Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

South Haven Health and Rehabilitation Center
(CCN: 01-5043),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-09-349

Decision No. CR2108

Date: April 07, 2010

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose remedies against Petitioner, South Haven Health and Rehabilitation Center, consisting of: (1) a civil money penalty of $4,550 for each day of a period that began on November 29, 2008 through December 8, 2008; and (2) a civil money penalty of $150 for December 9, 2008.

I. Background

Petitioner is a skilled nursing facility in the State of Alabama. It participates in the Medicare program. Its participation in Medicare is governed by sections 1819 and 1866 of the Social Security Act (Act) and by implementing regulations at 42 C.F.R. Parts 483 and 488.

Alabama State survey agency surveyors completed a compliance survey of Petitioner's facility on December 9, 2008 (December Survey). The surveyors found that Petitioner was noncompliant with Medicare participation requirements. Specifically, the surveyors concluded that Petitioner was not complying substantially with the requirements of 42 C.F.R. §§ 483.25(h) and 483.75. The

first of these two regulations requires a skilled nursing facility to ensure that its resident environment remain as free of accident hazards as is possible and that it provide each of its residents with adequate supervision and assistance devices to prevent accidents. The second regulation states that a skilled nursing facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain each resident's highest practicable state of physical, mental, and psychosocial well being.

The surveyors concluded that Petitioner's noncompliance with these two regulations was so egregious as to comprise immediate jeopardy for residents of the facility. "Immediate jeopardy" is defined at 42 C.F.R. § 488.301 to mean a situation where noncompliance causes, or is likely to cause, serious injury, harm, impairment, or death to a resident or residents of a facility.

CMS concurred with the surveyors' conclusions and determined to impose the civil money penalties that I describe in the opening paragraph of this decision. Petitioner requested a hearing to challenge CMS's determination, and the case was assigned to me for a hearing and a decision.

I ordered the parties to complete pre-hearing exchanges that comprised pre-hearing briefs plus proposed exhibits, including the written direct testimony of all witnesses. The parties complied with my order. CMS then moved for summary disposition. I denied the motion and scheduled the case for an in-person hearing. However, the parties then agreed that the case could be heard and decided based on their written submissions. Each party filed a final brief.

CMS filed 29 proposed exhibits that it identified as CMS Ex. 1 – CMS Ex. 29. Petitioner filed 36 proposed exhibits that it identified as South Haven Ex. 1 – South Haven Ex. 36. I receive all of the parties' proposed exhibits into evidence.[1]

II. Issues, findings of fact and conclusions of law

A. Issues

The issues are whether:

1. Petitioner failed to comply with Medicare participation requirements.

[1] For brevity's sake, I refer to Petitioner's exhibits as "P. Ex.," rather than as "South Haven Ex."

2. CMS's determination of immediate jeopardy level noncompliance is clearly erroneous.

3. CMS's civil money penalty determinations are reasonable in duration and amount.

B. Findings of fact and conclusions of law

I make the following findings of fact and conclusions of law (Findings).

1. Petitioner failed to comply with the requirements of 42 C.F.R. §§ 483.25(h) and 483.75.

CMS's allegations of noncompliance focus in large measure on the care that Petitioner gave to three of its residents, who are identified as Residents #s 1, 2, and 5 in the report of the December Survey. CMS Ex. 1. In summary, CMS asserts that each of these residents was at high risk for sustaining falls and had been identified as a falls risk by Petitioner's staff. The interventions that the staff developed to protect each of these residents included bed alarms and the wearing of personal alarms (sometimes also referred to as "tab" or "TAB" alarms). According to CMS, Petitioner's staff relied on these alarms as warning devices when residents engaged in movement or activities that put them at heightened risk for falling. However, CMS contends that the staff did not assure that the residents wore their alarms, or that their alarms functioned as intended, and, thus, the residents were deprived of one of the interventions that the staff had determined to be essential for their protection. Moreover, according to CMS, Petitioner's management failed to put systems into place that assured that alarms were worn and maintained as directed.

I find CMS's arguments to be persuasive and supported by the weight of the evidence. I am not persuaded by Petitioner's arguments and assertions that it protected its residents adequately. Consequently, I sustain CMS's findings of noncompliance.

a. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h).

The applicable regulation has been the subject of much litigation. It is settled that it requires a facility to take all reasonable measures to protect its residents from accident hazards that are known or that are foreseeable.

The evidence offered by CMS describes similar circumstances involving Residents #s 1, 2, and 5. Each of these residents was known to be at a great risk for falling. Each of them also suffered from mental or cognitive impairments that precluded the possibility that the resident would be responsible for her own safety. And, with each of these residents, Petitioner's staff relied on the use of personal and/or bed alarms as a way of protecting them.

Resident # 1 had impairments that rendered it difficult for her to make decisions and which required the staff to give her extensive assistance in the activities of daily living. CMS Ex. 25 at 3-8. Furthermore, the resident was incontinent, which meant that she needed assistance from the staff when she needed to use the bathroom. *Id.* The resident was not only at a great risk for falling but had actually sustained at least four falls while residing at Petitioner's facility. CMS Ex. 4 at 7-8; 75; 85-86; 142-45. Two of these falls caused the resident to sustain severe injuries. On May 8, 2008, the resident fell while unobserved by Petitioner's staff and sustained a broken left hip and right arm, necessitating surgery. *Id.* at 15. On November 29, 2008, Resident # 1 fell again while unobserved and sustained a broken right hip that required surgical stabilization. *Id.* at 153-55.

At some point after the resident's first fall in May 2008, Petitioner's staff decided that the resident needed to wear a personal alarm. The staff concluded that the resident had a history of falls and that she was "at risk for more falls due to incontinence and inability to transfer herself." CMS Ex. 4 at 38. The staff developed falls care plans for Resident # 1. P. Ex. 6. These plans show that the use of alarms was one of the principal elements implemented by Petitioner to protect the resident. The resident was given a personal alarm consisting of a tab alarm that attached to her clothing, her wheelchair, and a bed alarm. *Id.* The care plans show that Petitioner's staff relied on these alarms throughout the resident's stay as devices for warning the staff about inappropriate or dangerous activity by the resident. On December 2, 2008, the staff wrote a series of care guidelines for Resident # 1 that included the following admonition:

> Resident must have tab alarm on @ all times.

Id. at 5.

However, and these plans notwithstanding, the weight of the evidence establishes that Petitioner's staff did not assure that the resident's alarms functioned correctly. After the fall of November 29, 2008, Petitioner's staff determined that the resident's bed alarm – although attached to the resident's bed – failed to sound when the resident rose from her bed and fell. CMS Ex. 4 at 148-50. On this occasion the resident had ambulated from her bed to the hallway and fell without the alarm ever sounding. *Id.* Furthermore, the evidence shows that the staff did

not assure that the resident's alarm was properly connected. On December 4, 2008, surveyors observed the resident in bed but with the alarm cord disconnected from the alarm box to the mattress alarm. CMS Ex. 8 at 37.

Resident # 2 began her stay at Petitioner's facility in February 2006. The resident suffered from mental limitations and was assessed by Petitioner's staff as being moderately impaired in her daily decision making and as having both long and short term memory problems. CMS Ex. 6 at 3, 7. On October 30, 2008, the resident sustained a fall while unobserved by Petitioner's staff. She was found by staff on the floor of her room, between her bed and the wall. CMS Ex. 6 at 39-40. Petitioner's staff determined that the resident needed a TAB bed alarm to protect her from sustaining additional falls. *Id.* at 36, 40.

The resident was observed in bed by surveyors on December 3 and 4, 2008. On neither occasion was the TAB bed alarm attached and working. CMS Ex. 8 at 12, 15.

Resident # 5 was admitted to Petitioner's facility in June 2007. Her diagnoses included dementia that caused her to experience moderately impaired decision making skills and both short and long term memory problems. CMS Ex. 7 at 5, 8. She had experienced a right leg amputation and was assessed by Petitioner's staff to be at risk for falls. *Id.* at 26-27. Indeed, the resident fell several times, while she resided at the facility. She sustained falls on February 10, June 24, August 15, and August 19, 2008. *Id.* at 26-27, 45, 78, 82-85.

Petitioner's staff determined that the resident needed to wear an alarm. Her July 3, 2007 care plan stated that the resident should "use tab alarm while in wheelchair" and admonished the staff to "make sure tabs alarm is working and intact after rounds." CMS Ex. 7 at 46.

The resident was observed by surveyors on December 4 and 5, 2008. On none of these occasions was the resident's personal alarm in place. CMS Ex. 1 at 18.

The evidence offered by CMS leads to certain inescapable conclusions. It is evident that Residents #s 1, 2, and 5 were extremely vulnerable individuals. Each of them suffered from physically limiting conditions that made her prone to falling and, indeed, each of them fell while residing at Petitioner's facility. These residents' vulnerability to falls was heightened by their dementia or other mentally limiting conditions. None of these residents was an individual who could be trusted to make the kind of judgments that a physically limited individual would have to make to avoid encountering falls risks.

Petitioner had a duty to assure that all reasonable measures be taken to protect these residents from falling. Petitioner's staff understood the limitations that the residents manifested and planned interventions that were designed to protect them. These interventions included the use of personal and bed alarms.

Alarms, in and of themselves, do not protect a resident against falling. An alarm is at most a device that extends the reach of the staff by buying a few seconds time for the staff to react to a dangerous situation. If the staff determines to rely on alarms as a way of extending their reach, they must assure that these devices are worn properly and are functioning. Providing the resident with an alarm that fails to function properly may put the resident in greater jeopardy than if the resident had never been supplied an alarm. That is because alarms can create an expectation in the staff that they will sound if triggered. If the staff has that expectation and an alarm fails to work as intended, the staff may assume that no danger exists to the resident when, in fact, the resident is in potentially life-threatening straits.

The evidence introduced by CMS establishes unequivocally that Petitioner's staff decided to rely on alarms to protect Residents #s 1, 2, and 5, in lieu of providing these residents with continuous supervision. In other words, the staff relied on the alarms as a substitute for having staff members watch falls prone residents continuously. Given that reliance, it was vitally important that the residents wore their alarms as prescribed and that the alarms that were furnished to the residents functioned as intended.

These residents' alarms either did not function as intended or the alarms were not attached in a manner that would enable them to function. These failures deprived Petitioner's staff of the precise warning devices that they had determined were necessary to protect the residents. That is a conspicuous failure to protect these residents.

Petitioner does not challenge evidence showing that during the survey the residents' alarms were not functional. Rather, Petitioner attempts to deflect this evidence by arguing that it undertook many interventions to protect Residents #s 1, 2, and 5 and that the use of alarms was merely one of those interventions. The conclusion that Petitioner would have me draw from the laundry list of interventions that it implemented is that alarms were but a minor thread in a large fabric of interventions. Petitioner asserts, essentially, that if it failed to implement and monitor the use of alarms, it more than compensated for that with the other interventions it developed.

Among the many interventions Petitioner recites are general interventions that Petitioner implemented for all of its residents:

- All new residents were assumed to be at risk for sustaining falls until their cases were reviewed by the staff's interdisciplinary team. Petitioner's Final Brief at 4.

- Newly admitted residents were placed in a Falling Star program, a special program designed to identify and protect falls prone residents. Elements of that program included placing special identifying stars on the residents' beds, wheelchairs, and other items to apprise staff that these residents were at risk for falling. *Id.*

- Residents who fell were assessed and treated for injuries. Then, Petitioner's staff initiated a post-fall review process that included reviews of the resident's status and notification of the resident's physician and family. *Id.*

- Petitioner undertook at least monthly interdisciplinary reviews of all residents who had experienced falls. *Id.* at 5.

- Petitioner notified a resident's physician and family about any change in a resident's condition that might increase the resident's risk of falling. *Id.*

- Petitioner's staff received training to assure that they were able to deal with falls prone residents. *Id.*

Petitioner asserts also that it took effective specific measures for each of the three residents whose care is at issue, in addition to those general measures that I have just described. It asserts that, in the case of Resident # 1, the staff developed a special care plan for her that addressed her propensity to remove her personal alarm. Petitioner's Final Brief at 6; P. Ex. 6. That plan, according to Petitioner, included targeted education for the resident's family involving the use of alarms, staff reinforcement with the resident that the personal alarm was for her safety, and staff monitoring of the resident's attempts to remove her alarm. *Id.* at 6-7. Petitioner contends that it appropriately reassessed Resident # 1 after each of her falls and added interventions to her care plan, including: providing physical therapy to the resident; removing the resident's bedside table; and moving the resident's room closer to Petitioner's nurse's station. *Id.* at 7.

Petitioner contends that it implemented multiple interventions to protect Resident # 2, which included: using mattress guards to protect her; placing her call light within reach; ensuring that the lighting in the resident's room would support visual mobility; orienting the resident to her room environment; encouraging the resident to ask for assistance when needed; putting a personal alarm on the resident's chair; and referring the resident to therapy as needed. Petitioner's Final Brief at 7; P. Ex. 15. It asserts that it responded appropriately to the resident's October 2008 fall by putting an alarm on the resident's bed and adding fall guards to protect the resident. *Id.* at 8.

As respects Resident # 5, Petitioner argues that it undertook interventions that included providing the resident with a special "scoop mattress" that was intended to prevent her from rolling out of her bed. Petitioner's Final Brief at 8. Petitioner asserts that it provided the resident with a special reclining wheelchair with a pommel cushion that was designed to protect her from sliding out of the chair. *Id.* It contends that it implemented other interventions including: keeping the resident's call light in reach to encourage use; placing a non-skid safety mat on the floor next to the resident's bed; keeping the resident in a supervised area when she was in her wheelchair; providing the resident with a personal alarm; and referring her to therapy as needed. *Id.* It argues that it reassessed the resident after she sustained her August 15, 2008 fall and added physical therapy to the resident's interventions. After the resident sustained a second fall on August 20, 2008, according to Petitioner, it placed the resident on maxi-float mattress. *Id.* at 8-9.

However, all of these interventions do not compensate for Petitioner's failure to assure that the residents' alarms were worn by the residents and were in working order. It is evident from Petitioner's own recitation of the interventions it implemented for the three residents that its staff relied on the use of personal and bed alarms as mechanisms for warning them about hazardous developments that could precipitate a fall. Petitioner's recitation of its interventions makes it clear that alarms were an essential element of the care that Petitioner planned for the residents. Petitioner has not explained how any of the other interventions that it introduced for these residents would substitute for that essential element.

As I have explained, alarms serve a unique role in providing protection to residents. They are used solely as a way to enhance – or in some instances to substitute for – direct supervision of residents who are at risk for falls. None of the other interventions recited by Petitioner performed this vital function, and, thus, none of them substituted for alarms in the scheme of care that Petitioner developed for its residents. Consequently, the failure by Petitioner to assure that residents wore alarms as directed and that the alarms functioned was a fatal flaw in Petitioner's protection scheme that could not be compensated for by other interventions, such as Petitioner's Falling Star program or its issuance of special

mattresses. Indeed, the several falls experienced by residents – many of which occurred while these residents were not observed by Petitioner's staff – conclusively shows why enhanced supervision and alarms was a vital protection that could not be substituted for with some other intervention.

b. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.75.

The intent of 42 C.F.R. § 483.75 is that a facility's management assure that its staff are conducting their activities consistent with the facility's obligations under the Act and regulations, and with applicable standards of nursing care. As respects the use of alarms by residents, a facility's management has a duty to assure that the facility's staff is trained properly in the use and maintenance of alarms and that the residents of the facility receive care consistent with the unique plan of care that was developed for each of them.

CMS offered evidence that establishes that Petitioner failed to manage effectively the use of alarms by residents in its facility. This was a systemic problem and not simply a failure to attend to the needs of three residents.

It is a professionally-recognized standard of care governing the use of alarms by a facility that it maintains a master list of which residents are provided alarms. CMS Ex. 28 at 8.

> It is not realistic, due to time constraints and staffing, for staff to look at each resident's individual chart to determine if someone is provided a safety device.

Id.

The weight of the evidence establishes that Petitioner had no system to assure that alarms were being worn by those residents for whom they had been assigned and that these alarms were in working condition. A nursing supervisor told the surveyors that Petitioner maintained no master list of residents who wore alarms. CMS Ex. 8 at 48. Petitioner's director of nursing admitted that, prior to December 9, 2008, Petitioner lacked an effective system for monitoring the functioning and placement of alarms. *Id.* at 113-14. She also admitted that there was no list of residents who wore alarms that could be consulted by Petitioner's nursing staff. *Id.* Petitioner's administrator admitted that prior to December 9, 2008, Petitioner's staff was not held accountable for monitoring alarms and safety devices. *Id.* at 112.

The absence of an easily accessible centralized record system that showed which residents wore alarms sowed confusion among Petitioner's staff. It also made it very difficult for staff to determine easily who wore alarms and whether those alarms were functioning as intended. Some staff members told surveyors that they needed to check a card system to determine which residents had been given alarms. CMS Ex. 8 at 36, 41. Others said that they could ascertain which residents had been given alarms by checking their care plans. *Id.* at 42. One licensed practical nurse told the surveyors that she thought that the facility's certified nursing assistants (CNAs) were responsible for checking whether residents wore alarms and assuring that the alarms worked. *Id.* at 40. There was also confusion among staff as to where the monitoring of alarms was documented in resident records. Some thought that it was documented in the residents' medication administration records when, in fact, that was not the case. *See* CMS Ex. 8 at 44. Some thought that it was documented in nurse's notes when, in fact, that was almost never the case. CMS Ex. 8 at 34, 48; *see* CMS Ex. 4 at 91.

I have considered Petitioner's arguments and supporting evidence contesting that which I have just described, and I find them not to be persuasive. Petitioner recites that it had a number of systems in place, including its Fall Management System, its Personal Alarms Policy, a Falling Star Program, and an Incident/Accident Investigation Policy and Procedure. It also argues that these systems, in combination, assured that the use of alarms was managed properly. Petitioner's Final Brief at 23; *see* P. Ex. 23; P. Ex. 24, P. Ex. 32 – P. Ex. 35. But, Petitioner does not point to anything in these systems that provided its staff with a list of those residents who were given alarms or which assured that the alarms were being checked and monitored systematically.

For example, Petitioner asserts that its Falling Star Program enabled its staff to identify those residents who were at risk for sustaining falls. Petitioner's Final Brief at 23. That may be so, but that begs the question of whether the staff knew which of these fall-risk residents had been assigned alarms. The fact that staff may have known that there were residents who were falls risks does nothing to assure that specific staff members were assigned the task of checking alarms to ascertain whether they were being worn and that they were in good working order.

Petitioner asserts that its resident care plans and its card index maintained at the nurse's station constituted a system for determining which residents wore alarms. Petitioner's Final Brief at 24. I disagree. I do not doubt that there were documents on file at Petitioner's facility that, when read closely, would have informed staff which residents had been assigned alarms. But, requiring staff to read through many pages of care plans to ferret out such information, on a shift-by-shift basis, is simply not practicable. The point made by CMS, which I find that Petitioner failed to rebut, is that there was no easily accessible single

document anywhere in Petitioner's facility that listed which residents had alarms or which contained an easy-to-access account of whether the alarms functioned. That was a fatal flaw in the system. Moreover, the problem at Petitioner's facility was compounded by the fact that no one on the staff was specifically assigned the task of monitoring the residents with alarms. The systems described by Petitioner do not compensate for that failure.

Petitioner contends that its nurses conducted rounds checks, which assured that residents had properly functioning alarms in place. Petitioner's Final Brief at 24. However, it has provided no evidence, from which I can reasonably infer, that the nurses were assigned to check alarms on a routine basis or that they did so. Petitioner points to evidence showing that, on November 29, 2008, a nurse checked Resident # 1's personal alarm to assure that it functioned. P. Ex. 25. But, that event is merely one instance. What CMS alleges – and Petitioner has failed to rebut – is that there was no system in place to assure that Petitioner's staff made such checks routinely and regularly. It is that systemic failure that comprises Petitioner's noncompliance.

2. CMS's determination of immediate jeopardy level noncompliance is not clearly erroneous.

The evidence presented by CMS strongly supports findings that Petitioner manifested immediate jeopardy level noncompliance with the requirements of 42 C.F.R. §§ 483.25(h) and 483.75. There was, in my judgment, a likelihood of serious injury, harm, or death, to residents of Petitioner's facility as a consequence of Petitioner's failure to protect its residents adequately and to have systems in place to assure that alarms were worn as directed and functioned properly.

As I discuss above, alarms do not prevent falls. At most, alarms serve as warning devices that allow staff in a facility to respond promptly to a potential emergency. When staff chooses to rely on alarms, it certainly means that it is substituting them for direct and continual observation of residents. In that circumstance, it is absolutely vital that the alarms that substitute for direct observation are worn by their recipients and that they function perfectly. If an alarm that is issued to a resident is not worn by that resident, or fails to function as intended, it means that the resident can be in a situation of extreme danger without the vital protection that the staff determined would substitute for direct observation. That is a recipe for disaster.[2]

[2] Indeed, several of Petitioner's residents fell while unobserved and, on at least one of those occasions, the resident's alarm was subsequently determined not to have functioned correctly. CMS Ex. 4 at 148-50.

In arguing that CMS's determination of immediate jeopardy is clearly erroneous, Petitioner recites again all of the interventions it put into place for its falls prone residents. Petitioner's Final Brief at 25. I do not find this litany of interventions to be a persuasive rebuttal of the evidence establishing a likelihood of harm, or worse, to residents in Petitioner's facility. As was evident from the residents' care plans, Petitioner considered alarms to be a vital element in protecting the residents. The other interventions may have been useful, or even important, but they were no substitute for functioning and properly worn alarms.

Petitioner also argues that at no time during the December Survey did any of the three residents whose care is at issue in this case experience a fall. That may be so, but that does not derogate from my conclusion that there existed immediate jeopardy level noncompliance. The risk to residents from non-functioning alarms and alarms that were not properly worn was palpable. Moreover, one of Petitioner's residents, Resident # 1, sustained a fall that resulted in serious injuries only a few days prior to the survey.

3. CMS's civil money penalty determinations are reasonable in duration and amount.

a. Petitioner has not challenged CMS's determinations as to duration of noncompliance.

CMS determined that Petitioner manifested immediate jeopardy level noncompliance beginning on November 29, 2008 through December 8, 2008. It determined additionally that Petitioner remained noncompliant, albeit at the non-immediate jeopardy level of noncompliance, on December 9, 2008.

Petitioner has offered neither evidence nor argument to challenge CMS's duration determinations, and so I sustain them. Petitioner has not argued, for example, that if it was noncompliant at the immediate jeopardy level, that noncompliance began after November 29, 2008, or that it corrected that noncompliance earlier than December 8, 2008.

b. Immediate jeopardy level penalties of $4,450 per day for each day of the November 29 through December 8, 2008 period are reasonable.

Daily civil money penalties that are imposed to remedy immediate jeopardy level noncompliance must fall within a range of $3,050 to $10,000 per day. 42 C.F.R. § 488.438(a)(1)(i). There are criteria for deciding where within that range a penalty should fall. Penalty amount depends on factors, which may include: the

seriousness of a facility's noncompliance; its compliance history; its culpability; and its financial condition. 42 C.F.R. §§ 488.438(f)(1) – (4); 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)).

The evidence in this case establishes that $4,450 per day immediate jeopardy level civil money penalties are reasonable. The penalties are, in fact, quite modest when measured against the maximum amounts that CMS could have imposed. CMS elected to impose penalties *totaling* $4,450 per day as a remedy for two immediate jeopardy level deficiencies when, in fact, it could imposed penalties of at least $3,050 per day for *each* of those deficiencies. Furthermore, CMS determined the starting date of Petitioner's noncompliance to be November 29, 2008, when, in fact, Petitioner's noncompliance clearly predated November 29. For example, Petitioner's failure to have systems in place to monitor the assignment, use, and maintenance of alarms did not begin on November 29, 2008, but at some point that was previous to that date.

Second, the daily penalty amount of $4,450 is amply justified by the seriousness of Petitioner's noncompliance and by its compliance history. As I discuss above at Finding 2, the noncompliance in this case was egregious. The failure by Petitioner's staff to assure that residents wore functioning alarms put these residents at grave risk for harm.

Moreover, Petitioner has a history of immediate-jeopardy level noncompliance in the past. In June 2006, Petitioner was found to be noncompliant at the immediate jeopardy level with regulations that were designed to protect residents against elopement and which governed management of its facility. That noncompliance involved similar problems as those that are addressed in this case. Specifically, in June 2006, Petitioner was found to have failed to ensure that a resident received an alarm-like device (a Wanderguard bracelet) to protect the resident against eloping Petitioner's premises. CMS Ex. 27 at 8-17. The fact that Petitioner manifested past noncompliance of a nature that is similar to that which is addressed in this case convinces me that meaningful remedies need to be imposed to deter Petitioner from future noncompliance.

Petitioner has not offered evidence or arguments that prove that a penalty amount of $4,450 per day is unreasonable. In opposing the penalty amount, Petitioner reasserts its alleged non-culpability for the immediate jeopardy level deficiencies. Petitioner's Final Brief at 26-27. I have explained in detail above why I do not consider those arguments to be persuasive, and I do not revisit them here.

c. A non-immediate jeopardy level civil money penalty of $150 for December 9, 2008 is reasonable.

Daily civil money penalties for non-immediate jeopardy level deficiencies must fall within a range of $50 to $3,000 per day. 42 C.F.R. § 488.438(a)(1)(ii). The same criteria are used for deciding where within that range a penalty should fall as are used for deciding immediate jeopardy level penalty amounts. 42 C.F.R. §§ 488.438(f)(1) – (4); 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)).

Here, CMS determined to impose a minimal civil money penalty – only five percent of the maximum allowable non-immediate jeopardy penalty amount – for Petitioner's one day of noncompliance at the non-immediate jeopardy level. Petitioner has offered neither argument nor evidence to challenge that determination, and, consequently, I sustain it.

/s/
Steven T. Kessel
Administrative Law Judge