Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
JFK Hartwyck at Oak Tree	)	Date: May 13, 2008
(CCN: 31-5251),	)	
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-06-167
	)	Decision No. CR1788
Centers for Medicare & Medicaid	)	
Services.	)	
	)	

DECISION

For the reasons set forth below, I uphold the Centers for Medicare & Medicaid Services' (CMS's) initial determination that JFK Hartwyck at Oak Tree failed to substantially comply with participation requirements governing nursing home facilities. CMS presented evidence which established *prima facie* that Petitioner was not in substantial compliance with 42 C.F.R. §§ 483.25, 483.25(h)(2), and 483.70(c)(2), and Petitioner was not able to rebut CMS's claim by a preponderance of the evidence.

I. Background

JFK Hartwyck at Oak Tree (Petitioner or facility), is a long-term care facility, located in Edison, New Jersey. Petitioner is authorized to participate in the federal Medicare program as a skilled nursing facility (SNF). On March 21, 2005, in response to the facility's reporting an incident, the New Jersey State Department of Health and Senior Services (state agency) conducted an investigation of the facility. The state agency determined, as reported in the CMS Form 2567 Statement of Deficiencies (SOD), that from March 4 through March 22, 2005, Petitioner was not in substantial compliance with federal Medicare participation requirements and for one day its deficiencies posed immediate jeopardy to residents. As a result, on August 16, 2005, CMS notified Petitioner that it was imposing a Civil Money Penalty (CMP) of $4000: $3100 for past noncompliance at an immediate jeopardy level on March 4, 2005, and $50 per day for 18

days (March 5 through March 22, 2005) of substantial noncompliance that did not amount to immediate jeopardy. CMS Exhibit (Ex.) 9, at 1-3. Before CMS sent its notification, Petitioner participated in Informal Dispute Resolution (IDR), after which the state agency recommended deleting the F698 Tag (42 C.F.R. § 483.25, past noncompliance). However, CMS did not agree with the results of IDR, and on November 15, 2005, informed Petitioner that all of the remedies in the August 16, 2005 letter remained in effect. P. Ex. 18.

On December 19, 2005, Petitioner requested a hearing. On May 9, 2006, Petitioner moved for summary judgment, and on June 9, 2006, CMS opposed Petitioner's motion and filed a cross motion for summary judgment. I denied both requests for summary judgment and set a schedule for briefing and a hearing. The parties filed pretrial memoranda (CMS Memo and P. Memo). On July 16-17, 2007, I conducted a hearing in this matter. CMS introduced 23 exhibits (CMS Exs. 1-23) and Petitioner introduced 25 exhibits (P. Exs. 1-25). I admitted the exhibits into the record. On November 16 and 19 2007, the parties filed post-hearing briefs (CMS Cl. Br. and P. Cl. Br.), and on December 5, 2007, they filed reply briefs (CMS Reply and P. Reply).

II. Issues

The issues before me are: (1) whether Petitioner was in compliance with applicable regulations, specifically 42 C.F.R. §§ 483.70(c)(2), 483.25(h)(2), and 483.25, from March 4 through March 22, 2005; (2) if the facility was out of substantial compliance, whether the deficiencies amounted to immediate jeopardy on March 4, 2005; and (3) if the facility was out of compliance, whether the proposed CMP is reasonable.

III. Applicable Law

The Social Security Act (Act) sets forth the requirements for nursing facility participation in the Medicare program 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 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.

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.

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. The facility must overcome CMS's showing by a preponderance of evidence to prevail. *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 set forth in the Departmental Appeals Board (Board) decision in the *Hillman* case, and is 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.

A. From March 4 through March 22, 2005, the facility was not in compliance with 42 C.F.R. §§ 483.25, 483.25(h)(2), and 483.70(c)(2).

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 (Tag F698). A subsection of that regulation requires facilities to ensure that "each resident receives adequate supervision and assistance devices to prevent accidents." 42 C.F.R. § 483.25(h)(2) (Tag F324). The regulations also require facilities to maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. 42 C.F.R. § 483.70(c)(2) (Tag F456).

This case involves Petitioner's maintenance of personal alarms on residents' beds and chairs, the supervision and assistance devices Petitioner provided for its residents, and Petitioner's response to an emergency. Resident 1 (R1) was admitted to the facility on February 7, 2005. CMS Ex 1, at 7. He had a history that included Parkinson's Disease, Depression with Hallucinations and Major Depression with Psychosis. CMS Ex. 1, at 1. R1 also had a history of falls, including several at the facility. CMS Exs. 15; 16; 18. He spoke Russian and little or no English, so the facility had one of its staff members who spoke Russian visit R1 when possible and create a communications book for him. Tr. 144:2-4; CMS Ex. 3, at 1-2. The facility's social services progress notes show that R1 was having trouble adjusting to the facility and that he was restless. CMS Ex. 6, at 1. On several occasions he attempted to get out of his bed or wheel chair without assistance. He was able to tip his wheelchair forward to get out. CMS Ex. 18, at 14-15. The facility addressed these problems with various interventions, including providing R1 with a low bed with side rails and an adjacent mat, providing him with an alarm on his bed and on his wheelchair, adding an anti-tip device to his wheelchair, recommending a "merry walker," using restraints, and recommending close supervision. On at least one occasion at night R1 was given Ambien. CMS Ex. 15, at 1-3; CMS Ex. 16, at 1; CMS Ex. 18, at 22; Tr. 143:5-15. One of the restraints the facility used was a rear-closing seatbelt on R1's wheelchair.

On March 1, 2005, R1 was restless and agitated. Tr. 54:4-11. At 10:45 p.m. he got out of bed without assistance, so a staff member put him in his wheelchair with the rear-closing seatbelt and took him to the day room. CMS Ex. 5, at 6-7. CNA Vergie Staggs was folding linens near the day room at that time. *Id*. She went down the hall to take residents' temperatures, which she estimates took five or six minutes. *Id.* at 8.

When CNA Staggs returned, R1 was on the floor with the rear-closing seatbelt, which was still attached to the wheelchair, around his neck. CMS Ex. 5, at 6-7. In an interview, CNA Staggs said, "I panicked." *Id.* at 8. She tried to loosen the seatbelt for what the interviewer recorded as a "couple of minutes." CNA Staggs reported that she told LPN Elsie Fouchard that she needed help, but LPN Fouchard said she never heard her. *Id.* at 7; Tr. 28:8-9. CNA Staggs said that she went down the hall to tell another CNA, Linda Rudy. When questioned about that decision, CNA Staggs said she did not know why she did it. *Id.* at 8. She reported feeling afraid, frightened, and not being able to "yell." *Id.* She also said R1 looked like he would "be OK." *Id.*

CNA Staggs said that she told CNA Rudy that the seatbelt was around R1's neck. However, CNA Rudy did not recall CNA Staggs telling her anything about a belt around R1's neck, only that R1 was on the floor and needed her help. CMS Ex. 5, at 9, 15. On their way to the day room, the two CNAs stopped to put a thermometer in its case before attending to R1. *Id.* at 14. When they got to the day room, CNA Rudy immediately called out for LPN Fouchard. *Id.* at 9, 14. When LPN Fouchard arrived she found R1 sitting on the floor in front of his wheelchair with the rear-closing seatbelt around his neck. He was unresponsive, not breathing, and did not have a pulse. LPN Fouchard got scissors and cut the seatbelt. *Id.* at 9. Staff initiated CPR, intubated R1, and called 911. R1 regained his pulse and was transferred to the hospital. CMS Ex. 4, at 1; CMS Ex. 5, at 1, 14. He died several days later at the hospital. Tr. 13:15-22.

1. The facility did not maintain all essential mechanical, electrical, and patient care equipment, specifically residents' personal alarms, in safe operating condition as required by 42 C.F.R. § 483.70(c)(2) (Tag F456).

I consider first whether this incident establishes that the facility was not in substantial compliance with 42 C.F.R. § 483.70(c)(2), which requires facilities to maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Petitioner focuses much attention on explaining why R1's chair alarm did not sound – because his head was on the sensor pad. This argument does not adequately address the cited deficiency. First, it does not address the fact that the volume was turned down on the particular chair in question. If pressure were released from the sensor pad, the alarm would have sounded at the nurses station, but it would not have sounded at the chair itself. If the volume was turned down on the chair itself, it would not be unreasonable to assume that the alarm was not in safe operating condition. An alarm on a chair would alert staff within hearing distance, who would almost certainly be able to respond sooner than staff at the nurses station to the problem of a resident getting out of his seat. Second, even assuming that R1's particular chair was in safe operating condition, that does not address the broader problem of other equipment failures in the facility. The surveyor investigated other patient equipment in the facility and found that many alarms were not in safe operating condition.

When tested, Resident 2's bed alarm did not sound in the resident's room or at the nurses station. CMS Ex. 23, at 1. The alarm on Resident 3's wheelchair had a cut wire, so when he stood up, the alarm did not sound. *Id.* at 2. Resident 4 was supposed to have a alarm on her bed and chair. The alarm was not in place, and the pad sensor and cord on the bed were not connected to anything. The alarm's sensor box was found in Resident 4's wheelchair, which was in the hall. *Id.* at 3. Resident 5 was supposed to have a alarm on his bed and on his wheelchair. The alarm on Resident 5's bed was not connected to anything, and when the facility's maintenance man shook the sensor box, he said that it sounded as if it had broken parts in it. When staff assisted Resident 5 to his wheelchair, no alarm was placed on the wheelchair. CMS Ex. 1, at 4. Resident 6's bed alarm did not sound when tested. *Id.* Resident 7's bed alarm did not sound when tested. *Id.*

I need not find that R1's chair was not in safe working condition to determine that the facility was not in substantial compliance with this requirement.[1] I find that the facility did not maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Moreover, the alarms that were not working properly would not have constituted adequate assistance devices as required by 42 C.F.R. § 483.25(h)(2).

2. *The facility did not provide an adequate level of supervision or assistance devices to prevent accidents as required by 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 (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.").

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[1] Facility documents indicate that Petitioner had been experiencing problems with the alarms. On February 12, 2005, R1 fell. His alarm was in place, but it was not working at the time of the incident and the alarm did not sound. That alarm was replaced. CMS Ex. 18, at 10-11.

Here, the facility did not anticipate the potential for accidents and 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).

While no previous incident involved identical circumstances, R1 had attempted on several occasions before March 1, 2005, to escape his wheelchair and bed and had injured himself doing so. CMS Ex. 5, at 2; CMS Ex. 6; CMS Ex. 18, at 14-15, 16, 18-19, 20-21. On February 17, 2005, R1 got out of the rear-closing seatbelt on the floor. CMS Ex. 18, at 16, 20. On February 18, 2005, R1 was found on the floor with his wheelchair on top of him and with the rear-closing seatbelt still on.[2] CMS Ex. 2, at 5; CMS Ex. 18, at 20; Tr. 78-79. As surveyor Ann Yates, R.N., testified, it is not uncommon for residents to slip down in their wheelchairs.[3] It is uncommon for residents to be strangled by their restraints, but that does not make it unforeseeable. Tr. 81:2-18. The nurses notes show that R1 often tried to get out of his wheelchair, and Petitioner intended the restraint in question to address R1's history of falls. CMS Ex. 2, at 5.

The facility was aware of R1's restlessness and it was trying to address the problem. Tr. 22:1-6. It should have anticipated and planned for his attempts to get out of his wheelchair with the restraint in place, especially after the incidents on February 17 and 18, 2005. The facility could have used different assistance devices, or it could have planned for R1 to have a higher level of supervision when he was awake at night.

However, I need not find that the supervision of R1 or the assistance devices provided to him were inadequate to find that the facility was not in substantial compliance with this requirement: as I have pointed out above, several other assistance devices provided by the facility were not adequate simply because they were non-functional or not installed. As discussed above, several of the residents in the facility had personal alarms on their beds or chairs that did not function properly. An alarm that does not sound is not an adequate assistance device. *See Lake Shore Inn Nursing Home, Inc*., DAB CR1361, at 6 (2005); *Heritage Park Nursing Center*, DAB CR1051, at 29 (2003).

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[2] This incident occurred after the facility had added the anti-tip device to the wheelchair. A facility investigation report says the device was ineffective and that it "bent under pressure and also allows chair to tip too far before stopping." CMS Ex. 18, at 21.

[3] During the hearing, Ann Yates, R.N, testified that it is not unusual for residents to slip under seatbelts in wheelchairs. She said, "residents frequently slip out of their chairs . . . they're either restless, and they wiggle, and they get down under a seat belt, or some other device, or they – you know, if you've had a stroke or something like that, and you don't have good control of your body, it's possible that you could slip down under a seat belt or some other device." Tr. 81:10-18.

While a facility's duty of care owed to its residents is not one of strict liability, 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. For the reasons discussed above, 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).

3. Facility staff left R1 unattended for a prolonged period of time after finding him on the floor with a seatbelt around his neck still attached to his wheelchair, violating the quality of care regulation 42 C.F.R. § 483.25 (Tag F698).

Under the Act and the "quality of care" regulation, 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. Act § 1819(b); 42 C.F.R. § 483.25.

This deficiency was based on CMS's determination that facility staff left R1 unattended for a prolonged period of time *after* he was found on the floor being strangled by the rear-closing seatbelt which was still attached to his wheelchair. CMS Ex. 1, at 6-7. CMS established its *prima facie* case on this point. Petitioner contends that CMS cannot prove how much time elapsed between the CNA discovering R1 and the seatbelt being cut. P. Cl. Br. at 15. Although the evidence does not show precisely how much time elapsed between the CNA finding R1 on the floor and a nurse arriving to cut the seatbelt, if CNA Staggs had immediately shouted for help when she found R1, the time would have been close to zero. This is a close case, but because the burden is on Petitioner to rebut CMS's *prima facie* case, and Petitioner has not been able to do so by a preponderance of the evidence, I find that Petitioner was not in substantial compliance with this requirement.

The CNA did not respond properly to the incident. Petitioner argues that the CNA's response was appropriate because she did not recognize the situation as an emergency, but appears to concede that *if* she had recognized the event as an emergency, then her response *would have* been wrong. P. Cl. Br. at 19. I do not find this to be a credible argument, especially considering that when the CNA found R1 he was being strangled by his restraint and she reported that she panicked.[4] *See* CMS Ex. 5, at 8. Even if I were to

[4] As Ann Yates, R.N. testified, "I think [CNA Staggs] recognized that it was an emergency based, on the fact that she tried to get the seat belt from around his neck. . . . [Y]ou wouldn't need to be a certified nursing assistant or a nurse to know that's a very dangerous situation." Tr. 89:18-23. Petitioner casts the CNA's subsequent actions as an

(continued...)

find this argument to be credible, it does not help Petitioner's case. If the facility's actions, or inactions, caused or were likely to cause serious harm to R1, immediate jeopardy existed. If the CNA could not be expected to recognize an emergency situation, the facility should have hired other professionals who could recognize emergency situations to supervise the residents.

To rebut CMS's determination that R1 was left for a prolonged period of time, Petitioner offered the testimony of a nurse, Elsie Fouchard, R.N. However, R.N. Fouchard is only able to testify as to her own observations of R1, which covered a period of 10 to 15 minutes. Tr. 181:2-182:1. When someone is not able to breathe, even one or two minutes is a prolonged and inherently perilous period of time to be left alone.

Petitioner also argues that CMS should adopt the state agency's Informal Dispute Resolution (IDR) decision, in which the state agency recommended deleting the immediate jeopardy finding. However, as the Board has observed, "the Act clearly provides that a state's role in the enforcement process is merely to recommend the imposition of remedies . . . the Secretary is the ultimate decision-maker." *Bergen Regional Medical Center*, DAB No. 1832 (2002); *see* Act §§ 1819(h)(1) and (2); 42 C.F.R. § 488.11(a). CMS is not bound to accept the IDR resolution in reaching its determinations to cite Petitioner, and I am not bound by those IDR resolutions here.

Based on my review of all of the evidence before me on this issue, I find that the facility did not 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 as required by 42 C.F.R. § 483.25 (Tag F698). This deficiency posed a "greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. CMS established a *prima facie* case and Petitioner did not successfully rebut it by a preponderance of the evidence.

B. *CMS's determination that for one day 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." 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

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[4](...continued)
indication that she did not view the situation as an emergency, but this characterization of the facts is not enough to rebut CMS's *prima facie* case.

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).

Petitioner offers evidence to show that it properly responded to R1, but it has not met its heavy burden to show that CMS's determination — that the facility's noncompliance "caused, or [was] likely to cause, serious injury, harm, impairment or death to a resident"— was clearly erroneous. *See* 42 C.F.R. § 488.301.

Petitioner argues that CMS is not able to prove how long R1 was left unsupervised after CNA Staggs found him. However, the burden is on Petitioner to rebut CMS's *prima facie* case, and it has only presented evidence showing that its response was appropriate after the LPN arrived. CMS based the deficiency on the CNA's actions, not the LPN's actions. *See* CMS Ex. 1, at 6-7 (deficiency cited because R1 left unattended for a prolonged period of time after staff found him). As discussed above, I found that the facility was not able to rebut CMS's *prima facie* case that R1 was left unsupervised for a prolonged period of time.

I therefore find and conclude that CMS's finding — that for one day the deficiency posed immediate jeopardy to resident health and safety — was not "clearly erroneous."

C. The proposed CMP of $3100 per day on March 4, 2005, and a per-day CMP of $50 from March 5 through March 22, 2005, is reasonable.

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.

Petitioner argues that there was no immediate jeopardy, and therefore, the CMP is unreasonable. However, I have found that immediate jeopardy existed for one day. 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. If CMS had imposed the lowest CMP permitted by the regulations for the period of immediate jeopardy, it would be 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). Here, the per-day CMP for immediate jeopardy is only $50 higher than the statutory minimum, and I find that to be reasonable. Because CMS imposed the lowest per-day CMP for the remaining days of noncompliance, I am without the discretion to set aside or reduce it. 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.").

VI. Conclusion

For the reasons discussed above, I affirm CMS's determination to impose a per-day CMP in the amount of $3100 for March 4, 2005, and a per-day CMP of $50 from March 5 through March 22, 2005.

/s/
Richard J. Smith
Administrative Law Judge