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

Fireside Lodge Retirement Center, Inc.
Docket No. A-17-20
Decision No. 2794
May 26, 2017

# FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Fireside Lodge Retirement Center, Inc. (Fireside), a skilled nursing facility (SNF), appeals the decision of an administrative law judge (ALJ) granting summary judgment to the Centers for Medicare & Medicaid Services (CMS) and upholding the imposition of sanctions for noncompliance, including a period of noncompliance at the immediate jeopardy level, with several of the requirements for long-term care facilities (including SNFs) at 42 C.F.R. § 483.1 et seq. *Fireside Lodge Retirement Center, Inc*., DAB CR4715 (2016). The ALJ concluded that Fireside was not in substantial compliance with sections 483.13(c), 483.25(c) and 483.75; that the noncompliance with the first two regulations was at the immediate jeopardy level from August 20 through August 26, 2014; and that the civil money penalties (CMPs) imposed by CMS for the noncompliance at both the immediate jeopardy and less than immediate jeopardy levels were reasonable in amount. Fireside argues on appeal that the ALJ's "findings are not supported by the law or the undisputed evidence" and that "the ALJ sustained a punitive and unreasonable CMP." Petitioner's Request for Appellate Division Review (RR) at 5.

We affirm the ALJ Decision in all respects except that we modify the ALJ's holdings regarding the duration of the immediate jeopardy level noncompliance and the noncompliance at less than an immediate jeopardy level and alter the CMP amounts consistent with those modifications. We hold that the immediate jeopardy level noncompliance (and the $6,150 per day CMP imposed for it) continued from August 20 through August 25, 2014 (rather than August 26 as found by the ALJ) and that the noncompliance at less than the immediate jeopardy level (and thus the $800 per day CMP imposed for it) continued from August 26 (rather than August 27 as found by the ALJ) through September 25, 2014. As modified, the total CMP amount is $61,700, consisting of $36,900 for the immediate jeopardy level CMP and $24,800 for the non-immediate jeopardy level CMP.

## Legal Background

To participate in the Medicare program, a SNF must be in "substantial compliance" with the participation requirements in 42 C.F.R. Part 483, subpart B. 42 C.F.R. §§ 483.1, 488.400. The term "noncompliance," as used in the applicable regulations, is synonymous with lack of substantial compliance. *Id.* § 488.301 (defining "noncompliance").[1] Compliance with the Part 483 requirements is verified through onsite surveys performed by state health agencies. *Id*. §§ 488.10(a), 488.11. A state survey agency reports any "deficiency" (failure to meet a participation requirement) it finds in a Statement of Deficiencies (SOD). *Id*. §§ 488.301, 488.325. CMS may impose enforcement "remedies," including CMPs, on a SNF found to not be in substantial compliance. *Id.* §§ 488.400, 488.402(b), (c), 488.406. When CMS elects to impose a CMP, it sets the CMP amount based on, among other factors, the "seriousness" of the SNF's noncompliance. *Id.* §§ 488.404(b), 488.438(f). "Seriousness" is a function of the noncompliance's scope (whether it is "isolated," constitutes a "pattern," or is "widespread") and severity (whether it has created a "potential for harm," resulted in "actual harm," or placed residents in "immediate jeopardy"). *Id.* § 488.404(b). The most serious noncompliance is that which puts one or more residents in "immediate jeopardy." *See id*. § 488.438(a) (authorizing the highest CMPs for immediate jeopardy level noncompliance); *Woodland Oaks Healthcare Facility*, DAB No. 2355, at 2 (2010) (citing authorities).

## Case and Procedural Background[2]

The surveys

On August 26, 2014, Texas state agency surveyors completed a health survey at Fireside.[3] The surveyors cited noncompliance with multiple requirements, including the three at issue here: sections 483.13(c), 483.25(c) and 483.75. The section 483.13(c) citation involved a fracture suffered by resident 13 (R. 13) and Fireside's failure to report

[1] On October 4, 2016, CMS issued a final rule that amended the Medicare requirements for long-term care facilities) and re-designated some sections. *See* Final Rule, Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 81 Fed. Reg. 68,688, 68,847 (Oct. 4, 2016). Our analysis and decision is based on the requirements, and their code designations, as they existed in August 2014, the month in which the Texas Department of Aging and Disability Services (state agency) performed the compliance survey providing the bases for CMS's determinations of noncompliance. *See Carmel Convalescent Hospital*, DAB No. 1584, at 2, n.2 (1996) (applying regulations in effect on the date of the survey and resurvey).

[2] The facts stated in this section are not our findings; rather, they are from the ALJ Decision and the record. The stated facts are undisputed unless we note otherwise.

[3] On August 19, 2014, the state agency completed a life safety code survey and found D-level deficiencies. The ALJ found that CMS had not made a prima facie case with respect to those deficiencies, and CMS has not appealed that finding. ALJ Decision at 2, n.1. Accordingly, we need not address that ALJ finding.

and investigate the fracture as required by the federal regulation and Fireside's own abuse and neglect prevention policy. ALJ Decision at 6-8. The section 483.25(c) citation involved failure to provide necessary treatment and services to promote healing of a pressure sore that resident 2 (R. 2) developed. *Id*. at 8-10. The section 483.75 citation involved Fireside's failure to administer the facility in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical mental and psychosocial well-being of each resident, a failure derived from the facility's cited noncompliance with the other requirements. *Id*. at 11.

Facts regarding R. 13

R. 13 was a 99-year-old woman who suffered from heart failure, Alzheimer's disease, anxiety and a psychotic disorder. ALJ Decision at 6, citing CMS Ex. 3, at 1, 49. R. 13 was at high risk for falls and used a wheelchair. *Id*., citing CMS Ex. 3, at 7, 15; P. Ex. 1, at 14. She was receiving hospice care. *Id*., citing P. Ex. 1, at 15.

A June 17, 2014 nursing note, entered at 1:38 p.m. on that date, states that R. 13 complained of pain in her right knee and leg and had pitting edema that signified moderate swelling. *Id*., citing CMS Ex. 3, at 30. The nurse notified R. 13's physician and her grandson, and arranged for x-rays and a dopplar vein study. *Id.*, citing CMS Ex. 3, at 4, 11, 30; P. Ex. 1, at 7. The x-rays showed a tibial compression fracture of the right knee (i.e. a break in the bone that disrupts osseous tissue and collapses the affected bone). *Id*., citing CMS Ex. 3, at 14; CMS Ex. 7, at 5. R. 13's physician referred her to an orthopedist. *Id*., citing CMS Ex. 3, at 11. A June 19 nursing note described moderate swelling and bruising to the right knee and complaints of pain by R. 13 when she was turned and repositioned. *Id*., citing CMS Ex. 3, at 30; P. Ex. 1, at 7. Fireside's resident incident worksheets did not mention R. 13's fracture. *Id*., citing CMS Ex. 3, at 17-19. Fireside did not report the fracture or investigate its origins. *Id*., citing CMS Ex. 8 (LeBlanc declaration (Decl.), ¶ 3). Fireside's designated "abuse coordinator" – the facility's Assistant Administrator – told surveyors she had not investigated because no one reported the injury to her. *Id*., citing CMS Ex. 5, at 4; CMS Ex. 6, at 1; CMS Ex. 8, at 4.

Facts regarding R. 2

R. 2, admitted to Fireside on November 5, 2011, was an 84-year-old woman who suffered from Alzheimer's disease, hypertension, arthritis, osteoporosis, depression and cataracts. ALJ Decision at 9, citing CMS Ex. 4, at 1, 8, 22-23; CMS Ex. 9, at 2 (Declaration of surveyor Sheila Hooks, R.N. (registered nurse); hereafter "Hooks Decl."). The resident also was incontinent of bowel and bladder, severely cognitively impaired and dependent on staff for all activities of daily living. *Id*., citing CMS Ex. 4, at 12, 15-16, 19, 20-21; CMS Ex. 9, at 2, 3 (Hooks Decl.). On December 18, 2013, Fireside assessed R. 2 as

being at mild risk of developing pressure ulcers, and on March 17, 2014, reassessed her as high risk. *Id*., citing CMS Ex. 9, at 3 (Hooks Decl.). A care plan entry on July 8, 2014 documented a stage 2 pressure ulcer on R. 2's left buttock. *Id*., citing CMS Ex. 4, at 51; CMS Ex. 4, at 29-30; CMS Ex. 9, at 3 (Hooks Decl.).[4] Care plan entries for July 28 and August 13, 2014 do not include any assessment or staging information. *Id*., citing CMS Ex. 4, at 51. A skin assessment flow sheet for July 8, 2014 (the same day the pressure sore was documented as a stage 2 on R. 2's care plan) as well as flow sheets for July 17 and 23, however, document a stage 1 pressure sore with granulation. *Id*., citing CMS Ex. 4, at 49; CMS Ex. 9, at 3 (Hooks Decl.); *see also* CMS Ex. 4, at 48 (showing code G as "granulation"). Flow sheet entries for August 7 and 13, 2014 show no staging information. *Id*., citing CMS Ex. 4, at 49. The August 7, 2014 flow sheet indicates an apparent decline in the width of the pressure sore – from 1.5 cm. to 1.0 cm. – but the August 13, 2014 flow sheet showed "the wound width [to be] greater than it had ever been, going from 1.0 cm to 4 cm." *Id*., citing CMS Ex. 4, at 49; CMS Ex. 7, at 29; CMS Ex. 9, at 3 (Hooks Decl.). Otherwise, "[e]ach entry [on the flow sheets] is virtually identical," and the flow sheets do not reflect the deterioration of the pressure ulcer. *Id*., citing CMS Ex. 7, at 29; CMS Ex. 9, at 3 (Hooks Decl.).

An August 13, 2014 physician order for R. 2 instructed Fireside staff "to cleanse the left inner buttock with wound cleaner, pat dry, pack the wound bed with Therahoney sheet (a moist medium that helps remove dead tissue), cover the wound with Maxorb (an absorbent wound dressing), and secure with Exuderm sacrum dressing every two days and as needed." *Id*., citing CMS Ex. 4, at 50; CMS Ex. 4, at 51; CMS Ex. 9, at 3 (Hooks Decl.) (internal quotation marks omitted).

On August 19, 2014, Surveyor Hooks observed a licensed vocational nurse (LVN) treat R. 2's pressure sore, and the sore was not susceptible of staging due to the wound being obscured by yellow slough, which is dead tissue in the process of separating from viable tissue. *Id.*, citing CMS Ex. 9, at 3-4 (Hooks Decl.). Surveyor Hooks described the wound as follows: "The pressure ulcer had yellow slough . . . inside the wound bed and the edges had a dried appearance. The center of the pressure ulcer bed had a black discoloration. The right side of the wound bed had a dried-brown discoloration." *Id*., citing CMS Ex. 9, at 4 (internal quotation marks omitted). Surveyor Hooks described the treatment provided by the LVN. The LVN measured the length and width of the wound (4 cm. x 4 cm.) but not its depth. She then folded a Therahoney sheet into a small square and applied it to the bed of the pressure ulcer, but "'the wound bed sank, and the outer edges of the bed separated around the pressure ulcer.'" ALJ Decision at 10, citing CMS Ex. 9, at 4 (Hooks Decl.). The LVN, according to the surveyor, "*did not* pack the wound,

[4] The exhibits, briefs and ALJ Decision sometimes use the term "pressure ulcer" instead of or interchangeably with the term "pressure sore." The terms mean the same thing. In our discussion, we use the term "pressure sore" since that is the term used in the regulation.

which left an empty space." *Id*. The LVN "covered the wound with Maxorb and applied Optifoam Adhesive dressing (another highly absorbent dressing)." *Id*. The surveyor explained that the LVN's not packing the wound with a Therahoney sheet so that it eliminated the empty space was a failure to follow the physician order. *Id*. When questioned by the surveyor, the LVN admitted to not assessing the wound for "undermining" or "tunneling" but claimed those are measurements made by hospice. *Id*.

The surveyor also reviewed Fireside's July 15, 2014 nutritional assessment of R. 2 and found no treatment recommendation for the pressure ulcer or even a mention of the ulcer. *Id*. Although the assessment occurred a week after the pressure ulcer nursing notes reported the ulcer, the assessment marked R. 2's "'Decubiti/Skin Condition' as 'clear.'" *Id*., quoting CMS Ex. 4, at 53.

The ALJ proceeding

The parties filed initial briefs and proposed exhibits. CMS submitted 11 exhibits, and Fireside submitted six exhibits. ALJ Decision at 3-4. CMS thereafter filed a motion for summary judgment, and Fireside filed a brief opposing the motion. *Id*. at 4. The ALJ granted CMS's motion after finding the above-stated facts undisputed and concluding that those undisputed facts demonstrated Fireside's failure to comply with the abuse and neglect prevention requirements in section 483.13(c); the requirements in section 483.25(c) regarding treatment of pressure sores; and the requirements in section 483.75 addressing facility administration. *Id*. at 1, 5, 8, 10. The ALJ then upheld CMS's determination that Fireside's noncompliance with sections 483.13(c) and 483.75 was at the immediate jeopardy level for the period August 20 through 26, 2014, finding that determination not clearly erroneous. *Id*. at 11-12. Finally, the ALJ determined that the amounts of the CMPs were reasonable. *Id*. at 12-13.

**Standard of Review**

We review de novo an ALJ's decision to grant summary judgment. *Southpark Meadows Nursing & Rehab. Ctr*., DAB No. 2703, at 5 (2016) (citations omitted). "Summary judgment is appropriate when the record shows there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law." *Id*. "The applicable substantive law will identify which facts are material, and only disputes over facts that might affect the outcome of the [case] under the governing law will properly preclude the entry of summary judgment." *Id*. (internal quotation marks omitted). In deciding whether there is a genuine dispute of material fact, we "view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor." *Avalon Place Kirbyville*, DAB No. 2569, at 7 (2014) (citations and internal quotation marks omitted).

We also "view the evidence presented through the prism of the substantive evidentiary burden." *Anderson v. Liberty Lobby*, 477 U.S. 247 at 254 (1986). Under the substantive law that applies here, CMS has the initial burden to make a prima facie case. *Evergreen Nursing Care Ctr.*, DAB No. 2069, at 7 (2007). To make a prima facie case, CMS must "com[e] forward with evidence related to disputed findings that is sufficient (together with any undisputed findings and relevant legal authority) … to support a decision in its favor absent an effective rebuttal." *Id*. Once CMS has made a prima facie showing of noncompliance, however, "the SNF must carry its ultimate burden of persuasion by showing, by a preponderance of the evidence, on the record as a whole, that it was in substantial compliance during the relevant period." *Id*.

Hence, in deciding whether a SNF has defeated an adequately supported motion for summary judgment – a motion that identifies facts sufficient to make out a prima facie case – we consider whether a rational trier of fact, viewing the entire record in the light most favorable to the SNF, and drawing all reasonable inferences in its favor, could find its presentation sufficient to carry its burden of persuasion (to show substantial compliance). *Dumas Nursing & Rehab., L.P.*, DAB No. 2347, at 5 (2010) (stating that, on summary judgment, "it is appropriate for the tribunal to consider whether a rational trier of fact could regard the parties' presentations as sufficient to meet their evidentiary burdens under the relevant substantive law"). Where the evaluation of credibility or weighing of competing evidence is required to decide whether the SNF has demonstrated substantial compliance, however, summary judgment is not appropriate. *See, e.g.*, *Kingsville Nursing & Rehab. Ctr.*, DAB No. 2234, at 8-9 (2009); *Madison Health Care, Inc.*, DAB No. 1927, at 6 (2004).

**Discussion**

A. <u>The ALJ properly concluded that undisputed facts establish Fireside's noncompliance with sections 483.13(c), 483.25(c) and 483.75.</u>

On appeal, Fireside does not raise any dispute about the facts set out in the Background section above, all of which the ALJ found undisputed. However, Fireside disputes the ALJ's conclusions that those undisputed facts establish its noncompliance with sections 483.13(c), 483.25(c) and 483.75. RR at 4-5. Fireside argues that the ALJ "overlook[ed] significant facts in the evidence on the record, which affect whether or not CMS' evidence of the facility's non-compliance, and especially non-compliance at an immediate jeopardy level is undisputed." *Id*. at 5. As we explain below, we find no merit in Fireside's argument.

1. *The undisputed facts establish that Fireside staff violated section 483.13(c) by not reporting R. 13's fracture or investigating to try to determine its cause.*

Section 483.13(c) requires long-term care facilities like Fireside to "develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents . . . ." Section 483.13(c)(2) and (3) require facilities to "[e]nsure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source . . . are reported immediately to the administrator of the facility and to other officials in accordance with State law. . . and have evidence that all alleged violations are thoroughly investigated . . . ." Fireside developed a written policy addressing abuse and neglect prevention. That policy sets out in detail procedures for reporting and investigating allegations of abuse or neglect, including injuries of unknown source. CMS Ex. 5, at 1-7. The policy directs staff to report such alleged abuse or neglect to Fireside's Assistant Administrator who, in turn, must conduct an investigation consisting of specifically identified steps and report incidents of alleged abuse or neglect to the State. *Id.*; CMS Ex. 8, at 4. Notwithstanding these Federal requirements and Fireside's own policies, it is undisputed that none of the Fireside staff involved in identifying and treating R. 13's knee fracture reported the fracture to the Assistant Administrator who, consequently, neither conducted an investigation to determine the source of the fracture nor reported the injury to the State. Indeed, the Assistant Administrator admitted to the surveyor that she did not receive a report and, therefore, did not investigate. CMS Ex. 6, at 1 ("I can't investigate if I'm not aware of the incident."); CMS Ex. 8, at 4. These undisputed facts establish a clear violation of sections 483.13(c)(2) and (3).

Fireside argues that the fracture was not an injury of unknown origin and, thus, did not need to be reported or its source investigated. Fireside bases this assertion on the fact that R. 13 had osteoporosis and that staff "would have known of this condition without making a formal inquiry" and "likely" reasoned that "the osteoporosis likely facilitated an accidental injury." RR at 8. Fireside's use of the word "likely" (twice) shows that its assertion is sheer speculation as to why staff did not report. Fireside points to no interviews with staff or any other inquiry into why they did not report. In any event, it is well-settled that the regulations do not permit facility staff to not report alleged abuse or neglect – which includes injuries of unknown origin – by pre-judging whether an injury was caused by abuse or neglect. When the source of an injury is unknown, a determination of whether that source is abuse or neglect may only be made after the alleged abuse or neglect is reported and investigated. *See, e.g., Rosewood Care Ctr. of Inverness*, DAB No. 2120, at 8 (2007) ("We have emphasized . . . that the duty to investigate under 42 C.F.R. § 483.13 applies even in cases where facility administrators

have some reason to suspect what the cause of an injury may be."). In *Tri-County Extended Care Ctr.*, DAB No. 1936, at 19-20 (2004), *aff'd*, *Tri-County Extended Care Ctr. v. Leavitt*, 157 F. App'x 885 (6th Cir. 2005), the Board upheld a finding of noncompliance under section 483.13 where the administrator had not investigated the source of a hip fracture because she inferred, as Fireside argues here, that it was a spontaneous fracture attributable to the resident's osteoporosis.

But, even assuming the regulations would allow such pre-determination, as the ALJ noted, there is "no evidence to support Petitioner's suggestion that facility staff considered the issue, determined that the fracture was spontaneous, and decided that it need not be reported. Not one note mentions any such assessment." ALJ Decision at 8.

We reject Fireside's argument that a CMS letter to State Survey Agency Directors clarifying the meaning of "injury of unknown source" supports its assertion that R. 13's knee fracture was not an injury within the meaning of that phrase. RR at 10. The letter states as follows:

> An injury should be classified as an "injury of unknown source" when both of the following conditions are met:
>
> - The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; **and**,
>
> - The injury is suspicious because of the extent of the injury **or** the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.

CMS December 16, 2004 Letter to State Survey Agency Directors, S&C-05-09, at 2; *see also* CMS March 18, 2011 Letter to State Survey Agency Directors, S&C:11-15-ICF/MR (essentially the same clarification for ICF/MR surveys).

Fireside agrees that "the source of [R. 13's] injury was not observed." RR at 10. While Fireside asserts that R. 13 "would verbalize if she had been abused," it presented no evidence to support that assertion (which is significant in light of R. 13's serious cognitive impairment) or that staff even questioned her about the source of the fracture. RR at 9. Fireside argues, however, that the source of the injury "could be explained, and the injury was not suspicious because [R. 13] was known to have osteoporosis and the injury was not one of several serious injuries observed at that particular point in time, or even over time." RR at 10-11.

While it is undisputed that R. 13 had osteoporosis, there is nothing in the record definitively identifying that diagnosed illness as a source of the fracture. Indeed, Fireside's own equivocal statement, quoted earlier, that R. 13's osteoporosis "likely facilitated" the injury is essentially a concession that another source, including possible abuse or neglect, could not be ruled out without reporting and investigating the injury.[5] Fireside states that the resident's attending physician "twice made the definitive statement that Resident No. 13 suffered a spontaneous fracture[,]" RR at 9 (citing "Pet. Ex. 2 at 3, first and last paragraphs"), but that is a mischaracterization of the physician's testimony. In the first paragraph on page 3 of the cited exhibit, the physician stated as follows:

> Resident No. 13 sustained a right tibial fracture in the absence of any known external event or force. She was at risk for a spontaneous fracture as was documented in her June 2012 Care Plan which identified the Resident's diagnosis of osteoporosis and her risk of "spontaneous fractures/falls," as well as her history of degenerative joint disease for which the [sic] she was prescribed Fosamax and subsequently Oscal D for calcium supplementation.

In the third paragraph on page 3 of the same exhibit, the physician stated as follows:

> Based upon my education and experience and of my knowledge of her medical condition, I believe Resident No. 13's fracture to be totally consistent with a spontaneous fracture without any medical evidence of improper care or force.

Contrary to what Petitioner argues, neither statement by R. 13's physician is a "definitive statement that Resident No. 13 suffered a spontaneous fracture." RR at 9. The physician's first statement actually concedes there was no "known external event or force," and while the physician then proceeded to discuss the resident's risk for spontaneous fracture, he stated no opinion that that is what occurred. The physician's second statement is simply an opinion that spontaneous fracture was one of multiple possible explanations for R. 13's injury, as the ALJ essentially concluded. *See* ALJ Decision at 7 (citing P. Ex. 2, at 3 as "attending physician opining that, in the absence of evidence of improper care or force, R13 *could* have sustained a spontaneous fracture") (emphasis in ALJ Decision). Although Fireside objects to that reading of the physician's testimony, it is an accurate reading based on the plain language of the testimony. The

[5] We note that although Fireside made this same argument below, it also stated, inconsistent with that argument, that "Resident No. 13 sustained a right tibial fracture of unknown origin on June 17, 2014." Petitioner's Response to Respondent's Motion for Summary Judgment at 15, (emphasis added).

ALJ also noted that in its brief Fireside quoted research suggesting that osteoporosis is not a likely cause of a spontaneous fracture of the knee, as opposed, for example, to the hip. *See* ALJ Decision at 7, citing P. Br. at 12. Fireside does not discuss that aspect of the ALJ Decision or repeat here the research quotations it made before the ALJ.

In any event, as the ALJ concluded, the issue is Fireside's failure to investigate the source of the fracture, not the source itself.

> But the question is not whether [R. 13], in fact, suffered a spontaneous fracture (which we will never know because the facility did not investigate her injury). The question is whether facility staff followed the regulations and the facility's own policies requiring them to report and investigate this very serious injury of unknown source. Her injuries could have been caused by an unreported fall (for which she was at risk) or by her knee hitting something as she was wheeled around a corner; it could have been caused by rough handling; or, as Petitioner speculates, it might have been caused by a "routine transfer." P. Br. at 11. Given her age and fragility, "routine" handling might not have been sufficient to keep her safe. If so, her care plan could have included instructions to staff to exercise extra care in handling her.

ALJ Decision at 7.

With respect to its noncompliance with section 483.13(c) (failure to implement its abuse and neglect policy), Fireside argues that the ALJ improperly concluded that its failure to report or investigate R. 13's fracture showed a "systemic problem in implementing policies and procedures." RR at 11, citing ALJ Decision at 7, 8. Fireside, in essence, reiterates here its argument before the ALJ that since CMS cited no additional failures to report or investigate alleged abuse or neglect, CMS could not reasonably view Fireside's failure to report and investigate R.13's fracture as a policy implementation failure. The ALJ rejected this argument, citing Board decisions emphasizing that the focus of the federal regulation "is not simply on the number or nature of the instances of neglect (i.e., failure to provide necessary care or services) but on whether the facts . . . surrounding such instance(s) demonstrate an underlying breakdown in the facility's implementation of the provisions of an anti-neglect policy." ALJ Decision at 7, citing, *e.g*., *Oceanside Nursing & Rehab Ctr.*, DAB No. 2382, at 11 (2011) (internal quotations and other case citations omitted). The ALJ concluded that the circumstances surrounding staff failure to report and investigate R. 13's injury of unknown origin evidenced a systemic problem with implementing the facility's policy.

> Here, multiple staff at all levels must have known about R13's serious injury. Yet, it seems that no staff member considered reporting or investigating the incident. This establishes that the facility had a systemic problem in implementing its policies and procedures.

ALJ Decision at 8. Fireside's response on appeal is, "Whether or not anything was documented, staff considered the possible cause of the injury and decided it was not reportable." RR at 10. Fireside cites the Assistant Administrator's statement to the surveyor: "[Staff] didn't report it to [her] because they didn't feel like they needed to report it." *Id*., citing CMS Ex. 7, at 7. However, as the ALJ found, there is "no evidence to support [Fireside's] suggestion that facility staff considered the issue, determined that the fracture was spontaneous, and decided that it need not be reported." ALJ Decision at 8. We also note the Assistant Administrator's statement to the surveyor that she and the Director of Nursing "did not investigate unless they suspected abuse." CMS Ex. 7, at 22. This provides further evidence of a systemic problem or breakdown in Fireside's policy because, as previously discussed, the federal regulation, which Fireside's policy reflects, requires reporting and investigation of all allegations of abuse (including injuries of unknown origin); facilities cannot avoid reporting and investigation based on speculation about causation.

We thus conclude that the undisputed facts of record support the ALJ's conclusion that Fireside was not in substantial compliance with section 483.13(c) and (c)(2) and (3).

2. *The undisputed facts show that Fireside failed to provide necessary treatment and services for R. 2's pressure sore.*

Section 483.25(c)(2) requires facilities to ensure that "[a] resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing." The ALJ concluded Fireside did not substantially comply with this requirement because its staff did not consistently and completely document its treatment of R. 2's pressure sore; an LVN in Fireside's employ did not follow the physician order for treating the pressure sore; and Fireside staff ignored the pressure sore when assessing R. 2's nutritional needs. ALJ Decision at 9-10. The ALJ found this conclusion supported by the undisputed facts of record (summarized in the background section of our decision), noting that "Petitioner tendered no evidence suggesting a dispute concerning any of these facts." *Id*. at 10. Fireside objects that it "was not able to present evidence to the contrary, mainly because CMS presented its CMS Exhibit 4, containing Resident No. 2's medical records, and CMS Exhibit 7, the survey [SOD]" and the ALJ's order directed Petitioner not to file duplicate exhibits. RR at 12-13. This statement is essentially a concession by Fireside that it has no evidence capable of raising a genuine dispute about CMS's evidence regarding the noncompliance involving R. 2. Significantly, Petitioner also states that it "does not contest that the care of [R. 2's] pressure sore was less than perfect." RR at 13.

Fireside takes exception to a few of the ALJ's findings based on the undisputed facts. The ALJ found that Fireside ignored the pressure sore when assessing R. 2's nutritional needs. ALJ Decision at 10. She based this finding on the fact that the nutritional assessment, which was dated July 15, 2014 (a week after staff identified the pressure sore), "does not even mention a pressure ulcer." *Id*. Petitioner does not dispute that the assessment does not mention the pressure sore but argues that the assessment "was in essence accurate" because "CMS's evidence shows that the wound was initially improving since it was assessed as a Stage I pressure ulcer with granulation." RR at 13, citing CMS Ex. 7, at 29. That is not what CMS's evidence shows. The SOD entry on which Fireside seems to rely refers to a skin assessment flow sheet dated "07/08/14" which indicated the pressure sore was a Stage 1 with granulation. CMS Ex. 7, at 29. However, this entry does not support the statement that the pressure sore "was initially improving" since an entry in R. 2's care plan documented the pressure sore as being at stage 2, and Fireside staff made that entry on the same date the stage 1 entry was reported on the skin assessment.[6] CMS Ex. 4, at 51. Fireside does not address the multiple examples of inconsistencies and incomplete information about the pressure sore appearing in its records, one of the deficiencies cited by the ALJ for her noncompliance conclusion.

Firseside argues it is unreasonable to expect that R. 2's "pressure ulcer would heal in light of her overall declining health," noting that she had been receiving hospice services for about two weeks before staff identified the pressure sore. RR at 14. The issue, however, is not whether the pressure sore could be expected to heal, but, rather, whether Fireside staff was providing the necessary care and services to promote healing. Fireside does not dispute any of the facts on which the ALJ relied for her conclusion that they were not.

Fireside also takes issue with what it characterizes as the surveyor's "insinuation," based on the LVN's statement that hospice measures pressure sore wound depth, "that the facility staff is unwilling to provide proper wound assessment . . . ." *Id.* Fireside also argues that since the surveyor stated that the pressure sore was "unstageable" – meaning all of the wound could not be visualized and, thus, not fully measured – her observation about the LVN's failure to measure the depth is "unreliable as evidence." RR at 14-15. We find no insinuation (in the record or in the ALJ Decision) that staff was "unwilling" to measure the wound depth; the surveyor merely observed that the LVN did not do a depth measurement. With respect to the surveyor's remark about the ulcer not being susceptible of full measurement because not all of the wound could be visualized, the

[6] This page of the SOD also refers to skin assessment flow sheets dated "07/17/14 and 07/23/14" which also referred to the pressure sore as "Stage 1." However, since these flow sheets were completed after the nutritional assessment, they are not relevant to Fireside's argument.

surveyor did not go on to state that no depth measurement at all (or at least an attempt to do it), was possible, and Fireside points to no such evidence. In any event, it is clear from the surveyor's testimony that the LVN's failure to measure the depth was not her primary concern; rather, her primary concern was the LVN's failure to follow the physician order to pack the wound bed properly so that there would be no empty space. CMS Ex. 9, at 4. Fireside says nothing about this concern.

Finally, Fireside states, "With regard to the assessment of the pressure ulcer for undermining or tunneling, what is missing from CMS's evidence is any documentation that the surveyor checked the hospice's records to verify the LVN's statement" that hospice assesses for undermining or tunneling. RR at 15. The hospice evidence was not essential to CMS's prima facie case or the ALJ decision given all of the other evidence related to the multiple flaws in the LVN's treatment of R. 2's pressure sore. Fireside had the burden to rebut that prima facie case and present evidence establishing its compliance. If Fireside believed the hospice evidence important to carrying its burden of persuasion, Fireside should have procured that evidence from hospice and introduced it in the ALJ proceeding.

In summary, we conclude that Fireside has not raised a genuine dispute of material fact precluding the entry of summary judgment that Fireside was not in substantial compliance with section 483.25(c)(2).

*3. The undisputed facts establishing Fireside's noncompliance with section 483.13(c) also establish noncompliance with section 483.75.*

Section 483.75 requires that a long-term care facility be "administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." As the ALJ stated, a finding of noncompliance with this requirement may be derived from findings of noncompliance with other requirements. ALJ Decision at 11, citing *Asbury Ctr. at Johnson City*, DAB No. 1815, at 11 (2002), *aff'd, Asbury Center v. Dep't of Health & Human Servs.*, No. 02-3438 (6th Cir. Oct. 2, 2003); *Odd Fellow & Rebekah Health Care Facility*, DAB No. 1839, at 7 (2002); *Stone Cnty. Nursing & Rehab. Ctr.*, DAB No. 2276, at 15-16 (2009). The ALJ concluded that the undisputed facts supporting noncompliance with section 483.13(c) supported a finding of noncompliance with section 483.75 as well. ALJ Decision at 11. The ALJ cited, in particular, the fact that "facility staff were not aware of (or disregarded) their responsibilities to report to the administration all injuries of unknown origin, which suggests that they were inadequately trained and supervised, for which the facility administration is accountable." *Id.* She also noted that "reporting such incidents to the state agency is an administrative responsibility." *Id*. Fireside makes no specific challenge to either ALJ statement; accordingly, we uphold the ALJ's conclusion that Fireside was noncompliant with section 483.75 without further discussion.

B. The ALJ did not err in concluding that Fireside had not shown CMS's immediate jeopardy determination to be clearly erroneous; however, her conclusion as to the duration of the immediate jeopardy was incorrect by one day since Fireside abated the immediate jeopardy on August 26, 2014.

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. In order to overturn CMS's determination about the "level" (scope and severity) of a SNF's noncompliance, when it is subject to challenge at all (such as when it affects the applicable range of CMP amounts – as it does here), a SNF must show that the determination "is clearly erroneous." *Id*. § 498.60(c)(2); *Crawford Healthcare & Rehab*., DAB No. 2738, at 14-15 (2016). The Board has held that "[t]he 'clearly erroneous' standard means that CMS's immediate jeopardy determination is presumed to be correct, and the burden [on the SNF] of proving the determination clearly erroneous is a heavy one." *Glenoaks Nursing Ctr*., DAB No. 2522, at 16 (2013).

CMS determined that Fireside's failure to report and investigate an injury of unknown origin placed all 80 of its residents, including R. 13, in immediate jeopardy because it was likely to cause further serious harm to R. 13 and to Fireside's residents generally for the period August 20, 2014 through August 26, 2014.[7] The ALJ, applying the correct "clearly erroneous standard of review," upheld CMS's determination. The ALJ stated,

[7] CMS first notified Fireside of the noncompliance and immediate jeopardy determinations and imposition of CMPs in a letter dated September 24, 2014 which stated that the immediate jeopardy began June 17, 2014 (the date Fireside identified R. 13's injury) and continued through August 26, 2014 (the date the survey was completed) and that CMS was imposing a CMP of $7,550 per day for the immediate jeopardy period and $950 per day "beginning August 27, 2014, and continuing until further notice." CMS Ex. 2, at 6. In an October 9, 2014 letter, CMS revised the immediate jeopardy period to August 20 through August 26, 2014 and the amount of the immediate jeopardy CMP to $6,150 per day; that letter also revised the amount of the CMP imposed for the remaining period of noncompliance (beginning August 27, 2014 and continuing until the facility achieved substantial compliance) to $800 per day. CMS Ex. 2, at 3. In a November 20, 2014 letter, CMS notified Fireside that the facility had achieved substantial compliance on September 26, 2014; reiterated that the immediate jeopardy period (and the previously revised $6,150 per day CMP for that period) were in effect from August 20, 2014 through August 26, 2014; stated that the amount of the CMP for the non-immediate jeopardy period remained at $800 per day and was in effect from August 27 through September 25, 2014; and advised that CMS had rescinded the previously imposed remedies of termination and denial of payment for new Medicare and Medicaid admissions. *Id*. at 1.

> Disregarding the possible cause of [R. 13's] injury meant that the facility did not know how to prevent its recurrence, which put [R. 13] at ongoing risk of another serious injury. Moreover, that management and staff did not know how to respond to an unexplained injury (or opted not to respond) leaves residents unprotected from potential abuse or neglect, a dangerous situation for frail and vulnerable residents.

ALJ Decision at 12, citing *Rosewood Care Ctr. [of] Swansea*, DAB No. 2721, at 12-13 (2016), *appeal pending*, citing *Rosewood Care Ctr. of Swansea*, DAB CR4408, at 8 (2015).[8]

On appeal, Fireside does not argue that CMS's immediate jeopardy determination was clearly erroneous and that the ALJ, therefore, erred in concluding otherwise. Fireside questions, however, how CMS could find noncompliance at the immediate jeopardy level based on the facility's failure to report and investigate an injury of unknown origin that occurred approximately two months before the survey where the surveyors made the observations that identified the noncompliance. Fireside states that "[t]he [SOD] fails to recite a single ***ongoing*** failure of the facility to protect its residents that would give rise to an ***immediate jeopardy*** situation occurring ***at the time of the survey***." RR at 6 (emphasis in original). Fireside's question ignores the fact that the regulations permit CMS to "impose a [CMP] for the number of days of past noncompliance since the last standard survey, including the number of days of immediate jeopardy." 42 C.F.R. § 488.430(b); *see also* 42 C.F.R. § 488.440(a)(1) (a per-day CMP "may start accruing as early as the date that the facility was first out of compliance, as determined by CMS or the State"). Based on this authority, CMS could have decided that the immediate jeopardy began on June 17, 2014 (the date Fireside discovered but did not report or investigate R. 13's fracture), as CMS initially proposed to do. *See* n.7, *supra*. However, CMS was authorized to determine (and ultimately did determine) that the immediate jeopardy began on August 20, 2014 during the survey in which the surveyors identified it following policy and record review, observations and interviews with facility staff. *Id.*; *see also* CMS Ex. 7, at 18 (SOD statement that "[a]n IJ was identified on 08/20/14."); *Deltona Health Care*, DAB No. 2511, at 21 (2013)("CMS could have determined that Deltona was first out of compliance on June 26, 2010 [but] had discretion . . . to choose a later effective date."). *Regency Gardens Nursing Ctr*., DAB No. 1858, at 10 (2002)("From the provision that remedies may be imposed as early as the first day of noncompliance, it follows that CMS may choose to begin any remedy at a later date.") (emphasis in original).[9]

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[8] In the ALJ Decision, the citation to the ALJ Decision in *Rosewood* states the year of that decision as 2005, but the correct year is 2015.

[9] While it makes no difference to our decision, we also note that CMS's revised determination benefitted Fireside by significantly reducing the amount of the CMP.

Fireside also challenges CMS's citation of the immediate jeopardy as "widespread" in scope, arguing that "[t]he lack of additional incidences demonstrating the facility's alleged lack of policy implementation shows that the issue was an isolated incident and not a widespread failure." RR at 7. CMS's determination of the scope of the immediate jeopardy is not relevant to determining whether the immediate jeopardy determination is clearly erroneous. To the extent that an immediate jeopardy determination is subject to review at all (and it is here) that determination can be overturned only if the determination that the noncompliance was serious enough to pose immediate jeopardy to resident health or safety is found clearly erroneous, regardless of whether that noncompliance was isolated, a pattern or widespread. CMS's determination, upheld by the ALJ, that Fireside's failure to report and investigate R. 13's fracture posed an ongoing threat of serious harm to her would have been sufficient to cite the noncompliance with section 483.13(c) at the immediate jeopardy level, and Fireside has not raised a genuine challenge to the factual basis for that determination, much less shown it to be clearly erroneous. Furthermore, as we discussed above, the ALJ concluded that the circumstances surrounding staff failure to report or investigate R. 13's fracture – a failure that reached management levels – not only caused actual serious harm to R. 13 but showed a policy implementation failure that put all of Fireside's vulnerable residents in danger.

Based on the foregoing, we conclude that the ALJ did not err in upholding CMS's determination that Fireside's noncompliance posed immediate jeopardy to the facility's residents for a period of time beginning August 20, 2014. Fireside has not challenged CMS's or the ALJ's determination that the immediate jeopardy period continued through August 26, 2014. However, as a matter of law, we find it necessary to modify that determination because the SOD shows that "[t]he [immediate jeopardy] was removed on 08/26/14."[10] CMS Ex. 7, at 16. Since Fireside abated the immediate jeopardy on August 26, 2014, the immediate jeopardy period continued through August 25, 2014, even though Fireside's noncompliance at a less than immediate jeopardy level continued on August 26 and through September 25, 2014. *See* 42 C.F.R. § 488.454(a)(1) (stating that remedies, with exceptions not relevant here, continue "until . . . [t]he facility has achieved substantial compliance, as determined by CMS or the State . . . ."); *Golden Living Ctr. – Riverchase*, DAB No. 2314, at 22 (2010) (reinstating immediate jeopardy level CMP "for the period February 17, 2007 … through March 2, 2007, the day before the immediate jeopardy was abated") (emphasis added), *aff'd Golden Living Center-Riverchase v. U.S. Dep't of Health & Human Servs.*, 429 F. App'x 895 (11th Cir. 2011); *Cf. Texan Nursing & Rehab. of Amarillo, LLC*, DAB No. 2323, at 25-26 (2010) (directing

[10] Although CMS's notice letters state that the immediate jeopardy period continued through August 26, 2014, there is no indication in the record that CMS made a determination that the immediate jeopardy was abated on August 27, 2014 rather than on August 26, 2014 as stated on the SOD.

ALJ to clarify on remand his statement that the denial of payment for new admissions (DPNA) "was in effect from April 5 through July 16, 2007, [which] implies that Texan was found in substantial compliance the day after July 16, 2007, or July 17, 2007, not July 16, 2007") (emphasis in Board decision); *Chicago Ridge Nursing Center*, DAB No. 2151, at 27 (2008) (modifying ALJ finding that DPNA continued "*until* February 24, 2005 . . . to make it clear that because Chicago Ridge was found to be back in substantial compliance on February 24, 2005, no DPNA may be imposed for that date.") (emphasis in Board decision).

Based on the foregoing modification, we must also reduce the total CMP imposed for the immediate jeopardy period by $6,150, the per-day amount imposed for the immediate jeopardy, so that the total CMP for the immediate jeopardy period is now $36,900 ($6,150 per day for 6 days). We must also add one day (August 26, 2014) at the lower level per-day CMP amount ($800) to the total CMP for the period of continuing noncompliance at less that the immediate jeopardy level, making that total $24,800 ($800 per day for 31 days). Accordingly, the total CMP, as revised by our modifications, is $61,700, rather than $67,050 as stated by the ALJ.

C. Fireside has not demonstrated that the amounts of the CMPs are unreasonable.

CMS may impose a per-day CMP for "the number of days a [SNF] is not in substantial compliance with one or more participation requirements . . . ." 42 C.F.R. § 488.430(a). When it imposes that remedy for noncompliance at the immediate jeopardy level, CMS sets the daily penalty amount within the "upper range" of $3,050 to $10,000. *Id.* §§ 488.408(d)(3)(ii), 488.438(a)(1)(i). When CMS imposes a CMP for noncompliance below the immediate jeopardy level, it sets the daily penalty within the "lower range" of $50 to $3,000. *Id.* §§ 488.408(d)(1)(iii),488.438(a)(1)(ii). A SNF may challenge the reasonableness of the amount of any CMP imposed. *Golden Living Ctr. – Superior*, DAB No. 2768, at 26 (2017), citing *Lutheran Home at Trinity Oaks*, DAB No. 2111, at 21 (2007). An ALJ reviews the amount of the CMP de novo based on the evidence in the record. *Pearsall Nursing and Rehab. Ctr. – North*, DAB No. 2692, at 10 (2016). In reviewing the reasonableness of CMP amounts, an ALJ and the Board may not reduce the daily amount below the applicable range. *Crawford*, DAB No. 2738, at 18-19. The administrative law judge and the Board may consider only the factors specified in 42 C.F.R. § 488.438(f). *See* 42 C.F.R. § 488.438(e)(3); *Golden Living Center – Superior*, DAB No. 2768, at 26.

There is also a presumption that "CMS considered the regulatory factors in choosing a CMP amount and that those factors support the penalty imposed." *Crawford*, DAB No. 2738, at 19 (citing decisions). "Accordingly, the burden is not on CMS to present evidence bearing on each regulatory factor, but on the SNF 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*., citing *Oaks of Mid-City Nursing & Rehab. Ctr.*, DAB No. 2375, at 26-27 (2011) (internal quotation marks omitted); *see also Brian Ctr. Health & Rehab. – Goldsboro*, DAB No. 2336, at 12 (2010) ("[T]he burden is on the [facility] to demonstrate, through argument and the submission of evidence addressing the regulatory factors, that a reduction is necessary to make the CMP amount reasonable.").

Here, CMS imposed a $6,150 per day CMP for the period of immediate jeopardy (August 20-26, 2014) and a CMP of $800 per day for the remaining period of noncompliance at less than an immediate jeopardy level (August 27 through September 25, 2014). The ALJ found those amounts reasonable based on the regulatory factors relying, in part, on the facility's culpability for the immediate jeopardy level noncompliance (which existed under two regulations – sections 483.13(c) and 483.75) and the less than immediate jeopardy noncompliance under sections 483.25(c). The ALJ stated –

> Applying the remaining factors, I find that the facility's administration and multiple staff members disregarded facility policies when they failed to report or investigate [R. 13's] serious injury, for which the facility is culpable. In addressing [R. 2's] pressure sore, nursing staff did not follow her physician's orders, and its dietary staff either did not know or disregarded her serious skin condition. These are serious omissions for which the facility is also culpable.

ALJ Decision at 13. As we noted earlier, the ALJ found that Fireside's disregard of its policies, and federal law, requiring staff to report and investigate injuries of unknown source created a dangerous situation for all of its frail and vulnerable residents. *See id.* at 12.

Fireside does not challenge the ALJ's consideration of the seriousness or culpability factors. Fireside's only argument has to do with how the ALJ addressed the financial condition factor in 42 C.F.R. § 488.438(f)(2). Fireside contends summary judgment was improper because, Fireside maintains, there are disputed facts related to its financial condition. Fireside cites a declaration it submitted during the ALJ proceeding to address its financial condition. RR at 18,

citing CMS Pet. Ex. 3 (Decl. of Michael McGrath). Fireside argues that a hearing is necessary for the ALJ to review and weigh that evidence because "[i]t would have been difficult for CMS to consider the facility's financial condition when CMS had not yet received the information by the time it rendered its decision regarding the reasonableness of the amount of the imposed monetary penalty." *Id.*

This argument has no merit because it ignores the Board's holding "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." *Pearsall*, DAB No. 2692, at 11, citing *Pinecrest Nursing & Rehab. Ctr.*, DAB No. 2446, at 23 (2012) (internal quotation marks omitted). Fireside cannot rebut that presumption by citing a declaration it could have submitted, but did not submit, to CMS when CMS gave Fireside an opportunity to submit evidence on its financial condition prior to deciding the amount of the CMP. *See* CMS Ex. 2, at 6. Moreover, it is settled law that ALJ review of the reasonableness of CMP amounts imposed by CMS is *de novo*. Thus, whether CMS considered the declaration is irrelevant since the ALJ did consider it.

The ALJ discussed the declaration at some length. ALJ Decision at 13. Fireside seems to insinuate, without actually stating it, that summary judgment was improper because in deciding for CMS, the ALJ weighed the declaration against other financial evidence or declined to draw inferences favorable to Fireside. *See* RR at 19 ("Weighing the evidence presented, and drawing inferences from the facts is a matter for hearing on the merits, or for a decision on written submissions, but not for a Summary Judgment proceeding."). The record does not support that insinuation. In her discussion of the declaration, the ALJ credited the declarant's assertions that Fireside "has already lost a significant amount of money and paying the penalties imposed will cost it even more" and that "[e]ven though CMS ultimately did not deny payments for new admissions . . . the threat alone caused [Fireside] to lose admissions over a two to three month period, and, because of this and other factors, its patient census is low." ALJ Decision at 13, citing McGrath Decl. ¶¶ 6, 7, 8.[11] The ALJ also credited Fireside's assertion that it "does not have cash on hand to pay the penalties." *Id.* However, the ALJ noted that notwithstanding those assertions, Fireside, through the same declarant, "also concedes that it has been able to secure financing and (except for the fall-out from the survey findings) is generally on a secure footing financially." *Id.*, citing McGrath Decl. ¶ 6. In short, the ALJ's discussion indicates to us that while she accepted the facts as presented in the declaration, she concluded that those facts

[11] The McGrath declaration is P. Ex. 3.

did not meet Fireside's burden to show that the CMP would put it out of business or compromise resident health or safety, the test for finding a CMP unreasonable based on financial condition articulated in Board decisions. *Id*., citing *Van Duyn Home & Hosp.*, DAB No. 2368 (2011); *Gilman Care Ctr*., DAB No. 2357 (2010). As the ALJ put it, "Petitioner has not shown, nor even alleged, that paying the penalty would cause it to go out of business." ALJ Decision at 13. Fireside itself concedes that the ALJ applied the correct standard. *See* RR at 16-17 (citing *Gilman* and other Board decisions holding that the appropriate inquiry is whether the facility's assets are adequate to pay the CMP without going out of business or compromising resident health or safety). Fireside's statement before us that "[t]he CMP will not be paid from profit or surplus funds, but from funds supporting the operation of the building[]" falls far short of meeting the standard for considering a reduction of CMP amounts based on financial condition. RR at 17. Accordingly, we conclude, as did the ALJ, that Fireside has not shown the per-day CMP amounts to be unreasonable, and we uphold those amounts.

**Conclusion**

For the reasons stated above, we uphold the ALJ Decision except that we modify the period of immediate jeopardy so that it began August 20, 2014 and continued through August 25, 2014 and the period of continuing noncompliance at less than the immediate jeopardy level so that it began August 26, 2014 and continued through September 25, 2014 and, in addition, modify the CMP amounts consistent with this modification. The CMP for the immediate jeopardy period, as modified, is $36,900 ($6,150 per day for 6 days), and the CMP for the non-immediate jeopardy period of noncompliance, as modified, is $24,800 ($800 per day for 31 days). The total CMP, as revised by our modifications, is $61,700.

/s/
Constance B. Tobias

/s/
Susan S. Yim

/s/
Sheila Ann Hegy
Presiding Board Member