Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Trisun Care Center Meadow Creek,	)	
(CCN: 67-6031)	)	Date: April 21, 2008
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-06-629
	)	Decision No. CR1773
Centers for Medicare & Medicaid	)	
Services.	)	
	)	

DECISION

Based on a survey completed March 30, 2006, I decide that Petitioner Trisun Care Center Meadow Creek was not in substantial compliance with federal participation requirements governing skilled nursing facilities by failure to ensure that one of its residents received adequate nutrition as alleged by the Centers for Medicare & Medicaid Services (CMS).

I. Background

Petitioner, located in San Angelo, Texas, is a skilled nursing facility (SNF) certified to participate in the Medicare program and the Texas Medicaid program as a nursing facility (NF). On March 30, 2006, the Texas Department of Aging and Disability Services ("TDADS" or "state agency") conducted a complaint survey of Petitioner's facilities. As a result of the survey Petitioner was determined to be out of substantial compliance with Medicare and Medicaid participation requirements. The state agency subsequently recommended to the CMS that remedies be imposed. By letter dated June 19, 2006, citing a violation of 42 C.F.R. § 483.25(i)(1) (Tag F325), CMS notified Petitioner that it was imposing a per-instance civil money penalty (CMP) in the amount of $2,000. The letter also informed Petitioner that the state-recommended termination of the facility's provider agreement and denial of payment for new admissions had been rescinded.

By letter dated August 21, 2006, Petitioner requested a hearing before an administrative law judge (ALJ). The case was assigned to me for hearing and decision on September 5, 2006, and a Pre-hearing Order was issued at my direction on that date. On November 2,

2006, Petitioner filed an unopposed motion for a 30-day stay of the pre-hearing schedule for the purpose of settlement. That motion was granted by order dated November 14, 2006. On December 15, 2006, CMS filed its report of readiness. On December 15, 2006, Petitioner filed its exhibits, exhibit list, and witness list. Petitioner submitted Exhibits (P. Exs.) 1-4, which I admit into evidence without objection. On January 5, 2007, CMS "requested clarification" for filing documents in this case. On January 29, 2007, for the purpose of establishing exchange deadlines, I held a pre-hearing telephone conference in this matter. During the pre-hearing conference I set this case for hearing April 25-26, 2007, and I established a briefing schedule. On March 9, 2007, CMS filed its final list of witnesses and exhibits. CMS submitted Exhibits (CMS Exs.) 1-15 which I admit into evidence without objection. By letter dated March 26, 2007, pursuant to 42 C.F.R. § 488.66(a), Petitioner waived its right to appear (in-person) and present evidence at oral hearing stating that "Petitioner and Respondent agree that the essential and relevant facts are not at issue . . . Similarly the credibility of statements and evidence are not at issue." *See* Petitioner's Waiver of Oral Hearing. In an order dated April 6, 2007, I canceled the hearing and established a new briefing schedule.[1] On April 30, 2007 CMS filed its brief (CMS Brief). On May 31, 2007, Petitioner filed its written submission in lieu of oral hearing (P. Brief). On June 15, 2007 Respondent filed a reply brief (CMS Reply); and on June 28 Petitioner filed a sur-reply brief (P. Sur-Reply).

II. Applicable Law

The Social Security Act (Act) sets forth requirements for long-term care facility participation in the Medicare and Medicaid programs and authorizes the Secretary to promulgate regulations implementing the statutory provisions. Act §§ 1819 and 1919. The Secretary's regulations governing nursing facility participation in the Medicare program are found at 42 C.F.R. Part 483. Regulations governing survey, certification, and enforcement procedures, and regulations governing provider agreements, are found at Parts 488 and 489, respectively. Regulations governing appeals procedures are found at Part 498.

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[1] In my Order cancelling the hearing I cautioned the parties that their final briefs must address *each and every issue* that they believe to be relevant to the case. Moreover, a party must cite specifically to any exhibit that it believes is relevant to its arguments. It is not sufficient for a party to refer generally to exhibits as support for a contention without explaining why those exhibits provide the alleged support. Nor is it sufficient for a party to say that it is relying on unspecified exhibits or testimony to support its contentions of fact. If a party relies on an exhibit it must cite to the specific exhibit and page that it believes to be relevant and must explain why it believes that the citation is relevant. If a party fails to support a contention with appropriate citations I may find that the contention is without support or I may decide that the party has abandoned the contention.

To participate in the Medicare and Medicaid programs, facilities periodically undergo surveys to determine whether they comply with applicable statutory and regulatory requirements for Medicare and/or Medicaid. They must maintain substantial compliance with program requirements, and, to be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301. If a facility is not in substantial compliance with program requirements, CMS has the authority to impose, in addition to termination, one or more of the enforcement remedies listed in 42 C.F.R. § 488.406, including a denial of payment for new admissions, directed in-service training, and imposition of a CMP. *See* Act § 1819(h).

CMS may impose a CMP against a facility either for the number of days during which the facility fails to comply substantially with one or more participation requirements or for each instance in which a facility fails to comply substantially with a participation requirement. 42 C.F.R. § 488.430(a). Therefore, CMS may impose a per-instance CMP within the range of $1,000 to $10,000 for each instance of noncompliance regardless of whether or not the deficiencies constitute immediate jeopardy. 42 C.F.R. § 488.438(a)(2). The specific amount of the per instance CMP must be reasonable. If a basis to impose is found, the ALJ cannot reduce the per-instance CMP below $1,000. In this case, CMS imposed a per instance CMP in the amount of $2,000 in this case.

A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); *see also* 42 C.F.R. §§ 488.330(e) and 498.3. However, a facility may not appeal the choice of remedies by CMS or the factors CMS considered when choosing a remedy. 42 C.F.R. § 488.408(g)(2).

When a remedy is imposed, CMS must make a prima facie showing that the facility has failed to comply substantially with federal participation requirements. To prevail, a long-term care facility must overcome CMS's showing by a preponderance of the evidence. *Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004); *Batavia Nursing and Convalescent Inn*, DAB No. 1911 (2004); *Emerald Oaks*, DAB No. 1800 (2001); *Cross Creek Health Care Center*, DAB No. 1665 (1998); *Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd Hillman Rehabilitation Center v. U.S. Dep't. of Health & Human Servs.*, No. 98-3789 slip. op. at 25 (D.N.J. May 13, 1999). A preponderance of evidence is "superior evidentiary weight that, though not sufficient to free the mind wholly from all reasonable doubt, is still sufficient to incline a fair and impartial mind to one side of the issue rather than the other." Black's Law Dictionary (7th ed. 1999) (cited by the Departmental Appeals Board (Board) in *Beechwood Sanitarium*, DAB No. 1906, at 38 (2004)).

Scope and severity levels are used by CMS and a state when selecting remedies. The scope and severity level is designated by an alpha character, A through L, selected by CMS or the state agency from the scope and severity matrix published in the State

Operations Manual (SOM), section 7400E; see also 42 C.F.R. § 488.408. A scope and severity level of A, B, or C indicates a deficiency that presents no actual harm but has the potential for minimal harm. Facilities with deficiencies of a level no greater than C remain in substantial compliance. 42 C.F.R. § 488.301. A scope and severity level of D, E, or F indicates a deficiency that presents no actual harm but has the potential for more than minimal harm that does not amount to immediate jeopardy. A scope and severity level of G, H, or I indicates a deficiency that involves actual harm that does not amount to immediate jeopardy. Scope and severity levels J, K, and L are deficiencies that constitute immediate jeopardy to resident health or safety. The matrix, which is based on 42 C.F.R. § 488.408, specifies which remedies are required and optional at each level based upon the frequency of the deficiency. *See* SOM, section 7400E.

In this instance, the remedy imposed by CMS against Petitioner was determined to be at the scope and severity level of "G" – actual harm that does not amount to immediate jeopardy.

III. Issues

The issues are –

> Whether Petitioner was in substantial compliance with 42 C.F.R. § 483.25(i)(1) (Tag F325); and
>
> Whether the amount of the per-instance CMP imposed by CMS is reasonable.

IV. Discussion

A. Findings of Fact

The following findings of fact are based upon the parties' arguments and the exhibits admitted. Citations to exhibit numbers related to each finding of fact may be found in the analysis section of this decision if not indicated here.

1. Petitioner is a long-term care facility located in San Angelo, Texas, that was authorized to participate in the Medicare and Medicaid programs.

2. The state agency conducted a complaint survey of Petitioner's facility on March 30, 2007.

3. The state agency determined that Petitioner was not in substantial compliance with federal program participation requirements at 42 C.F.R. § 483.25(i)(1) (Tag F325).

4. The violation of 42 C.F.R. § 483.25(i)(1) involved one resident in a sample of six.

5. On August 21, 2007, Petitioner requested a hearing before an ALJ.

6. Resident 1 experienced an unplanned weight loss of 5.4 pounds between March 2, and March 23, 2006.

7. Resident 1's unplanned weight loss was due to inadequate nutrition.

8. Resident 1's unplanned weight loss was not unavoidable.

B. Conclusions of Law

1. Petitioner's request for hearing was timely and I have jurisdiction.

2. Petitioner violated 42 C.F.R. § 483.25(i)(1) (Tag F325) by failing to ensure that Resident 1 maintained acceptable parameters of nutritional status.

3. CMS made a prima facie showing of a violation of 42 C.F.R. § 483.25(i)(1) (Tag F325).

4. Petitioner failed to rebut CMS's *prima facie* showing of a violation of 42 C.F.R. § 483.25(i)(1) (Tag F325) by a preponderance of the evidence.

5. Petitioner's violation of 42 C.F.R. § 483.25(i)(1) presented a pattern of actual harm.

V. Analysis

A. *Petitioner was not in substantial compliance with C.F.R. § 483.25(i)(1) (Tag F325).*

Under 42 C.F.R. Part 488, CMS may impose remedies against a long-term care facility where a state agency ascertains that the facility is not in substantial compliance with participation requirements. "Substantial compliance" means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to the resident health or safety than the potential for causing minimal harm. 42 C.F.R. § 488.301. In the instant case, CMS determined that Petitioner was not in substantial compliance with the quality of care requirement at 42 C.F.R. § 483.25(i)(1).

The regulation requires that:

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.
>
> Based on a resident's comprehensive assessment, the facility must ensure that a resident --
>
> (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible . . . .

42 C.F.R. § 483.25(i)(1).

CMS alleges that Petitioner failed to maintain acceptable nutritional parameters to prevent weight loss for Resident 1. CMS Ex. 2, at 1. To support the allegation that Petitioner failed to comply with the requirements set forth above, CMS relied on the surveyors' detailed findings in a SOD and the SOM. CMS Ex. 2.

The Guidance to Surveyors from the SOM provides that "(p)arameters of nutritional status which are unacceptable include unplanned weight loss as well as other indices such as peripheral edema, cachexia and laboratory tests indicating malnourishment (e.g., serum albumin levels)." SOM, app. P, at PP-106 (June 1995). The SOM also includes an investigative protocol for unintended weight loss which has two objectives: (1) to determine if identified weight loss is avoidable or unavoidable, and (2) to determine the adequacy of the facility's response to the weight loss. The protocol requires surveyors to determine whether: (1) the facility properly assessed a resident for risks for unintended weight loss; (2) the facility assessed the resident's nutritive and fluid requirements, need for dining assistance including need for assistive devices, food preferences, allergies, and frequency of meals; (3) there is information or documentation of identified causes for the weight loss; (4) a care plan was developed based on clinical conditions and risk factors identified by the assessment for the unintended weight loss and whether interventions were developed; and (5) the care plan was evaluated and revised based on the response, outcomes, and needs of the resident. SOM, app. P, at P-45 to 46.1 (rev. 10).

The surveyors are instructed for all cases of unintended weight loss to make observations to determine whether interventions have actually been implemented. The protocol states that unintended weight loss may be found unavoidable if the facility properly assessed, care planned and implemented the care plan, evaluated outcomes, and revised the care plan as necessary. If the facility failed to do any of the steps, then the weight loss should

be considered avoidable and the facility cited for violation of Tag F325. SOM, app. P, at P-45 to 46.1 (rev. 10).

The Board discussed deficiency citations under Tag F325 in both *The Windsor House*, DAB No. 1942 (2004), and *Carehouse Convalescent Hospital*, DAB No. 1799 (2001). In *Carehouse,* the Board interpreted the regulation not to require that a facility maintain a resident's weight at a fixed level. The Board also determined that a facility is not strictly liable for a resident's weight loss. The Board said that the regulation requires maintenance of weight only to the extent that weight is a "parameter of nutritional status," i.e., if a resident receives adequate nutrition and weight loss is due to non-nutritive factors, then the weight loss is not a "parameter of nutritional status and the weight loss alone is not a basis for a deficiency finding." *Carehouse,* at 21. Nevertheless, the Board concluded that weight loss raises an inference of inadequate nutrition sufficient to be a CMS *prima facie* showing of a deficiency. *Id.* at 22.

A *prima facie* case based upon the inference arising from weight loss is rebutted if the facility shows by a preponderance of the evidence that it "provided the resident with adequate nutrition" or weight loss was due to non-nutritive factors. *Carehouse,* at 22. In *Windsor* the Board used the formulation that a "facility is responsible for taking all reasonable steps to ensure that the resident receives nutrition adequate to his or her needs." *Windsor,* at 15. The Board explained that if CMS makes a *prima facie* showing based on weight loss, the facility may rebut that showing with evidence that the resident did receive adequate nutrition or that weight loss was due to non-nutritive factors, such as the resident's clinical condition. *Id.* The Board commented that the "clinical condition exception" is a narrow one that applies only when the facility demonstrates that it cannot provide nutrition adequate for the resident's overall needs so that weight loss is unavoidable. *Id.* The Board affirmed the ALJ's findings and conclusions in *Windsor* indicating that the ALJ correctly concluded that the presence of a significant clinical condition alone does not prove that maintaining acceptable nutrition is unavoidable. Rather, the Board further indicated that the ALJ correctly focused upon *Windsor*'s own assessment of the residents' nutritional needs and whether *Windsor* met its own plan for how to meet those needs. *Id.* at 17.

Turning to the facts of this case, the weekly weight recorded for Resident 1, from January through March 2006, showed the following weights:

January 4, 2006	90.0 lbs
January 11, 2006	88.0 lbs
January 18, 2006	90.2 lbs
January 25, 2006	90.6 lbs

There were no weekly weights for the month of February 2006.

March 2, 2006	89.4 lbs
March 9, 2006	87.6 lbs
March 16, 2006	85.0 lbs
March 23, 2006	84.0 lbs
March 30, 2006	84.6 lbs

P. Ex. 1, at 32-33.

A review of Resident 1's weekly weights revealed that between January 4, 2006 and March 30, 2006, Resident 1 lost 5.4 pounds (a 6.0 percent weight loss); and between March 2, 2006 and March 30, 2006 the resident lost 4.8 pounds (a 5.3 percent weight loss). Severe weight loss can be demonstrated by a loss of more than 5 percent of body weight in one month. *See SOM, App. PP*.

Petitioner does not dispute that Resident 1 lost weight as alleged by CMS. P. Brief at 11, 13-14; P. Reply at 1. Petitioner contends, however, that Resident 1's weight loss was unavoidable. Based on the language of 42 C.F.R. § 483.25(i)(1) and the Board's analysis in *Carehouse* and *Windsor*, I conclude that the admitted weight loss, supported by the clinical records admitted as evidence, are sufficient to establish a *prima facie* case of a violation.

B. *Petitioner has not proven by a preponderance of the evidence that Resident 1 received adequate nutrition*.

Once CMS has made a *prima facie* case that nutritional parameters have not been maintained for Petitioner's residents, then the burden of persuasion by a preponderance of the evidence is upon Petitioner to show it took all reasonable steps to ensure that the residents received adequate nutrition but that weight loss nevertheless occurred or that weight loss was unavoidable. To establish that it took all reasonable steps, Petitioner must show that it complied with regulatory requirements to assess the resident's nutritional needs (42 C.F.R. § 483.20(b)), that it care planned to meet the resident's nutritional needs and followed the care plan including implementation of planned interventions (42 C.F.R. § 483.20(k)), and that it reviewed the efficacy of care planned interventions and revised as necessary (42 C.F.R. § 483.20(k)(2)(iii)). If Petitioner fails at any step in the process, it cannot show that the weight loss was unavoidable.

Petitioner does not dispute that Resident 1 lost weight as alleged by CMS. P. Brief at 11, 13-14. Petitioner contends, however, that Resident 1's weight loss was unavoidable due to multiple factors including advanced age; chronic pain; chronic obstructive pulmonary

disease (COPD); pulmonary fibrosis; exercise limitations due to pulmonary impairment; and gastric reflux disease. P. Brief at 14.

Additionally, Petitioner argues that the facility nursing staff intervened by providing nutritional supplements; conducting weekly weight monitoring; providing dietician consultation; conducting a pharmacy evaluation of medication that may cause anorexia; pain management; modification of meals/substitutes; providing gastric medication to reduce reflux; weight committee monitoring. P. Brief at 13-14.

Weekly weight monitoring

Petitioner contends that the resident was monitored by the weight committee on several occasions, as demonstrated by the meetings conducted on May 26, 2005, August 4, 2005 and August 18, 2005 that addressed the resident's weight status. These meetings confirm nursing staff members were aware of the resident's weight issues. P. Ex. 2, at 1-3. Yet despite Petitioner's awareness of Resident 1's "weight issues" Petitioner failed to (1) perform a comprehensive assessment of Resident 1's nutritional needs, (2) obtain updated physician's orders, and (3) implement a plan of care to prevent weight loss. CMS Ex. 2, at 2; P. Ex. 2, at 1-3, CMS Ex. 8, at 1; CMS Ex. 6, at 1-9; CMS Ex. 7, at 1-6; CMS 9, at 1. As a result, no goals were established with respect to total caloric intake and weight for Resident 1. The mere fact that Petitioner weighed Resident 1 weekly and documented her meal intake, does not demonstrate that Petitioner paid attention to Resident 1's nutritional needs.

Nutritional supplement

The most recent physician's order for Resident 1, dated March 6, 2006, included the following: multi vitamin supplement (ordered September 27, 2001); daily snacks at 2:00 p.m. (ordered October 17, 2004); a regular diet without dairy products (ordered December 3, 2004); and an order dated December 3, 2004 that a substitute should be offered to Resident 1 if she consumed less than 50 percent of any meal. CMS Ex. 9, at 1. There were no orders regarding Resident 1's diet after December 3, 2004. *Id*. The facility failed to implement any nutritional approaches to address Resident 1's nutritional problem. Resident 1's care plan, dated February 2, 2006, neither identified her as having a nutritional problem nor revealed interventions to address Resident 1's nutritional status. CMS Ex. 2, at 2; CMS Ex. 7.

Dietician consultation

According to the November consultation visit report dated November 29, 2005, the dietician recommended that Resident 1 receive a dietary supplement called Med Pass 2.0 (2 ounces four times a day). CMS Ex. 2, at 2; CMS Ex. 8, at 1. A review of the

Residents current physician orders and Medication Administration Record (MAR) both dated March 2006, reveal no order for the Med Pass supplement. According to an interview with the Director of Nursing (DON) on March 29, 2006, the fax sheet sent to the physician that would normally contain the dietician's recommendations could not be found. The DON could not locate any documentation to indicate the physician was notified regarding Resident 1's weight loss or the request for Med Pass supplement. CMS Ex. 2, at 3.

Indeed, Resident 1 did not receive Med Pass or any other nutritional supplement even though Resident 1 consumed insufficient calories. CMS Ex. 5, at 2.

Pharmacy consultation

Petitioner argues that there was appropriate intervention by the pharmacy consultant. Specifically, Petitioner asked the pharmacy consultant to review all of Resident 1's medications to ensure none of her medication would cause a loss of appetite. Petitioner's Written Submission; P. Ex. 3, at 2, 5. However, there is no evidence that the pharmacy consultation took place prior to the March survey. Petitioner also arranged for a nurse consultant to interview Resident 1 regarding her recent illness, weight history, food/meal intake habits and to discuss various ideas for weight gain with Resident 1. Petitioner's Written Submission; P. Ex. 3, at 4. All of the evidence indicates that any type of intervention occurred months before and/or months after the March survey. For example, Petitioner's dietary consultant recommended that Resident 1 be given Med Pass in November 2005, however, the Med Pass supplement was not given until March 31, 2006, four weeks after it was recommended.

Pain management

Petitioner asserts that the resident had been ill with an acute respiratory condition, with symptoms of cough sore throat, sore mouth and emesis that affected her oral intake and appetite, thus resulting in weight loss. Entries in the nurses notes reflect the administration of antibiotics during the latter part of January and early February 2006. The resident received antibiotic therapy, cough syrup, cough drops, inhaler, Phenegran suppositories, and fluids to combat her illness. Petitioner has presented no evidence that during Resident 1's illness it planned well-balanced meals to assure adequate nutrition for Resident 1.

Meal modification/substitutes

The dietary records from December 2005 through March 2006 confirm that Resident 1's intake was usually 25-50 percent of her meal. She refused substitutes. P. Ex. 1, at 42; P. Ex. 1, at 27-30. However, the facility failed to implement any nutritional approaches to

address Resident 1's nutritional problem. Petitioner has presented no evidence that it attempted to provide Resident 1 with a modified meal plan. In fact, Resident 1's care plan, dated February 2, 2006, neither identified her as having a nutritional problem nor revealed interventions to address Resident 1's nutritional status. CMS Ex. 2, at 2; CMS Ex. 7.

Gastric medication to reduce reflux

Petitioner argues that Resident 1's diagnoses of gastroesophageal (gastric) reflux disease may have contributed to the resident's weight loss, despite the use of Zantac, a gastric acid inhibitor and Reglan, a gastric motility medication. *See* P. Ex. 1, at 12-13. Yet, surprisingly, Petitioner explains that "adequate nutrition can be assured by careful planning of well-balanced meals spacing them so that the stomach is not overloaded at any one time, perhaps five small meals a day." P. Brief at 15. There is no evidence that Petitioner attempted to provide Resident 1 with the meal approach it suggests to assure adequate nutrition relative to Resident 1's gastric reflux disease.

Additionally, Petitioner argues that due to the resident's ongoing acute respiratory illness and the need for antibiotic therapy, she was predisposed to side effects of gastric upset and nausea. P. Brief at 14. According to Petitioner, it is not surprising that the resident exhibited a decline in weight loss during her two-month illness. *Id*. Again, Petitioner has presented no evidence that during Resident 1's illness that it planned well-balanced meals to assure adequate nutrition for Resident 1.

Petitioner lists a myriad of possible reasons for Resident 1's weight loss. While they all could or may have contributed to the resident's weight loss, Petitioner has not shown, based on the evidence before me, that Resident 1's weight loss was unavoidable. Resident 1 was at risk for weight loss and Petitioner was aware of the risk. The evidence shows that Petitioner did not have a planned approach to prevent Resident 1's weight loss. Petitioner was under an obligation to monitor Resident 1's weight loss, pay adequate attention to her nutritional needs, and address her weight loss through further assessments and interventions. *Rolling Hills Health Center*, DAB CR1354 (2006). In this case, Petitioner did none of the above. Petitioner failed to conduct a comprehensive evaluation of Resident 1's nurtional status taking into consideration Resident 1's medical diagnoses and, develop a plan and implement appropriate interventions to address Resident 1's nutritional needs to prevent weight loss. Petitioner has not proven that Resident 1's weight loss was unavoidable. Petitioner's argument without supporting evidence or testimony does not make a case for substantial compliance.

Petitioner also argues that based on Texas law the state surveyor is not qualified to make the findings that were made in this case. Petitioner states "Similarly, the requirement itself calls for more analysis than the surveyor at issue should be allowed to make." P. Brief at 20. I find this argument unpersuasive. Surveyors, using their professional judgment, evaluate a provider's performance against a particular requirement and document the nature and extent of their findings in a statement of deficiencies. 42 C.F.R. § 488.26(b). Additionally, the regulations specifically recognize surveyors as professionals who use their judgment, in concert with federal forms and procedures, to determine compliance with a particular requirement for Medicare participation. 42 C.F.R. § 488.26(c)(3). Findings by state surveyors have always been given prudent consideration by ALJ's based on their experience and expertise. I find the state surveyor qualified in making the findings that were made in this case.

Petitioner has not shouldered its burden of proof by a preponderance of the evidence. Petitioner failed to provide Resident 1 with adequate nutrition. All Petitioner has shown is that Resident 1 had a difficult time maintaining weight. Unintended weight loss is unavoidable if the facility properly assessed, care planned, implemented the care plan, evaluated the resident outcome, and revised the care plan as needed. If Petitioner does not take the afore-mentioned actions the weight loss is avoidable. Petitioner has failed to show that it did everything within its power to maintain the nutritional status of Resident 1. I find that CMS has made a *prima facie* case that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(i)(1). Moreover, Petitioner has failed to rebut CMS's *prima facie* showing by a preponderance of the evidence.

C. A per-instance CMP in the amount of $2,000 is reasonable.

Regulations provide that CMS may impose either a per-diem or per-instance CMP to remedy a nursing facility's deficiencies. 42 C.F.R. §§ 488.438(a)(1), 488.438(a)(2). CMS may impose penalties in the range of $3,050 to $10,000 per day for deficiencies constituting immediate jeopardy, and $50 to $3,000 per day for non-immediate jeopardy deficiencies. 42 C.F.R. § 488.438(a)(1). A per-instance CMP may range from $1,000 to $10,000 regardless of whether or not the deficiencies constitute immediate jeopardy. 42 C.F.R. § 488.438(a). In this case CMS determined to impose a per-instance CMP in the amount of $2,000.

In determining whether the amount of the CMP is reasonable, the following factors specified at 42 C.F.R. § 488.438(f) must be considered: (1) the facility's history of non-compliance, including repeated deficiencies; (2) the facility's financial condition; (3) the seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404; and (4) the facility's degree of culpability.

Neither party has offered complete evidence concerning the regulatory factors which bear on the per-instance penalty amount. CMS has offered no evidence of past noncompliance for me to consider. Petitioner has not argued or submitted any evidence to demonstrate that it is unable to pay the CMP in this matter. Petitioner's argument suggests that Resident 1's weight loss was not that serious. CMS argues that Petitioner's culpability is clearly established through the documentary evidence in this matter.

I must weigh the evidence that relates to the penalty amount independently and without regard to how CMS evaluated the same evidence. Thus, I base my decision to uphold the penalty determination of Petitioner's noncompliance on the evidence before me. I have found that CMS has established a *prima facie* case of noncompliance relative to the non-immediate jeopardy citation. Petitioner has not rebutted CMS's case by a preponderance of the evidence. The $2,000 per-instance CMP is at the low end of the applicable range and I find that the amount is fully supported by the evidence in this case. Therefore, I find that the $2,000 per-instance imposed by CMS in this case is reasonable.

VI. Conclusion

For the reasons addressed above, I sustain CMS's determination and find that Petitioner was not in substantial compliance with program participation requirements at 42 C.F.R. § 483.25(i)(1). I further sustain CMS's determination to impose a per-instance CMP and I find the CMP of $2,000 in this case to be reasonable.

/s/
Alfonso J. Montano
Administrative Law Judge