Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of: Burton Health Care Center, Petitioner, - v. - Centers for Medicare & Medicaid Services.	DATE: October 25, 2006 Civil Remedies CR1330 App. Div. Docket No. A-06-3 Decision No. 2051

FINAL DECISION ON REVIEW OF
ADMINISTRATIVE LAW JUDGE DECISION

Both parties appealed the August 3, 2005 decision of Administrative Law Judge (ALJ) Keith W. Sickendick in Burton Health Care Center, DAB CR1330 (ALJ Decision). The ALJ concluded that only one of two incidents on which the Centers for Medicare & Medicaid Services (CMS) relied in finding that Burton Health Care Center (Burton) was not in substantial compliance with the Medicare participation requirement at 42 C.F.R. § 483.25(h)(2) involved a violation of this section. The ALJ also concluded that the $2,800 per instance civil money penalty (CMP) that CMS had proposed to impose for Burton's noncompliance with section 483.25(h)(2) was not reasonable and reduced the CMP to $1,400.

For the reasons explained below, we uphold the ALJ's conclusion regarding the basis for a finding of noncompliance under section 483.25(h)(2) but reverse his conclusion that the $2,800 per instance CMP was not reasonable and reinstate the CMP in this amount.

Background

Burton is a skilled nursing facility (SNF) in Ohio certified to participate in the Medicare and Medicaid programs. The Ohio Department of Health conducted a standard survey at Burton in February 2002 which found that Burton was not in substantial compliance with several participation requirements. An April 2002 revisit survey found Burton in substantial compliance with all participation requirements. CMS notified Burton that it was therefore rescinding certain remedies it had proposed; however, CMS stated that it was imposing a per instance CMP of $2,800 for a deficiency identified in the Statement of Deficiencies under Tag F324, which corresponds to the participation requirement at 42 C.F.R. § 483.25(h)(2). ALJ Decision at 1-2; CMS Ex. 1, at 6-10.

Burton requested review by an ALJ pursuant to 42 C.F.R. § 488.408(g). A hearing was held on April 10, 2003. The ALJ admitted 26 exhibits offered by CMS (including parts of three exhibits to which Burton objected) and one exhibit offered by Burton. Tr. at 12-14.

The ALJ Decision includes fifteen findings of fact and six conclusions of law. Burton takes exception to Findings of Fact 10, 11, 12, 13, 14.a-c, and 15.a-g as well as to Conclusions of Law 3, 4, 5, and 6. CMS takes exception to Conclusions of Law 2 and 6. The disputed Findings of Fact are as follows:

> 10. Resident 36 had a history of falls from attempting to get up out of his wheelchair and walking.
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> 11. Resident 36 was restless, easily distracted, frequently confused, and was not able to balance while standing without physical help.
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> 12. Resident 36's care plan indicated that he should be reminded to call for assistance before trying to ambulate or transfer.
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> 13. Resident 36 needed a one to two person assist for toileting and transfers.
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> 14. On December 12, 2001, Resident 36 was in the bathroom with a nurse aide.
>
> > a. The nurse aide, while in the bathroom, turned away momentarily to get a button brief.

b. Resident 36, attempted to transfer himself from the toilet to his wheelchair, and fell.

c. Resident 36 suffered an abrasion to his head and left hip due to the fall.

15. On January 5, 2002, Resident 36 was placed in the bathroom by a nurse aide.

a. The nurse aide opened the front of Resident 36's pants and handed him a urinal.

b. The nurse aide did not assist Resident 36 with transferring from his wheelchair to the toilet, but left him in his wheelchair with his pummel cushion (a saddle shaped device for position in a wheelchair) in place.

c. The nurse aide left Resident 36 unattended in the bathroom.

d. Resident 36's care plan required that he have a non-release waist restraint in place while up in his wheel chair.

e. Although Resident 36's non-release waist restraint was in place while he was in the wheelchair in the bathroom, it was not secured on one side.

f. Resident 36 attempted to transfer himself from his wheelchair to the toilet without assistance and fell.

g. Resident 36 suffered lacerations to his head and the bridge of his nose when he fell.

ALJ Decision at 3-4 (citations omitted).

The disputed Conclusions of Law are as follows:

2. Petitioner did not violate the requirement of 42 C.F.R. § 483.25(h)(2) to provide Resident 36 assistance devices and supervision to prevent accidents on December 12, 2001, and CMS may not impose a CMP for the incident on that date.

> 3. There is *prima facie* evidence that Petitioner violated 42 C.F.R. § 483.25(h)(2) by not providing adequate assistance devices and supervision to prevent Resident 36 from falling on January 5, 2002, *i.e.*, Resident 36's non-release waist restraint was not applied properly because it was not secured on one side and Resident 36 was left unsupervised in the bathroom.
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> 4. On January 5, 2002, Resident 36 suffered injuries due to his fall that were actual harm within the meaning of the regulations.
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> 5. Petitioner has failed to rebut the CMS *prima facie* showing of a violation of 42 C.F.R. § 483.25(h)(2) on January 5, 2002, either by showing it was in substantial compliance or by an affirmative defense.
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> 6. A per instance CMP of $2,800 is not reasonable, but a CMP of $1,400 is reasonable.

ALJ Decision at 4-5 (citations omitted).[1]

Legal Background

SNFs participating in the Medicare program are subject to survey and enforcement procedures set out in 42 C.F.R. Part 488, subpart E, to determine if they are in substantial compliance with applicable program requirements which appear at 42 C.F.R. Part 483, subpart B. "Substantial compliance" means a level of compliance such that "any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. "Noncompliance," in turn,

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[1] The ALJ Decision also notes that Burton had objected to the admission of certain documents in CMS Exhibits 21, 22, and 23 that reflect remedial measures taken by Burton following each of the two incidents in question "on grounds that its remedial measures should not be construed as proof of liability, admission, or culpability." ALJ Decision at 11, n.5. The ALJ stated, however, that he had "not construed any remedial action by Petitioner to be an admission of fault, liability, or culpability." Id. On appeal, Burton renews its objection to the admission of these documents. Since Burton does not dispute that the ALJ limited the use of the documents in this manner or explain why it was prejudiced by the ALJ's admission of the documents, we see no reason to exclude them from the record.

is defined as "any deficiency that causes a facility to not be in substantial compliance." Id.

If a facility is not in substantial compliance with program requirements, CMS has the authority to terminate the facility and/or to impose alternative enforcement remedies. 42 C.F.R. § 488.406. Among the remedies CMS may impose is a CMP for the number of days that the facility is not in substantial compliance with one or more program requirements or for each instance that the facility is not in substantial compliance. 42 C.F.R. § 488.430(a). A per instance CMP may range from $1,000 to $10,000. 42 C.F.R. § 488.438(a)(2). The regulations set out a number of factors to be considered by CMS when determining an appropriate CMP amount. 42 C.F.R. § 488.438(f). These factors are: the facility's history of noncompliance, including repeated deficiencies; the facility's financial condition; the factors listed in section 488.404; and the facility's degree of culpability. The factors listed in section 488.404 include the seriousness (i.e., scope and severity) of the deficiencies and the relationship of one deficiency to other deficiencies resulting in noncompliance. The regulations define "culpability" as including "neglect, indifference, or disregard for resident care, comfort or safety." Section 488.438(f)(4).

The program requirement at issue here, section 483.25(h)(2), provides that "[t]he facility must ensure that . . . [e]ach resident receives adequate supervision and assistance devices to prevent accidents." This is part of the "quality of care" provision at section 483.25, which requires a facility to ensure that each resident receives "the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care."

Standard of Review

Our standard of review on a disputed finding of fact is whether the ALJ decision is supported by substantial evidence on the record as a whole. Our standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. Guidelines for Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs, www.hhs.gov/dab/guidelines/prov.html.

Substantial evidence is "more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Richardson v. Perales, 402 U.S. 389, 401 (1971), quoting Consolidated Edison Co. v. NLRB,

305 U.S. 197, 229 (1938). Under the substantial evidence standard, the reviewer must examine the record as a whole and take into account whatever in the record fairly detracts from the weight of the decision below. Universal Camera Corp. v. NLRB, 340 U.S. 474, 488 (1951). The reviewer does not, however, reweigh the evidence or substitute his or her judgment for that of the initial decision-maker. Casias v. Secretary of Health & Human Services, 933 F.2d 799, 800 (10th Cir. 1991). Thus, the reviewer must not displace a "choice between two fairly conflicting views," even though a different choice could justifiably have been made if the matter had been before the reviewer de novo. Universal Camera, 340 U.S. at 488. The reviewer must, however, set aside the initial conclusions when the reviewer "cannot conscientiously find that the evidence supporting that decision is substantial, when viewed in the light that the record in its entirety furnishes, including the body of evidence opposed to the [initial decision-maker's] view." Id. In addition, the Board has held that an ALJ need not "cite to everything in the record which supports" the ALJ's findings, but that the "evidence that the ALJ does cite must support the findings made." Reconsideration of Wesley Hal Livingston and Shoals Medical Equipment and Supply Co., Inc., DAB No. 1406, at 3 (1993).

Analysis

We note preliminarily that Burton disputes many of the ALJ's findings of fact without explaining why it thinks the evidence cited in the ALJ Decision in support of each disputed finding is not probative or identifying or discussing the evidence it thinks supports its position. The Board has previously held that it "may summarily affirm a factual or legal finding if a party's presentation of an issue regarding that finding is such that the Board cannot discern the legal or factual basis for the party's disagreement with it." See Wisteria Care Center, DAB No. 1892, at 10 (2003). Accordingly, we summarily affirm and adopt Findings of Fact 10, 11, 12, 13, 14.a - 14.c, 15.a-15.b, and 15.d - 15.g We also summarily affirm and adopt the findings of fact and conclusions of law to which neither party excepted.

Below, we first discuss Burton's general legal arguments. Next, we discuss Burton's other arguments regarding the ALJ's conclusion that the January 5, 2002 incident was a basis for finding that Burton was not in substantial compliance with section 483.25(h)(2). We then discuss CMS's arguments regarding the ALJ's conclusion that the December 12, 2001 incident was not a basis for finding Burton out of compliance with that section.

Finally, we discuss the parties' arguments regarding the ALJ's conclusion that a $1,400 per instance CMP is reasonable.

1. The ALJ did not employ an erroneous burden of proof.

The ALJ Decision states that the ALJ advised the parties prior to the hearing that he intended to apply the decisions of the Board in Hillman Rehabilitation Center, DAB No. 1611 (1997), aff'd, Hillman Rehabilitation Ctr. v. United States, No. 98-3789(GEB) (D.N.J. May 13, 1999), and Cross Creek Health Care Center, DAB No. 1665 (1998) "regarding the allocation of the burden of proof." ALJ Decision at 7. In Hillman, the Board held that, before the ALJ, a rehabilitation agency must prove substantial compliance by the preponderance of the evidence, once CMS has established a prima facie case that the agency was not in substantial compliance with relevant statutory or regulatory provisions. In Cross Creek, the Board found that this standard applies in cases involving nursing facilities. The ALJ Decision notes, however, that in Fairfax Nursing Home v. U.S. Dep't of Health and Human Servs., 300 F.3d 835 (7th Cir. 2002), cert. denied, 537 U.S. 1111 (2003) (affirming Fairfax Nursing Home, DAB No. 1794 (2001)), "the Court of Appeals declined to address whether *Hillman* was correct because the evidence in the case was not in equipoise and the allocation of the burden of proof had no bearing on the outcome of the case." ALJ Decision at 8. The ALJ Decision continues:

> The situation here is identical to that in *Fairfax* to the extent that the evidence in this case . . . is clearly not in equipoise. Thus, it is not necessary for me to rely upon any allocation of the burden of persuasion to decide this case . . . . Even if the evidence was in equipoise in this case, Petitioner points to no error in the logic or reasons of the Board in arriving at the allocation of the burden of persuasion in *Hillman* and *Cross Creek* . . . that would cause me to allocate the burden of persuasion in this case differently.

Id. In addition, the caption of the section in which the language just quoted appears states: "1. The evidence in this case is not in equipoise and allocation of the burden of proof has no effect upon the decision." ALJ Decision at 7.

Burton argues that the ALJ employed an erroneous burden of proof and that, contrary to what the ALJ held, the burden of proof is on CMS. According to Burton, the standard in Hillman conflicts with the Administrative Procedure Act (APA) and is also invalid because it is a substantive rule that was not promulgated

pursuant to the notice and comment procedures in the APA. Burton Request for Review (RR) at 3-6.

For the reasons discussed in section 3 of our analysis, we conclude that the evidence regarding the incident on January 5, 2002 is not in equipoise. Thus, as the ALJ indicated, for purposes of this case, it is immaterial where the burden of persuasion lies.

In any event, we reject Burton's contention that placing the ultimate burden of persuasion on the facility to show substantial compliance violates the APA. As the Board has previously stated, the burden of proof that the Board applies is not a rule under the APA but instead is in the nature of an order setting forth a rationale, based on the statute and regulations, that establishes precedent for ALJ hearings in these cases. See, e.g., Batavia Nursing and Convalescent Center, DAB No. 1904 (2004), aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson, No. 04-3325 (6th Cir. Apr. 15, 2005). Furthermore, while this rationale was originally set forth in Hillman, it has not been treated as a binding rule but has been reexamined as appropriate to different types of cases.

Notwithstanding the conclusion in the text of the ALJ Decision that the burden of persuasion is immaterial in this case, Conclusion of Law 3 states that "[t]here is *prima facie* evidence that Petitioner violated 42 C.F.R. § 483.25(h)(2)" on January 5 and Conclusion of Law 5 states that "Petitioner has failed to rebut the CMS *prima facie* showing of a violation of 42 C.F.R. § 483.25(h)(2) on January 5, 2002 . . . ." ALJ Decision at 5. These conclusions reflect the correct allocation of the burden of persuasion if the evidence were not in equipoise. Accordingly, we see no error in these conclusions.

2. The ALJ did not apply the wrong standard in determining what constituted substantial compliance.

Burton argues that the ALJ applied the wrong standard in determining whether Burton was in substantial compliance with section 483.25(h)(2). According to Burton, the ALJ "has taken the position that a provider's staff must at all times deliver the highest possible standard of medical care and services" and endorsed "a strict liability standard of deficiency." Burton RR at 7-8. Burton maintains that the correct standard is whether the facility takes "reasonable," or "practicable," measures to comply with this participation requirement. Id.

Burton mischaracterizes the ALJ Decision and articulates the wrong standard. In describing the applicable standard, the ALJ cited Woodstock Care Center, DAB No. 1726 (2000), aff'd, Woodstock Care Ctr. v. Thompson, 363 F.3d 583 (6th Cir. 2003). See ALJ Decision at 8-9. The Board there analyzed the wording, context, and history of section 483.25(h)(2) and, based on that analysis, set out a framework for evaluating allegations of noncompliance with that requirement. Woodstock at 25-30 (citing 54 Fed. Reg. 5316, 5332 (Feb. 2, 1989)). The Board determined that, although section 483.25(h)(2) does not hold a facility strictly liable for accidents that occur, it does require the facility to 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. Id. Thus, while a facility is permitted the flexibility to choose the methods it uses to prevent accidents, the chosen methods must be adequate under the circumstances. Id. Moreover, what are adequate supervision and assistance devices for a particular resident depends on the resident's ability to protect himself from harm. Id. The Board has identified this as the applicable standard in subsequent decisions as well. See, e.g., Odd Fellow and Rebekah Health Care Facility, DAB No. 1839 (2002); Northeastern Ohio Alzheimer's Research Center, DAB No. 1935 (2004); Estes Nursing Facility Civic Center, DAB No. 2000 (2005); Golden Age Rehabilitation & Care Center, DAB No. 2026 (2006); and Willow Creek Nursing Center, DAB No. 2040 (2006). Burton does not point to anything in the ALJ Decision that suggests that this was not the standard the ALJ actually applied in determining that the incident on January 5, 2002 violated section 483.25(h)(2). Thus, there is no basis for Burton's allegation of error.

Burton also argues that the ALJ Decision ignores the court's holding in Crestview Parke Care Ctr. v. Thompson, 373 F.3d 743 (6th Cir. 2004) (remanding Crestview Parke Care Center, DAB No. 1836 (2002)). Burton relies on the court's statement, in discussing a deficiency cited under section 483.25, that "it is possible for a petitioner to show there was a justifiable reason for the violation . . . ." Crestview, 373 F.3d at 754. As discussed below, however, Burton does not advance a justifiable reason for its failure, in the January 5, 2002 incident, to implement the interventions that it had determined were necessary to minimize Resident 36's risk of falls.

3. Substantial evidence supports the ALJ's conclusion that Burton failed to substantially comply with section 483.25(h)(2) on January 5, 2002.

The ALJ's conclusion was based on his finding that Burton "did not comply with its own care plan for Resident 36 on January 5, 2002 and failed to act reasonably to prevent him from falling." ALJ Decision at 12. The ALJ found that the care plan for Resident 36 required that he have a non-release waist restraint while up in his wheelchair and required all staff to observe the resident's out of bed activity. Id. at 9, 12. The ALJ also found that, during the incident in question, the resident was up in his wheelchair with the non-release restraint unsecured on one side and was left in the bathroom unattended. Id. at 10, 12. The ALJ concluded that–

> [t]he fact that Petitioner had adopted these interventions shows both that there was a foreseeable risk and that Petitioner believed the interventions reasonable and adequate. Petitioner violated 42 C.F.R. § 483.25(h)(2) by failing to ensure that its staff implemented the interventions on January 5, 2002.

Id. at 12.

Burton takes exception to the ALJ's underlying finding that "[t]he nurse aide left Resident 36 unattended in the bathroom" (Finding of Fact 15.c.). In support of this finding, the ALJ cites the surveyor's testimony (Tr. at 71), based on the facility's incident report, that "the staff member had given this resident a urinal while sitting in a wheelchair in the bathroom . . . and left him there to urinate[.]" The incident report specifically indicates that, although two aides were initially in the bathroom with Resident 36, they both left the room before he fell. CMS Ex. 22, at 3. Moreover, the testimony on which Burton relies does not support a contrary conclusion. Burton cites the testimony of its Director of Nursing (DON) that she disagreed that Burton did not provide adequate supervision during the January 5, 2002 incident since "[t]here [were] two STNAs [state tested nursing assistants] provided for [Resident 36's] care that night." Tr. at 147 (cited in Burton RR at 9). The DON later referred to the STNA "who stayed in the room with" Resident 36 after the first STNA left. Tr. at 151. However, the DON did not specifically state that either of the STNAs were in the bathroom with the resident when he fell. Burton also cites the surveyor's testimony that "Staff were always around when I observed [Resident 36]." Burton RR at 9, citing Tr. at 105. However, the fact that staff were with the resident during the limited times

when the surveyor observed him says nothing about whether staff were in the bathroom with him during the incident in question, which occurred prior to the survey. Accordingly, we affirm and adopt Finding of Fact 15.c.

Burton also takes the position that its failure to implement the interventions in its care plan was not a basis for finding a deficiency since "interventions can be successful only when the resident chooses to utilize them." Burton RR at 8. Burton asserts that Resident 36 "is a distinguished retired military officer unaccustomed to taking orders" who "chose to maintain his dignity and transfer himself to the toilet" without using the call light or verbally requesting assistance from the nursing assistant. Id. at 9, citing Tr. at 147.

This argument is not persuasive. Under the regulations, a resident has the right to refuse treatment, to choose health care, and to make choices about significant aspects of life in the facility. Sections 483.10(b)(4), 483.15(b)(1), and 483.15(b)(3). The facility must document in the resident's care plan any services that would otherwise be provided under section 483.25 but are not provided due to the resident's exercise of the right to refuse treatment, and the resident's right to choose health care must be "consistent with his or her . . . assessments, and plans of care." Sections 483.20(k)(1)(ii) and 483.15(b)(1). There is nothing in the record here that documents or even suggests that Resident 36 made a choice to be left unattended in the bathroom without his waist restraint secured on both sides. In addition, Burton's failure to implement the two care plan interventions in question, which were designed to minimize Resident 36's fall risk, put the resident in a situation where he was likely to fall and injure himself. Compromising the resident's safety in this way did not serve to maintain his dignity. Moreover, even if Resident 36 would have chosen not to have these interventions, this would not excuse the facility's failure to implement them since "the basic purpose for a resident being in the facility is for 'treatment and services[.]'" 54 Fed. Reg. at 5332 (preamble to final regulations). Pursuant to the lead-in language to the quality of care regulations in section 483.25, services must be provided in accordance with a resident's assessment and plan of care. See, e.g., Coquina Center, DAB No. 1860 (2002) (upholding deficiency findings where a facility failed to follow steps in a plan of care that were directed at preventing accidents).

We therefore conclude that substantial evidence in the record supports the ALJ's conclusion that Burton was not in substantial compliance with section 483.25(h)(2) on January 5, 2002.

4. Substantial evidence supports the ALJ's conclusion that Burton did not violate section 483.25(h)(2) on December 12, 2001.

The ALJ found that on December 12, 2001, Resident 36 was sitting on the toilet when a nurse aide who was in the bathroom with him turned away "momentarily" to get a brief for him that was stored in the bathroom on a cart near the door. ALJ Decision at 3 (Finding of Fact 14 and 14.a), 10. The ALJ further found that while the aide was turned away, Resident 36 attempted to transfer himself from the toilet to his wheelchair and fell, suffering an abrasion to his head and left hip. ALJ Decision at 4 (Finding of Fact 14.b and 14.c), 10. The ALJ concluded that, contrary to what CMS had found, there was no violation of section 483.25(h)(2), stating:

> The evidence shows that Petitioner had identified and implemented interventions intended to minimize the foreseeable risk of falls for Resident 36. . . . Petitioner's intervention of having Resident 36 supervised in the bathroom by an aide was adequate to prevent Resident 36 from making unassisted transfers and to stabilize him if necessary. It was not foreseeable, given evidence that Resident 36 was coherent and capable of following instructions, that during the brief time that the aide turned to retrieve a brief, Resident 36 would not ask for assistance but would rather attempt a self-transfer. The evidence does not show that it was unreasonable for Petitioner to continue to allow Resident 36 to use the bathroom toilet consistent with the requirement for Petitioner to ensure that its residents attain the highest level of activities of daily living possible. The evidence does not show that there might have been a better intervention than one-on-one supervision while Resident 36 used the toilet.

ALJ Decision at 11-12.

CMS argues that the ALJ erred in determining that the December 12 incident did not constitute a violation of section 483.25(h)(2). CMS RR at 2. In particular, CMS disputes the ALJ's conclusion that the resident's attempt to transfer himself from the toilet to his wheelchair without assistance was not foreseeable. CMS argues that, given Resident 36's "well-known physical limitations and behaviors, it was foreseeable that, if R 36 was left unattended while sitting (without restraints) on a toilet, he would attempt to transfer himself, fall, and suffer injuries." Id. at 3. According to CMS, the relevant facts included that Resident 36 had a history of falls from attempting to get up out

of his wheelchair and walking; that Burton had assessed the resident as being a high risk for falls; that the resident's diagnoses included progressive supranuclear palsy, which causes serious complications with gait and balance and increased the resident's risk for falls; that Burton staff described the resident as "very determined" and indicated that it was not uncommon for him to fail to ask staff for assistance when he wanted to transfer himself from one place to another; that the resident was identified in October 2001 as restless and easily distracted; and that nursing notes documented that the resident was frequently confused. CMS also disputes the ALJ's finding that the nurse aide provided Resident 36 with "one-on-one supervision" on this occasion. CMS contends that--

> [b]y the facility's own admission (CMS Exs. 21, p. 3, 23, p.1), the NA [nurse aide], by turning her back on the resident while he was seated on a toilet, left R36 'unattended.' [footnote omitted] As the facility recognized (CMS Ex. 21, pp. 1, 3), the NA should have obtained the brief before she began toileting the resident but, given that she had forgotten to do this, she should have called for assistance, rather than turning around to get the brief and thus leaving the resident unattended.

CMS RR at 4. CMS also suggests that the ALJ erred in concluding that one-on-one supervision was adequate. CMS asserts that the "kardex" for Resident 36--described by the surveyor as a "mini version of the care plan for nursing assistants" (Tr. at 58)--required two-person support for toileting. CMS relies on this as evidence of the resident's "known tendency to attempt to transfer himself without asking for assistance[.]" CMS Reply Br. at 3.

As discussed below, we conclude that substantial evidence in the record supports the ALJ's conclusion that the December 12, 2001 incident was not a violation of section 483.25(h)(2). As indicated above, the regulation requires that a facility take reasonable steps to ensure that a resident receives supervision and assistance devices designed to mitigate foreseeable risks of harm from accidents. Thus, even if it was foreseeable that Resident 36 would attempt to transfer from the toilet to his wheelchair without assistance, which indisputably would put him at a high risk of falls, this would not be sufficient to establish that Burton failed to substantially comply with section 483.25(h)(2) on December 12, 2001. The relevant inquiry is instead whether the supervision Burton provided was adequate under the circumstances.

In determining whether this was the case, we look first to whether Burton provided supervision in accordance with the resident's assessment and plan of care. If Burton failed to provide the type of supervision that it had determined was required to meet the resident's needs, this would support a conclusion that this incident violated section 483.25(h)(2).

The ALJ found in effect that Burton had determined prior to December 12, 2001 that Resident 36 required "one-on-one supervision" while he was in the bathroom. ALJ Decision at 12.[2] Burton does not dispute that it intended to require a staff member to supervise the resident in the bathroom even when he was not transferring on or off the toilet. CMS asserts, however, that Burton had determined that the resident required supervision by two staff members rather than one. CMS relies on the resident's kardex, on which the words "Support" and "1 person" are preprinted in the section on toileting but which also includes the handwritten notation "2 person" to the right of "1 person." CMS Ex. 20, at 2. There is no date next to the handwritten notation. However, the surveyor testified that she knew this notation dated to July 2001 because "[i]t's elsewhere in a lot of documentation throughout the medical record that the resident was a two-person." Tr. at 61. The surveyor did not specifically identify any such documentation, however. Moreover, the incident report for the December 12, 2001 incident says that staff was reminded after the incident to "use call bell for assist if forgot something" and "Don't leave 'R' unattended." CMS Ex. 21, at 1, 3. These documents are consistent with a finding that Burton required only one-person support at the time in question. Moreover, the surveyor's opinion regarding the date that a requirement for two person support was added to the kardex is undercut by her own testimony (based on her survey notes) that the July 2001 and January 2002 Minimum Data Set (MDS) for the resident indicated that one-person support was needed for toilet use.[3] (She stated that she had not recorded what was on the October 2001 MDS, but it was presumably no different than the earlier and later MDS.) Tr. at 47-49. Thus, the ALJ properly

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[2] This finding is not inconsistent with Finding of Fact 13 ("Resident 36 needed a one to two person assist for toileting and transfers") since that finding does not specify whether, for each of these activities, a one person or a two person assist was required.

[3] The MDS is a component of a resident assessment instrument which contains information about the resident's functional capacity.

considered only whether Burton provided one-on-one supervision in determining whether the December 12, 2001 incident violated section 483.25(h)(2).

We further conclude that, contrary to what CMS argues, there is substantial evidence to support the ALJ's conclusion that Burton provided one-on-one supervision of the resident during this incident. CMS takes the position that the aide left the resident unattended "by turning her back on the resident while he was seated on a toilet[.]" CMS RR at 4. However, CMS does not dispute the ALJ's finding that the nurse aide remained in the bathroom with the resident or that she turned away only "momentarily" to get the brief from the cart. In addition, there was undisputed testimony by the DON that the distance from the toilet to the wall where the cart with the briefs was located was three feet. Tr. at 148. CMS points to nothing in the record that indicates that Burton had determined that, in order to provide the resident with one person support for toileting, staff needed to keep the resident in their sight at all times even when in the bathroom in close proximity to the resident.[4]

Moreover, the ALJ could reasonably determine that the evidence from the resident's medical record on which CMS relies does not establish that Burton could have foreseen, prior to December 12, 2001, that the resident would be placed at risk if the staff member supervising the resident failed to visually observe the resident momentarily. The evidence cited by CMS goes only to whether it was foreseeable that the resident would attempt a self-transfer without requesting assistance and to the resident's risk of falling during such a self-transfer.

Accordingly, we conclude that substantial evidence in the record supports the ALJ's conclusion that Burton was not out of compliance with section 483.25(h)(2) on December 12, 2001.

5. The ALJ erred in determining that a per instance CMP of $1,400 was reasonable.

The ALJ stated that CMS had proposed a per instance CMP of $2,800 "based upon two alleged deficiencies" and that "some reduction is appropriate based upon my conclusion that only one deficiency existed." ALJ Decision at 13. The ALJ concluded that a CMP "of $1,400, which is at the low range of the scale for a per instance

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[4] Although the resident's care plan required all staff to observe the resident's out of bed activity, CMS does not allege that Burton failed to implement this intervention.

civil money penalty, is reasonable based upon all the facts of this case." Id. In reaching this conclusion, the ALJ examined

each of the four regulatory factors specified in section 488.438(f), stating as follows:

> I have little or no evidence to consider regarding the first two factors. The evidence does not show a significant history of noncompliance or repeated violations of 42 C.F.R. § 483.25. *See e.g.* CMS Ex. 6. Petitioner has not alleged an inability to pay and there is some evidence that Petitioner's owner also owns several other nursing homes.
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> Regarding the third . . . and fourth factors, seriousness and culpability: (1) actual harm occurred to Resident 36, he sustained injuries from his fall on January 5, 2002; (2) immediate jeopardy is not alleged; (3) Petitioner had identified interventions; but (4) Petitioner failed to ensure its staff implemented necessary interventions. Resident 36's fall was serious even though he experienced only minor injuries and Petitioner was culpable.

ALJ Decision at 13.

Burton argues that if the Board upholds the ALJ's findings, the CMP "should not be assessed at more than the minimum" since "the ALJ recognized that Burton had interventions in place and that only minor injuries resulted[.]" Burton RR at 11-12.[5] Burton also takes the position that its failure to allege an inability to pay was not a relevant consideration. In addition, Burton disputes the ALJ's finding that "Petitioner was culpable," stating, "There cannot be any significant degree of culpability when the facility did everything within its power to ensure compliance and any noncompliance resulted from the exercise of resident's rights or human error on the part of an employee." Burton RR at 12.

CMS, on the other hand, argues that a per instance CMP of $2,800 is reasonable even if the Board determines that the ALJ correctly concluded that the December 12, 2001 incident did not constitute a violation of section 483.25(h)(2). CMS asserts that a few months prior to the February 2002 survey, Burton had been cited for accidents related to transfers under the same tag as is involved here. CMS RR at 6, citing CMS Ex. 16, at 1. CMS also asserts that "there is no evidence that Burton's financial condition would make it unable to pay this relatively small CMP,

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[5] Elsewhere, Burton referred to "the $50/day minimum." Burton RR at 11. However, the minimum for a per instance CMP is $1,000.

. . . especially since the owners of Burton also own eight other nursing homes." Id., citing CMS Exs. 10 and 11. In addition, CMS argues that the seriousness of the deficiency was high since it resulted in actual harm to the same resident who had previously been injured. CMS notes that the resident's injuries "could very easily have been much more serious given that . . . he struck his head when he fell." Id. at 7. Finally, CMS argues that "[t]he facts involved in the deficiency also demonstrate a neglect and disregard" for the resident's safety, "and thus a very high degree of culpability on the part of Burton." Id. According to CMS, moreover, the December 12 incident constituted a "very clear warning" that it was unsafe to leave the resident unattended, and Burton's failure to heed it showed increased culpability even if the incident was not itself a violation of section 483.25(h)(2).

We conclude that the ALJ erred in determining that a $1,400 CMP was reasonable and in reducing the CMP from $2,800 to the lower amount. Contrary to what the ALJ Decision indicates, the ALJ was not required to reduce the CMP by any amount based on his conclusion that only one of the two incidents violated section 483.25(h)(2). In the preamble to the final rule authorizing the imposition of a per instance CMP, CMS stated as follows:

> [S]hould a survey team identify a particular instance of noncompliance during a survey, such as the presence of an avoidable pressure sore in a facility resident, we believe the statute authorizes us or a State to impose an immediate civil money penalty for that one instance of noncompliance. The only limitation that the statute would provide is that the civil money penalty liability for that instance of noncompliance could not be more than $10,000 for the day during which the noncompliance was identified. On the other hand, [CMS] or a State could identify several instances of noncompliance, perhaps relating to different aspects of facility obligations (as, for example, could be the case when deficiencies have been identified in areas of hydration, diet, resident assessment, and resident rights) and find itself imposing several different civil money penalties for each instance of noncompliance as long as the total facility liability did not exceed $10,000 per day.
>
> What we mean by an "instance" in this regulation is a single deficiency identified by the tag number used as a reference on the statement of deficiencies. While we consider an instance as a singular event of noncompliance, there can be more than one instance of noncompliance identified during a survey.

64 Fed. Reg. 13,354, at 13,356 (Mar. 18, 1999). CMS was therefore authorized to impose a per instance CMP of up to $10,000 based on only one instance of noncompliance by Burton with section 483.25(h)(2). The January 5, 2002 incident constituted such an instance.

The ALJ, however, treated his conclusion regarding the December 12, 2001 incident as reducing the number of deficiencies, automatically requiring some reduction in the CMP amount and leaving the issue of what amount would be reasonable for the remaining deficiency. See ALJ Decision at 13. In fact, CMS imposed the CMP based on only one deficiency--noncompliance with section 483.25(h)(2), although the Statement of Deficiencies addressed two incidents under the tag for this section. Thus, the ALJ should have considered whether the per instance CMP continued to be reasonable despite his disagreement with one of the underlying findings.

As discussed below, we agree with CMS that a $2,800 per instance CMP for the instance of noncompliance on January 5, 2002 is reasonable based on the factors listed in section 488.438(f).

- The facility's history of noncompliance. The exhibit cited by the ALJ shows that Burton was cited for one level D deficiency in a 3/9/00 survey and two level D deficiencies in a 5/24/01 survey.[6] The ALJ concluded that Burton did not have a "significant history of noncompliance or repeated violations of section 483.25." ALJ Decision at 13. Burton's history of noncompliance is not so significant that it would support a high penalty amount. However, its history of noncompliance is a factor that supports the $2,800 CMP proposed by CMS since this amount is at the lower end of the permissible range. The regulation does not require that there be repeated deficiencies or extensive prior noncompliance in order for a facility's history of noncompliance to be considered in determining the CMP amount.[7]

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[6] A Level D deficiency is isolated in scope and involves no actual harm with a potential for more than minimal harm that is not immediate jeopardy. See State Operations Manual, § 7500.

[7] CMS claims that the deficiency found here was a repeated deficiency. CMS RR at 6, citing CMS. Ex. 16, at 1. The cited document is a survey preparation worksheet for the February

(continued...)

- The facility's financial condition. The Board has previously stated that "[t]here is a presumption that CMS has considered the regulatory factors [in section 488.438(f)] in setting the amount of the CMP," and that CMS has a responsibility to produce evidence as to a particular factor only if the facility contends that the factor does not support the CMP amount. Harmony Court, DAB No. 1968, at 35 (2005), aff'd, Harmony Court v. Leavitt, No. 05-3644, 2006 WL 2188705 (6th Cir. Aug. 1, 2006), quoting Coquina Center at 32. Thus, in the absence of an allegation by Burton that it was unable to pay a $2,800 CMP, we assume that Burton was able to do so. Moreover, the fact that Burton's owners owned eight other facilities is affirmative evidence of Burton's ability to pay a CMP in this amount.[8]

- The seriousness of the deficiency. As the ALJ Decision notes, Resident 36 suffered "lacerations to his head and the bridge of his nose" on January 5, 2002. ALJ Decision at 4 (Finding of Fact 14.c). Even if we were to agree with Burton's characterization of these injuries as "minor" (which we do not), it was simply fortuitous that the resident was not more seriously injured when he fell on the bathroom floor while attempting to stand and transfer to the toilet. Moreover, the regulations specifically authorize the imposition of a per instance CMP of up to $10,000 for one or more deficiencies that constitute actual harm that is not immediate jeopardy. See 42 C.F.R. § 488.408(d)(2)(ii).[9]

- The facility's culpability. Burton's argument that it was not culpable because the January 5, 2002 incident resulted

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[7](...continued)
2002 survey which contains a reference to a complaint involving "F-324 - Accids [with] mechanical lifts transfer." However, CMS does not explain how this shows that Burton had a prior deficiency under this tag (which corresponds to section 483.25(h)(2)).

[8] The form identifying the eight facilities was signed by Burton's representative on February 27, 2002. CMS Ex. 10, at 3.

[9] "Immediate jeopardy" is defined as "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.

> from the resident's exercise of his rights is unavailing for the same reasons we discussed above in upholding the ALJ's finding of noncompliance. Burton also attempts to deny its culpability by blaming its employee for not implementing Burton's planned intervention. As the Board has previously held, however, a facility is ultimately responsible for ensuring that services are provided to meet its residents' needs, regardless of who provides those services. See, e.g., Northeastern Ohio Alzheimer's Research Center; Cherrywood Nursing and Living Center, DAB No. 1845 (2002) (and cases cited therein). Moreover, Burton's degree of culpability is increased since not only did the two STNAs leave the resident unattended in the bathroom but the first STNA left knowing that the resident's waist restraint was untied. CMS Ex. 1, at 8; CMS Ex. 22, at 2. In addition, Burton's degree of culpability was increased by the December 12, 2001 incident, notwithstanding the fact that this incident was not a violation of section 483.25(h)(2), since it put Burton on notice of the specific risk that the resident would attempt to transfer himself in the bathroom without asking for assistance if staff failed to visually observe him even momentarily.

In view of these factors, we conclude that a $2,800 per instance CMP for Burton's noncompliance with section 483.25(h)(2) on January 5, 2002 is reasonable. Accordingly, we substitute the following for Conclusion of Law 6:

> A per instance CMP of $2,800 is reasonable.

Conclusion

For the reasons explained above, we uphold the ALJ's conclusion regarding the basis for a finding of noncompliance under section 483.25(h)(2) but reverse his conclusion that the $2,800 per

instance CMP was not reasonable and reinstate the CMP in this amount.

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Judith A. Ballard

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Leslie A. Sussan

_____
Donald F. Garrett
Presiding Board Member