characterized as "uncomplicated" and healing. The physician ordered a foam elbow dressing and "pad wheelchair [arm]." CMS Ex. 14, at 30. An accompanying assessment notes a stage II pressure sore at the right elbow "secondary to senile skin and [patient] positioning of arm on rest," and places the wound at 2 cm x 1.3 cm with moderate drainage. It repeats that the physician ordered a topical foam dressing and a pad on the right arm rest of the resident's chair. CMS Ex. 14, at 31.

On April 18, the weekly ulcer record describes the elbow ulcer as stage II, 2 cm x 1.3 cm, shallow depth, with scant yellow drainage, and describes preventive measures as "pad [wheelchair] arm." CMS Ex. 14, at 11. An order dated April 18, 2008, calls for a nonadhesive heel pad to the right elbow, and a "foam pad to [the wheelchair] arm cushion for added protection." CMS Ex. 14, at 4, 21.

Remarkably, R415's quarterly assessment, dated April 28, 2008, says that she had *no ulcers of any type* within the previous seven days. CMS Ex. 14, at 9. A care plan dated April 28 again lists only general approaches to preventing skin breakdown, including "heel and elbow guards as necessary." It says nothing about her vulnerable right elbow.

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[6] Pressure sores (also referred to as pressure ulcers or decubitus ulcers) are classified into stages, based on the extent of the damage to skin and underlying tissues. At stage I, the skin may appear reddened, like a bruise. Although the integrity of the skin remains intact, the area is at high risk of further breakdown, so it is crucial that the area be identified promptly and treated properly. At stage II, the skin breaks open, wears away, and forms an ulcer. At stage III, the sore worsens and extends beneath the skin surface, forming a small crater, presenting a high risk of tissue death and infection. By stage IV, deeper tissues (muscles, tendons, bones) suffer extensive damage, which can cause serious complications, such as osteomyelitis (infection of the bone) or sepsis (infection carried through the blood). John L. Zeller et al., *Pressure Ulcers*, 296 J. MED. ASS'N 1020 (2006), *available at* www.jama.com; CMS Ex. 9, at 4.

CMS Ex. 14, at 18. This glaring omission raises questions about the quality of the assessment and care planning.

A June care plan repeats most of the 16 interventions contained in the April 15 care plan with minor deviations. CMS Ex. 14, at 17.

By June 4, 2008, the ulcer was still at stage II, measuring 1.2 cm x 1.6 cm, with scant yellow drainage. Preventive measures are listed as turn every two hours, and position with pillows for no pressure. CMS Ex. 14, at 15.

A note dated June 11 says that the nurse was unable to check R415's right elbow dressing because supplies had not been sent from the pharmacy. The nonadhesive dressing then in place is described as "intact." CMS Ex. 14, at 25.

Surveyor McKenny testified that on June 12, 2008, she saw R415 in the restorative dining room, sitting in a wheelchair, alert but confused. A dressing was attached to her right elbow, but a towel, rather than a foam pad, was wrapped around the wheelchair's right arm. CMS Ex. 20, at 2 (McKenny Decl. ¶ 6). A day later, Surveyor McKenny observed the stage II pressure sore, measuring 1.2 cm x 1.6 cm, on R415's right elbow. The depth was shallow with scant yellow drainage. CMS Ex. 20, at 2 (McKenny Decl. ¶ 7). She asked the treatment nurse about the interventions the facility had in place to prevent pressure sores, and the nurse told her that, after R415 developed a pressure sore, staff placed a towel on the right arm of her wheelchair. CMS Ex. 20, at 2-3 (McKenny Decl. ¶ 8).

Based on all of this, I do not consider that the facility took all necessary precautions to prevent pressure sores from developing. At a minimum, from the time staff observed her tendency to rest her right arm on her wheelchair's arm rest, staff should have targeted that behavior as problematic and taken steps (positioning, padding) to address it.

Petitioner nevertheless argues that the pressure sores were inevitable. First, the evidence does not support this conclusion. R415 was assessed at "moderate" risk, not high risk for pressure sores. Her attending physician recognized her vulnerabilities (very thin, senile skin, functionally chair-bound), but also cited the positioning of R415's arm as a cause for the sore's development. CMS Ex. 14, at 30. It was within the facility's power to correct the positioning of R415's arm. Moreover, the facility is not deficient because R415 developed a pressure sore; the facility is deficient because it did not take all necessary precautions to prevent the pressure sore from developing.

C. The penalty imposed is reasonable.

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

In reaching a decision on the reasonableness of the CMP, I consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found, and in light of the above factors. I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Community Nursing Home*, DAB No. 1807, at 22 *et seq*. (2002); *Barn Hill Care Center*, DAB No. 1848, at 21 (2002); *Emerald Oaks*, DAB No. 1800, at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1683, at 8 (1999).

CMS has imposed per-day penalties of $300 and $350 which are at the low end of the penalty range ($50-$3000). 42 C.F.R. §§ 488.408(d), 488.438(a).

CMS points to the facility history as a justification for increasing the penalty. In August 2007, the facility had G-level deficiencies under tags F324 and F325, and F-level deficiencies under tags F45, F52, and F106. CMS Ex. 9, at 2. CMS does not explain what these deficiencies represent, except to characterize them as the "same infractions." CMS Cl. Br. at 19. I, nevertheless, recognize that Tag F324 has, in the past, been cited for deficiencies under 483.25(h)(2). *See, e.g.*, *Kenton Healthcare, LLC*, DAB CR1666, at 3 (2007), *aff'd*, DAB 2186 (2008). In any event, I am satisfied that the facility has a history of noncompliance, including noncompliance related to its failure to prevent accidents. That history alone justifies a penalty above the minimum.

Petitioner complains that the facility's earlier deficiencies occurred when the "physical structure" was owned and operated by a prior owner. P. Cl. Br. at 8. I consider the change of ownership irrelevant. Regulations provide that when there is a change of a facility's ownership, the existing provider agreement will automatically be assigned to the new owner, and that an assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which the agreement was originally issued. 42 C.F.R. § 489.18(c), (d). Those terms and conditions include, but are not

limited to, any existing plan of correction and compliance with applicable health and safety standards. A facility's new owner thus necessarily "acquires the relevant compliance history/issues of the facility if it undertakes to assume the facility's provider number." *Kenton Healthcare, LLC*, DAB No. 2186, at 31 (2008).

Petitioner does not argue that its financial condition prevents it from paying the CMP. Applying the remaining factors, I note that the deficiencies were not trivial, and that they caused actual harm to facility residents. Further, the relatively low $300 per day penalty did not produce corrective action. When the surveyor returned to the facility in June, it still had not achieved substantial compliance. If anything, more deficiencies were cited, including a widespread infection control problem. The facility's failure to achieve substantial compliance by the time of the second survey more than justifies the slight increase in penalty amount.

The CMP is therefore reasonable.

IV. Conclusion

For the reasons discussed above, I find that, from May 15 through July 10, 2008, the facility was not in substantial compliance with Medicare requirements and affirm as reasonable the CMPs imposed – $300 per day for 29 days of noncompliance and $350 per day for 28 days of noncompliance.

/s/
Carolyn Cozad Hughes
Administrative Law Judge