Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
Countryside Manor, (CCN: 34-5390),	)	Date: November 2, 2007
Petitioner,	)	
v.	)	Docket No. C-04-539 Decision No. CR1679
Centers for Medicare & Medicaid Services.	)	

DECISION

Countryside Manor (Petitioner or the facility) is a long-term care facility located in Stokesdale, North Carolina. Petitioner is authorized to participate in the federal Medicare program as a skilled nursing facility and in the North Carolina State Medicaid program as a nursing facility. On June 29-30, 2004, the North Carolina Department of Health and Human Services (state survey agency) conducted a recertification survey at Petitioner's facility. Based on the findings of that survey, the Centers for Medicare & Medicaid Services (CMS) determined that, from June 29 through August 10, 2004, the facility was not in substantial compliance with Medicare requirements, and that, on June 29, 2004, its deficiencies posed immediate jeopardy to resident health and safety.

For the reasons set forth below, I conclude that Petitioner was not in substantial compliance with participation requirements governing nursing home facilities from June 29 through August 10, 2004, and its non-compliance posed immediate jeopardy to resident health and safety on June 29, 2004. Accordingly, I sustain CMS's determination to impose a per day civil money penalty (CMP) in the amount of $3050 for June 29, 2004, and a CMP in the amount of $50 per day from June 30, 2004 through August 10, 2004.

I. Background

The state survey agency conducted a recertification survey at Petitioner's facility on June 29-30, 2004. The state survey agency determined, as reported in the CMS Form 2567 Statement of Deficiencies, that on June 29, 2004, Petitioner was not in substantial compliance with federal Medicare and Medicaid participation requirements in the following areas:

- 42 C.F.R. § 483.20(g)-(h), Tag F278, Resident Assessment;
- 42 C.F.R. § 483.25(h)(2), Tag F324, Quality of Care; and
- 42 C.F.R. § 483.35(h)(2), Tag F371, Dietary Services.

Petitioner Exhibit (P. Ex.) 1, at 3, 6, 14.

The state survey agency found that the noncompliance with 42 C.F.R. § 483.25(h)(2) resulted in immediate jeopardy to resident health and safety. P. Ex. 1, at 1. Corrective actions were taken by the facility to remove the immediate jeopardy, and the scope and severity was reduced from a "J" to a "D" level deficiency. P. Ex. 2, at 2. CMS agreed with the state survey agency's findings and imposed a CMP of $3050 per day for June 29, 2004, for immediate jeopardy. CMS imposed a CMP of $50 per day beginning on June 30, 2004, when the facility was still not in compliance but its deficiencies no longer posed immediate jeopardy, until the facility was found to be in compliance on August 10, 2004. (Total CMP $5150). P. Ex. 2, at 2-3; P. Ex. 4. Petitioner requested a hearing, and the case was assigned to me for a hearing and a decision. I scheduled an in-person hearing in the case. Prior to the hearing, the parties agreed that the case could be decided based on their written submissions. Each party submitted a brief (P. Br. and CMS Br.), and Petitioner submitted a reply brief.[1] CMS filed 15 exhibits (CMS Ex. 1 – CMS Ex. 15), and Petitioner filed 15 exhibits (P. Ex. 1 – P. Ex. 15). The parties also filed joint stipulations of fact. There were no objections to any of the proposed exhibits. I admit the exhibits submitted by both parties into evidence.

II. Issues

The issues before me are: (1) was Petitioner in compliance with applicable regulations; (2) if the facility is found to be out of compliance, did the deficiency amount to immediate jeopardy on June 29, 2004; and (3) if the facility is found to be out of compliance, is the proposed CMP reasonable?

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[1] CMS failed to number the pages of its briefs, which violates Civil Remedies Division procedures. Nevertheless, in the interest of time, we have numbered the pages ourselves.

III. Applicable Law

The Social Security Act (Act) sets forth the requirements for nursing facility participation in the Medicare and Medicaid programs and authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations implementing the statutory provisions. Act, §§ 1819, 1919. The Secretary's regulations governing nursing facility participation in the Medicare program are found at 42 C.F.R. Part 483.

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

To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may "pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301.

Under the "quality of care" requirement, each resident must receive and a 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 resident's comprehensive assessment and plan of care. 42 C.F.R. § 483.25. Specifically, a facility must ensure that "each resident receives adequate supervision and assistance devices to prevent accidents." 42 C.F.R. § 483.25(h)(2).

If a facility is not in substantial compliance with program requirements, CMS has the authority to impose one or more of the enforcement remedies listed in 42 C.F.R. § 488.406, including the imposition of a CMP. *See* Act, § 1819(h). CMPs that are imposed against a facility fall into two broad penalty ranges. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMPs, from $3050 per day to $10,000 per day, is reserved for deficiencies that constitute "immediate jeopardy" to a facility's residents, and in some circumstances, for repeated deficiencies. 42 C.F.R. § 488.438(a)(1), (d)(2). The lower range of CMPs, from $50 per day to $3000 per day, is reserved for deficiencies that do not constitute "immediate jeopardy," but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1). "Immediate jeopardy" is defined to mean "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 determining the amount of the CMP, the following factors, specified at 42 C.F.R. § 488.438(f), must be considered: (1) the facility's history of noncompliance, including repeated deficiencies; (2) the facility's financial condition; (3) the factors specified at 42 C.F.R. § 488.404; and (4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort, or safety. However, the absence of culpability is not a mitigating factor.

IV. Burden of Proof

When a penalty is imposed and appealed, CMS must establish a prima facie case that the facility was not in substantial compliance with federal participation requirements. To prevail, the facility must overcome CMS's showing by a preponderance of evidence. *Emerald Oaks*, DAB No. 1800, at 4 (2001); *Cross Creek Health Care Center*, DAB No. 1665 (1998), applying *Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd*, *Hillman Rehabilitation Center v. HHS*, No. 98-3789 (GEB), slip op., at 25 (D.N.J. May 13, 1999). The burden is as set forth in the Board's decision in the *Hillman* case, and as stated and discussed in detail in the *Batavia Nursing and Convalescent Center* and *Batavia Nursing and Convalescent Inn* cases. *See Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004); *Batavia Nursing and Convalescent Inn*, DAB No. 1911 (2004).

V. Findings of Fact, Conclusions of Law and Discussion

I make findings of fact and conclusions of law (Findings) to support my decision in this case. I set forth each Finding below as a separate heading. I discuss each Finding in detail.

1. The facility did not provide an adequate level of supervision to prevent accidents, as required by 42 C.F.R. § 483.25(h)(2) (Tag F324).

The parties agree that on June 29, 2004, the state surveyors saw one of the facility's residents, referred to as Resident #10 (R10), sitting outside in his wheelchair smoking a cigarette. Jt. Stipulation No. 17; P. Ex. 5, at 3. R10 had a portable oxygen tank with him and was wearing the cannula on his face at the time the surveyors saw him. P. Ex. 1, at 11. There is some dispute as to whether oxygen was being delivered at that time. The equipment is designed to release oxygen only when the user inhales through the cannula. P. Ex. 5, at 2. R10 has insisted the cannula was not deep enough in his nostrils to deliver oxygen with the conservation device. P. Ex. 5, at 3. However, the surveyors observed the cannula on his face and in his nostrils. P. Ex. 1, at 12.

R10 was one of only two residents that smoked at the facility.[2] P. Ex. 1, at 6; P. Br. at 7. He had no long or short term memory problems. P. Ex 7, at 1. His latest quarterly Minimum Data Set (MDS) indicated that he only had cognitive difficulty in new situations. P. Ex. 8, at 1. However, his February 3, 2004 Resident Assessment Protocol (RAP) indicated that he experienced confusion when his oxygen saturation levels were low at night. P. Ex. 1, at 7; CMS Ex. 14, at 2-4, 6-8, 13. The nurses notes from that time period show that R10 experienced confusion on an almost daily basis and often spoke incoherently or needed to be reminded of where he was. P. Ex. 6, at 74-75, 78, 81-83, 85, 95, 97, 100-01, 103-08, 112-16. R10's care plan indicates that he was at risk for breathing difficulty due to a history of Chronic Obstructive Pulmonary Disease (COPD). CMS Ex. 14, at 15.

R10's physician recommended that he be on continuous oxygen at 3 liters/min, but that he could have a cigarette outside without his oxygen. P. Ex. 1, at 7-8. His care plan dated April 28, 2004, lists approaches to COPD, including encouraging him to limit smoking and to "[a]ssure and instruct resident to remove oxygen while smoking." CMS Ex. 14, at 16.

The nurses notes from April to June 2004, show that R10 went outside to smoke on a regular basis. P. Ex. 6, at 1-3, 5, 8, 11-17, 21, 24-27, 31-32, 34, 36, 39. The nurses notes also show that R10 left his oxygen in the building on at least one occasion, but on other occasions he went outside to smoke with his oxygen. *Id.* at 8, 11, 13, 16, 21. The facility provided R10 with a second wheelchair, one not equipped with an oxygen tank, to use when he went outside to smoke. P. Ex. 5, at 4. However, R10 complained that it was too painful to transfer himself between the chairs. *Id.* Because of Petitioner's experience with R10 and his ability to "understand and follow directions," it allowed him to smoke without supervision as long as his portable oxygen device was turned off.[3] *Id.*; P. Br. at 5, 8.

I consider first whether this incident establishes that the facility was not in substantial compliance with 42 C.F.R. § 483.25(h)(2). A facility must take reasonable steps to ensure that "[e]ach resident receives adequate supervision and assistance devices to prevent accidents." 42 C.F.R. § 483.25(h)(2); *Windsor Health Care Center,* DAB No. 1902, at 5 (2003); *Asbury Center at Johnson City,* DAB No. 1815, at 12 (2002); *Koester Pavilion,* DAB No. 1750, at 24 (2000); *Woodstock Care Center,* DAB No. 1726, at 25 (2000). The facility must anticipate potential accidents and take steps to prevent them

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[2] CMS incorrectly stated that R10 was one of three smokers at the facility at the time of the incident. CMS Br. at 7.

[3] Even after the incident, the facility allowed R10 to smoke with his oxygen tank present, so long as it was turned off. P. Ex. 6, at 2.

(increased supervision or the use of assistance devices). *Guardian Health Care Center*, DAB No. 1943, at 18 (2004). A facility is allowed flexibility in choosing the methods it uses to prevent accidents, but the chosen methods must constitute an "adequate" level of supervision. *Windsor*, DAB No. 1902, at 5; *see also Windsor*, DAB No. 1902, at 16-17; *Woodstock*, DAB No. 1726, at 25-30 (section 483.25(h)(2) imposes on facilities an affirmative duty designed to achieve favorable outcomes "to the highest practicable degree.")

Here, the facility anticipated the potential for accidents, but it did not take reasonable steps to ensure that each resident received adequate assistance devices and supervision to prevent accidents as required by 42 C.F.R. § 483.25(h)(2). The facility's smoking policy did not have a systematic procedure for assessing the degree of supervision required for its smokers. Although the facility had only two residents that smoked at the time that the deficiency was cited, the lack of a systematic procedure allowed the facility to casually assess the degree of supervision required by each of its smokers. This casual assessment ultimately resulted in allowing R10 to smoke while using oxygen. Whatever individual assessments the facility made, the approach used with R10 involved no supervision and the second wheelchair was not an adequate assistance device because he did not use it.

The facility realized that smoking near an oxygen tank posed a danger, as evidenced by the nurses notes and by the facility's providing R10 with the second wheelchair to use when he smoked. The second wheelchair was not an adequate assistance device because transferring between wheelchairs was too painful for R10, and he stopped using it. P. Ex. 5, at 4. The facility was aware of this fact. *Id.*; P. Br. at 8. Some of the nurses notes also indicate that the facility was aware of the danger posed by smoking with an oxygen tank present, regardless of whether it was delivering oxygen. One note says, "Advised [R10] of dangers of going outside [with] tank on the chair, even [with] it turn[ed] off. Advised him of need to change chairs leaving the tank inside. Yet he was noted going out with the chair with the tank on it." P. Ex. 6, at 8. Although Petitioner recognized the danger posed by smoking near an oxygen tank, Petitioner repeatedly allowed R10 to go outside to smoke with his oxygen tank. *Id.* at 8, 11, 12, 16, 34.

The facility was not relieved of its duty to protect R10 simply because R10 was alert and competent. The facility asserts that it respected R10's "right as a competent adult to make decisions for himself" when it allowed him to choose whether to smoke in his wheelchair that was equipped with oxygen. P. Br. at 8. A resident's right to make decisions ends where it conflicts with health or safety. The Act provides that residents have the right to "receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered . . . ." Act, § 1919(c)(1)(A)(v)(I).

The facility claims it had no notice or reason to restrict the rights of R10, and that R10 had not demonstrated unsafe smoking habits before this incident. P. Br. at 13. However, R10's wheelchair with the conserving regulator, which he used while smoking, was accompanied by a manual that provided: DO NOT ALLOW SMOKING NEAR THIS PRODUCT. CMS Ex. 13, at 3. Furthermore, while R10 was generally alert and oriented, he had experienced confusion many times, often when his oxygen levels were low. P. Ex. 6, at 74-75, 78, 81-83, 85, 95, 97, 100-01, 103-08, 112-16. These incidents of confusion occurred at different oxygen saturation levels, and occurred in the morning, in the middle of the day, and at night. *Id.* R10's refusal to use the second wheelchair without his oxygen tank is reason enough to provide extra supervision when he smoked. However, two other facts make supervision even more important in R10's case. First, R10 believed that smoking while on oxygen was not dangerous, and second, his RAP sheet and the nurses notes show that he was prone to confusion when his oxygen levels were low. *Id.*; P. Ex. 1, at 7; P. Ex. 5, at 3-4.

Petitioner asserts that it used education, warnings, and monitoring of R10's smoking as approaches to the resident's desire to smoke. P. Br. at 8; P. Ex. 5, at 5-6. Facilities are allowed flexibility in choosing methods to prevent accidents, but the methods must constitute an *adequate* level of *supervision* and *assistance devices*. 42 C.F.R. § 483.25(h)(2) (emphasis added). Education and warnings are not supervision, and the facility's monitoring of R10's smoking did not include supervising his smoking.[4] The second wheelchair could have been an adequate assistance device if R10 had used it. However, Petitioner knew that R10 did not use the second wheelchair when he went outside to smoke. Petitioner also knew that despite its persuasion and education efforts, R10, who experienced confusion, did not believe that smoking with his oxygen tank present – or even with his oxygen tank on – was dangerous. P. Br. at 7; P. Ex. 5, at 3-4; *see also* P. Ex. 6, at 1-3, 5, 8, 11-17, 21, 24-27, 31-32, 34, 36, 39. A facility's duty of care owed to its residents is not one of strict liability, but the facility must provide *adequate* supervision and assistance devices to prevent accidents. *Crestview Manor*, CR1350 (2005); *Windsor*, DAB No. 1902, at 5. Neither were present here.

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[4] If a facility were allowed to escape its duty under 42 C.F.R. § 483.25(h)(2) by educating and warning residents of potential dangers, the duty to prevent accidents would be shifted to residents, which goes against the underlying purpose of the regulations, which is to protect Medicare beneficiaries. Petitioner refers to R10's noncompliance in its brief, which seems to be an attempt to shift the duty to prevent accidents to the resident. P. Br. at 12.

Based on my review of all of the evidence before me on this issue, I find that the facility did not provide an adequate level of supervision to prevent accidents, as required by 42 C.F.R. § 483.25(h)(2) (Tag F324). This deficiency posed a "greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301.

2. CMS failed to prove its prima facie case with respect to 42 C.F.R. § 483.20(g)-(h) (Tag F278).

The regulations provide that resident assessments must accurately reflect the resident's status. 42 C.F.R. § 483.20(g). A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. 42 C.F.R. § 483.20(h).

CMS does not prove its prima facie case with respect to this deficiency. The state surveyors' citation for the deficiency references 42 C.F.R. § 483.20(g)-(h), which does not address the findings in the Statement of Deficiencies. Surveyors found that the facility did not properly sign the care plan portion of eight of fourteen survey sampled residents' RAP Summary Sheets. P. Ex. 1, at 3. The surveyors also found that the facility failed to properly sign one of fourteen survey sampled residents' MDS. *Id.* at 4. However, neither the state surveyors nor CMS made any allegations or produced any evidence to show that the RAP sheets or the MDS form in question were not accurate or that a registered nurse was not involved in the coordination of the assessments.

The deficiency citation should have included 42 C.F.R. § 483.20(i), which provides that (1) a registered nurse must sign and certify that the assessment is completed; and (2) each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. However, CMS does not discuss that tag or argue that the citation in the Statement of Deficiencies is incorrect. In its brief, CMS glossed over the deficiency and referred back to the incorrect sections of the regulations to support its proposition that the RAPs and MDS should have been signed. Neither party addresses the fact that the surveyors cited the incorrect section of the regulations for this deficiency. However, my role is not to make assumptions or to make arguments that should have been raised by the parties' legal counsel. My role is to apply the law as presented and argued by the parties. Therefore, I find that CMS has not proven its prima facie case with respect to Tag F278.

3. CMS did not establish its prima facie case as to 42 C.F.R. § 483.35(h)(2) (Tag F371).

42 C.F.R. § 483.35(h)(2) *Supervision*, provides: "(i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). (ii) In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system."

CMS has failed to establish its prima facie case as to this deficiency. CMS did not discuss this issue in its brief. The section of CMS's brief devoted to this deficiency consists of one sentence: "Respondent relies on the facts as represented in the subject 2567 as to this tag." CMS Br. at 8. The Statement of Deficiencies (2567) shows that surveyors observed one of Petitioner's staff members taking clean dishes out of the dish tray after the dishes had been washed and then storing them for service wet. P. Ex. 1, at 16. These observations are not related to the regulation cited. CMS does not argue that the citation in the Statement of Deficiencies is incorrect. As CMS relies on the incorrect citation, it fails in its burden to prove a prima facie case.

The state surveyors should have cited 42 C.F.R. § 483.35(i)(2), which provides that the facility must "[s]tore, prepare, distribute, and serve food under sanitary conditions." CMS does not discuss the surveyors' findings. While the Statement of Deficiencies is evidence, without more it is insufficient to establish a prima facie case. Again, my role is not to make assumptions or make arguments for legal counsel but to apply the law as presented and argued by the parties.

4. CMS's determination that, on June 29, 2004, the facility's deficiencies posed immediate jeopardy to resident health and safety was not clearly erroneous.

I next consider whether CMS's immediate jeopardy finding was "clearly erroneous."

Immediate jeopardy exists if the facility's noncompliance has caused or is likely to cause "serious injury, harm, impairment or death to a resident." 42 C.F.R. § 488.301. By focusing on definitions in the National Fire Protection Association (NFPA) Publication, NFPA 99, "Health Care Facilities," Petitioner disregards the severity of the harm that could have resulted from R10's smoking with his oxygen supply. *See* P. Br. at 11.

Petitioner makes two main arguments against immediate jeopardy, but the logic underlying the arguments fails. First, Petitioner argues that the state survey agency issued a memorandum on smoking safety the day before the survey took place, and that the facility was in compliance with recommendations in the memorandum and with federal

regulations. P. Br. at 10-11. Second, Petitioner argues that R10's activities were not *likely* to cause serious injury, harm, impairment, or death to a resident. P. Br. at 11. Petitioner also argues that CMS did not analyze the likelihood of harm, as required by the State Operations Manual (SOM).

Petitioner's first argument, that it was in compliance with the recommendations in the state survey agency's memorandum, misses the point that this case deals with federal regulations, and a memorandum issued by a state survey agency is not binding. However, even if the state survey agency memorandum were binding, the facility was not in compliance with the recommendations in the memorandum. Petitioner's attempt to show that immediate jeopardy did not exist because neither the NFPA nor the memorandum defined the outdoors as an oxygen-enriched atmosphere is not persuasive. P. Br. at 10-11. The purpose of the memorandum was "to alert and remind facilities of the need to provide adequate protections for residents who smoke." P. Ex. 13, at 1. The memorandum clearly provides that "according to NFPA-99 guidelines, smoking materials and any other source of ignition should be kept at least 15 ft (4.3 m) away from an oxygen-enriched atmosphere *such as a resident receiving oxygen via nasal canula . . . .*" P. Ex. 13, at 3 (emphasis added). With such guidance provided, the memorandum did not need to specifically address the obvious dangers of holding an open flame up to a flowing source of oxygen. Petitioner cites other provisions of NFPA-99 not referred to in the memorandum, as well as 42 C.F.R. § 470(a), as evidence that residents should only be restricted from smoking near oxygen while indoors. P. Br. at 10. However, Petitioner's compliance with 42 C.F.R. § 470(a) and with NFPA-99 is irrelevant to its compliance with 42 C.F.R. § 483.25(h)(2).

Petitioner knew that smoking with oxygen was dangerous. It provided R10 with the second wheelchair because his normal wheelchair was equipped with oxygen. The manual for the wheelchair with the conserving regulator provided: DO NOT ALLOW SMOKING NEAR THIS PRODUCT. CMS Ex. 13, at 3. Rather than find another option for R10 to smoke safely, Petitioner allowed R10 to smoke alone outside with his oxygen tank present. Petitioner did this with the knowledge that R10 did not consider smoking while using his oxygen supply to be dangerous. P. Ex. 5, at 3.

Petitioner's second argument is that harm was not "likely" to result from R10's smoking while using oxygen. Petitioner's brief does not refer to any evidence that would show that lighting a cigarette and smoking it while using a nasal cannula to deliver oxygen is not likely to cause serious harm. The only evidence Petitioner offers to show that serious harm was not likely to result is the fact that R10 smoked while using oxygen at home for years. P. Ex. 5, at 9. Petitioner concedes that there are no studies on the probability of injury from smoking while using oxygen. *Id.* Petitioner asserts that there is substantial evidence that smoking while using oxygen is a commonplace occurrence, but it does not provide any such evidence. *Id.* at 9-10.

With respect to Petitioner's complaint that the surveyors failed to follow provisions of the SOM to evaluate the likelihood of harm, I note that the SOM is not binding. It provides unpublished guidance to surveyors, but its provisions do not change the participation requirements set out in the regulations by which I am bound. *Alden-Princeton Rehabilitation & Health Care Center*, DAB No. 1873, at 8 (2003); *Beverly Health and Rehabilitation Center – Williamsburg*, DAB No. 1748, at 8 (2000). Even if the SOM were binding, Petitioner offers no evidence that the surveyors did not consider the likelihood of harm. Petitioner only notes that the survey report did not address the likelihood of harm, which does not show that the surveyors did not consider the likelihood of harm when making the deficiency determination.

CMS's determination as to the level of a facility's noncompliance, including a finding of immediate jeopardy, must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board has observed that the "clearly erroneous" standard imposes a "heavy burden" on facilities to show that no immediate jeopardy exists, and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1962, at 11 (2005) (citing *Florence Park Care Center*, DAB No. 1931, at 27-28 (2004) (citing *Koester Pavilion*, DAB No. 1750 (2000)); *see also* 42 C.F.R. § 498.3(d)(10). Reasonable minds can and do differ on issues such as these.

I therefore do not find "clearly erroneous" CMS's finding that, on June 29, 2004, the facility's deficiency posed immediate jeopardy to resident health and safety.

5. The proposed CMP of $3050 for June 29, 2004, and a per day CMP of $50 from June 30, 2004 through August 10, 2004, is reasonable.

By law, the minimum per day penalty for periods of immediate jeopardy is $3050, and the minimum per day penalty for periods of noncompliance that do not amount to immediate jeopardy is $50. Because CMS imposed the lowest CMP permitted by the regulations for the period of immediate jeopardy, it is presumptively reasonable. *See Century Care of Crystal* Coast, DAB No. 2076, at 25-26 (2007); *Wisteria Care Center*, 1892, at 11 (2003); *Hermina Traeye Memorial Nursing Home*, DAB No. 1810 (2002); *Woodstock*, DAB No. 1726, at 43 (2000) (finding that a $3050 per day CMP based on a finding of immediate jeopardy was reasonable because CMS imposed the lowest per day CMP possible under the regulations). I am without the discretion to set aside or reduce the lowest per day regulatory rate of $50 per day. 42 C.F.R. § 488.438(a) and (e)(1); *see also Alden Town Manor Rehabilitation & HCC*, DAB No. 2054, at 30-31 (2006) ("[t]he ALJ (and here the Board) is prohibited from setting or reducing a CMP amount to zero, which effectively means that the minimal CMP amount permissible where . . . a basis has been found for imposing a remedy and CMS has selected a CMP, is $50 per day."); *Health Nursing and Convalescent Center*, DAB CR610 (1999). The fact that CMS did not establish a prima

facie case relative to 42 C.F.R. § 483.20(g)-(h) (Tag F278) and 42 C.F.R. § 483.35(h)(2) (Tag F371) does not affect the amount of the CMP in this case as the citation established by CMS as to 42 C.F.R. § 483.25(h)(2) (Tag F324) fully supports the entire CMP imposed.

VI. Conclusion

For the reasons discussed above, I affirm CMS's determination to impose a per day CMP in the amount of $3050 for June 29, 2004, and a per day CMP of $50 from June 30, 2004 through August 10, 2004.

/s/ Alfonso J. Montaño
Administrative Law Judge