Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Alexandria Place (CCN: 35-5441),	)	Date: August 5, 2008
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-07-477
	)	Decision No. CR1827
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

Petitioner, Alexandria Place, a skilled nursing facility that provides care to Medicare beneficiaries in North Carolina, appeals the Centers for Medicare & Medicaid Services' (CMS's) determinations. The parties have agreed that this matter may be decided on the written record, without an in-person hearing. For the reasons set forth below, I sustain CMS's determination to impose a civil money penalty (CMP) in the amount of $3050 per day for the period of October 15, 2006 through February 21, 2007 and find that the deficiencies posed immediate jeopardy to resident health and safety. I also sustain the CMP in the amount of $150 per day for the period of February 22, 2007 through March 25, 2007.[1]

[1] Since I sustain the civil money penalties, the loss of the Nurse's Aide Training Program (NATCEP) is also sustained.

I. Background

On February 23, 2007, the North Carolina Department of Health and Human Services, the state survey agency, conducted a recertification and complaint survey of Alexandria Place. The state survey agency determined that Alexandria Place was not in substantial compliance with eleven participation requirements, four of those deficiencies constituted immediate jeopardy to residents' health and safety for a period beginning October 15, 2006 through February 22, 2007, when the immediate jeopardy was abated, and that substantial noncompliance continued at a lesser scope and severity until March 25, 2007.

I directed the parties to file a pre-hearing exchange consisting of their proposed exhibits, including the written direct testimony of their proposed witnesses, and brief. CMS filed a brief and proposed exhibits identified as CMS Exhibits (Exs.) 1-32 and CMS Attachment (Att.) A; Petitioner filed a brief and proposed exhibits identified as Petitioner (P.) Exs. 1-36. The case was scheduled for an in-person hearing. Prior to the hearing, the parties waived by joint written notice the in-person hearing and agreed that the case could be heard and decided based on their written submissions. I then cancelled the hearing but afforded each party the opportunity to file a final brief. Each party did so.

I receive into evidence all of the parties' proposed exhibits.

II. Issues, findings of fact and conclusions of law

A. Issues

The issues in this case are whether:

1. Petitioner failed to comply substantially with Medicare participation requirements;

2. CMS's determination that Petitioner's noncompliance during the period from October 15, 2006 through February 21, 2007, at the immediate jeopardy level of noncompliance, is clearly erroneous;

3. Petitioner remained noncompliant, albeit at a level of noncompliance that is less than immediate jeopardy, from February 22, 2007 through March 25, 2007; and,

4. The civil money penalty amounts that CMS determined to impose are reasonable.

B. Findings of fact and conclusions of law

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

1. Petitioner failed to comply substantially with Medicare participation requirements during the period that ran from October 15, 2006 through March 25, 2007.

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

The regulation requires a facility to provide each of its residents with the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with that resident's plan of care.

Resident # 19 was discharged to Petitioner's facility from the hospital on December 29, 2006, where she had been treated for abdominal pain. At time of discharge, she was wearing a "PICC line" (a catheter) that had been inserted into a vein near the bend of her elbow. The hospital discharge instructions stated that the PICC line dressing "should be changed weekly and as needed." P. Ex. 13, at 159. However, no order was entered into the resident's facility records for changing the dressing. CMS Ex. 1, at 2.

The dressing wasn't changed or removed at any time prior to January 22, 2007, when the resident was transferred back to the hospital for evaluation of abdominal pain and diarrhea. The attending physician noted that the last dressing change for the PICC line had been on December 29, 2006, the day the resident had been previously discharged from the hospital to the facility. P. Ex. 13, at 150, 152. The physician observed a foul smell when the bandage was removed and concluded that the PICC line was clearly infected. *Id.* at 153-154. The resident was noted to have all the signs and symptoms of sepsis and the physician opined that the sepsis was likely caused by the resident's infected PICC line. Two days later sepsis was confirmed; Resident # 19 was found with "positive bacteremia" and the blood cultures, which were obtained through the PICC line, were "positive for gram-positive cocci." P. Ex. 13, at 144-146. Resident # 19 was discharged from the hospital and readmitted to Petitioner's facility on January 24, 2007. The discharge physician at the hospital confirmed the PICC line infection and sepsis in his Discharge Diagnoses and only comfort measures were ordered for her as her condition appeared terminal. P. Ex. 13, at 145; CMS Ex. 17, at 110. Petitioner's readmission note for Resident # 19 dated January 24, 2007 stated that the resident had "PICC line sepsis." P. Ex. 13, at 99. Resident # 19 died on January 30, 2007. CMS Ex. 17, at 64.

On its face this evidence establishes a clear case of noncompliance by Petitioner with regulatory requirements. The prima facie evidence is that Petitioner's staff failed to carry out an explicit directive made to it by a hospital when Resident # 19 was discharged to Petitioner's care on December 29, 2006. That failure at the least exposed Resident # 19 to the possibility of a life-threatening infection.

A nursing facility's essential function is to provide skilled nursing care to those residents who are in its charge. The staff of a facility must be as attentive to the orders of physicians or hospital staff as would be nurses in any other setting. Here, the prima facie evidence shows a complete failure by Petitioner to discharge its responsibilities to Resident # 19.

Petitioner makes the following arguments in response to this prima facie evidence of noncompliance:

- It says that it followed hospital discharge orders, noting that it flushed the PICC line with saline and heparin consistent with the hospital's directive.

- It argues that it routinely assessed the area around the resident's PICC line.

- It asserts that the resident never complained of soreness or pain around the PICC line site.

- The physician saw the resident four times during the period at issue and never ordered the PICC line dressing be changed.

- It contends that the resident was already on antibiotics

- It asserts that it attempted to send the resident to the hospital on January 6, 2007 and the resident refused to go.

- It contends that the resident's PICC line wasn't infected.

- Petitioner contends that "two experts" determined that Petitioner cared appropriately for Resident # 19.

I find Petitioner's arguments to be without merit. The hospital's Discharge Instructions for the PICC line stated that the dressing on the insertion site should be changed weekly and as needed, and there was no other order for dressing changes in Resident # 19's medical record at the facility to contravene the Discharge Instructions. More importantly, Petitioner does not dispute that the dressing was not changed and there were no orders

other than the Discharge Instructions given for the care of the dressing. P. Ex. 31. The undisputed fact that Resident # 19 was returned to Petitioner from the hospital with a PICC line was sufficient to place Petitioner on notice that it needed to take measures to protect Resident # 19 against the possibility of infection.

Petitioner knew or should have known that a catheter can be a conduit for infection. But, Petitioner failed to take any meaningful measures to protect Resident # 19. Specifically:

- It failed to carry out the directives in the Discharge Instructions of December 29, 2006 that the PICC line dressing be changed weekly or as needed. Consequently, Petitioner failed to carry out all the hospital discharge orders.

- The failure to change the dressing at all from the time of Resident # 19's discharge on December 29, 2006 until her readmission to the hospital on January 22, 2007 plainly contravenes the professionally recognized standard for caring for PICC lines. The standard mandates that gauze dressings (like the one Resident # 19 wore) be changed every 24-72 hours and that transparent dressings (also like the one Resident # 19 wore) be changed every 7 days. CMS Ex. 1, at 4; CMS Ex. 17, at 28.

- It failed to plan for, or to implement, any plans for caring for the PICC line. The resident's facility record is devoid of any orders concerning changing the PICC line dressing.

- It had no policies in place governing care of residents' PICC lines. It was only after the incident involving Resident # 19 that Petitioner obtained a policy from a sister facility that requires PICC line dressing changes every 72 hours unless otherwise ordered by the resident's physician. CMS Ex. 17, at 72. Their inaction with respect to changing the dressing is contrary to every recognized standard of care for the care of PICC line.[2]

- Petitioner's assessing the area "around" the PICC line is no substitute for changing the dressing. Obviously, the staff could not have possibly assessed the area underneath the dressing because they never removed the dressing.

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[2] There are other additional professional guidelines that are consistent with changing dressings at least every 72 hours; some suggest changing the gauze tape every 24 hours and the transparent dressing every 7 days. See CMS Ex. 17, at 72; P. Ex. 13, at 197, 204-205, 208.

- It asserts that the resident never complained of soreness or pain around the PICC line site. But, Petitioner's obligations to the resident were not limited to responding to the resident's complaints. Petitioner had an affirmative duty to plan to protect the resident against infection (especially this resident who had just been treated for a significant infection) and to implement that plan, consistent with the hospital discharge order and with professionally recognized standards of care and that duty was not dependent on the resident's complaints (or lack of complaints) of pain.

- Petitioner's medical director, a physician, saw the resident four times during the period at issue and never ordered the PICC line dressing be changed. However, the physician apparently never noticed that the resident was wearing a PICC line. CMS Ex. 1, at 6-7; CMS Ex. 19, at 28; P. Ex. 13, at 92-94. Moreover, Petitioner had an independent duty to assess the resident, including assessing the dressing and the need to care for it. At a minimum, Petitioner's staff should have raised the issue of changing the dressing with the physician based on their knowledge of the PICC line and professionally recognized standards governing dressing changes. Furthermore, if the physician did not issue orders superseding the hospital directive to change the dressing, then the hospital directive still governed and Petitioner's staff should have implemented it.

- Whether the resident was on antibiotics is an irrelevant argument. The PICC line was a potential source of infection even if the resident was on antibiotics and the fact that the resident was receiving antibiotics did not relieve Petitioner from discharging its duties to the resident.

- Resident # 19's refusal to go to the hospital earlier does not excuse Petitioner from discharging its duties; it does not create an excuse for Petitioner simply to disregard its obligation to provide care that meets professionally recognized standards.

- Petitioner's contention that the resident's PICC line was not infected is simply wrong. It is premised on Petitioner's contention that the staff saw no swelling or redness around the line and that the resident did not complain of pain. But, in fact, the staff could not have made meaningful observations about what was going on at the insertion site because it never removed the dressing. And, of course, the resident was determined to have a fatal infection when she finally arrived at the hospital. P. Ex. 13, at 144-146; CMS Ex. 17, at 64, 110.

- Petitioner contends that its "two experts" determined that Petitioner cared appropriately for Resident # 19. The first, Linda Howard, Petitioner's corporate manager, says that the resident was cared for appropriately because the care that Petitioner gave was consistent with physician orders. P. Ex. 31, at 3. But, in fact, there are no physician orders saying "don't change the dressing." Here, the only orders governing this were issued by the hospital and they definitely told Petitioner to change the dressing. Petitioner's care thus was inconsistent with the only orders extant that governed the dressing. The second expert, Dr. Michele Haber, also opines that Petitioner's staff followed the doctor's orders. P. Ex. 32. That is not correct; Petitioner's staff clearly failed to follow the hospital discharge orders. She also contends that it cannot be determined that infection to the PICC line was the cause of the resident's death. It is unnecessary that I decide that a PICC line-related infection caused the resident's death and, in fact, it's unnecessary that I decide even that the resident's PICC line became infected. Petitioner's noncompliance is based on the facility's failure to discharge its professional responsibilities to the resident. An adverse outcome of Petitioner's noncompliance, while certainly not irrelevant, is not necessary in order for me to find noncompliance.

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

The basis for the noncompliance allegations with respect to this regulation is that, at no time between October 15, 2006 and February 22, 2007, did Petitioner have in place a policy or procedure to ensure that each resident of Petitioner's facility is offered pneumococcal pneumonia vaccination (PPV). 42 C.F.R. § 483.25(n)(2). CMS contends also that "as a result, 9 residents, who were eligible to receive the . . . [PPV] were not offered and had not received the immunization." CMS's final brief at 9.

CMS amended the regulations at 42 C.F.R. § 483.25(n) specifically to increase immunization rates in Medicare and Medicaid participating long-term care facilities by requiring those facilities to offer each resident immunization against influenza annually as well as lifetime immunization against pneumococcal disease with the intended result of decreasing the morbidity and mortality rates from influenza and pneumococcal disease. 70 Fed. Reg. 58,833 (October 7, 2005). These regulations became effective October 15, 2006. *See* CMS Manual System, Pub. 100-07 State Operations, Transmittal 21, October 26, 2006.

The regulation requires each facility to develop policies and procedures that enure that: each resident receive education regarding the benefits and potential side effects of the immunization; each resident is offered a PPV unless it is medically contraindicated or the resident has already been immunized; the resident or legal representative has the opportunity to refuse immunization; and the resident's medical record includes documentation that indicates at a minimum that the resident received education and the resident received the immunization or did not, due to medical contraindication or refusal. 42 C.F.R. § 483.25(n)(2). Nevertheless, the final rule requires every facility to offer immunization because a goal of the regulation is to prevent the spread of preventable illness. *See* 70 Fed. Reg. 58,840.

There is no dispute that at the time of the survey, Petitioner had no set policy or procedure in place for PPV. CMS Ex. 1, at 22; CMS Ex. 19, at 31. Petitioner argues that it had put in place a procedure by which it was obtaining residents' consent for the PPV as part of the admission process. But this is only one small part of the regulatory requirement for a policy or procedure. Petitioner has not pointed to a specific policy that encompasses all the specific requirements of the regulation. As a result, the medical records of the residents were not always accurately documented with respect to whether the immunization had been given and many of the residents who had previously consented to the immunization did not receive it until the surveyors were in the facility and determined that the facility had not actually offered the immunization to a significant number of the residents. CMS Ex. 24.

The evidence clearly demonstrates that there was no systematic and comprehensive policy in place to ensure that the requirements of 42 C.F.R. § 483.25(n) were effectuated; that the necessary interventions for PPV administration were planned and implemented for each resident. This failure by Petitioner to have in place policies and procedures to implement the regulatory requirements is, in and of itself, noncompliance, and as I discuss below, a reason for finding immediate jeopardy.

While not irrelevant, it is *not necessary* to establish that residents actually failed to receive the vaccine. Thus, the centerpiece of CMS's case is not the failure of residents to receive the vaccine. Any failure to give residents the vaccine is the *consequence* of Petitioner's noncompliance. While not unimportant, that consequence is not a necessary element of a finding of noncompliance.

The care of nine residents is at issue (Resident #s 3, 6, 7,10, 11, 12, 13, 17, and 20). The single most salient point about these residents is that none of them were offered the PPV during the period between October 15, 2006 and February 22, 2007 because Petitioner had no system in place to assess whether any of these residents needed to be vaccinated. Petitioner's arguments that some of these residents did not actually need to be vaccinated

are irrelevant because Petitioner was in no position to make rational determinations about these residents needs, nor was it able to meet their needs without a system in place in compliance with regulatory requirements for assessing the residents and providing them with the vaccine.

Petitioner argues that it had "put in place a procedure by which it was obtaining residents' consent for the PPV as part of the admission process. . . .,"citing P. Ex. 31. Petitioner's final brief at 13. But, P. Ex. 31 is a copy of the CMS Form 2567, the Statement of Deficiencies, and not a facility internal document. It is 95 pages long and Petitioner has not cited to anything specific within the exhibit. The only language in the exhibit that is even remotely relevant, aside from CMS's allegations of noncompliance, is Petitioner's plan of correction for its noncompliance with 42 C.F.R. § 483.25(n). But, the plan of correction states a completion date of February 23, 2007. So, the exhibit does not prove a thing about Petitioner's compliance as of October 15, 2006 or up until February 22, 2007.

Petitioner also says that the facility's compliance is proven by the residents' records. Petitioner's final brief at 13; P. Ex. 8, at 3[3]; P. Ex. 12, at 15[4]; CMS Ex. 9. at 7[5]; CMS Ex. 10, at 8[6]; CMS, Ex. 7, at 9[7]; CMS Ex. 12, at 8[8]; CMS Ex. 13, at 7[9], and CMS

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[3] Consent for the PPV was given on December 5, 2006, but there is no indication that this resident was given the PPV prior to her discharge on December 27, 2006.

[4] Although this resident was readmitted to the facility in 2003, the PPV consent form was signed on February 19, 2007 and the PPV given on February 22, 2007. CMS Ex. 24

[5]This resident's consent form was signed November 28, 2006, but the PPV was not administered to him until February 22, 2007. CMS Ex. 24.

[6] Resident's consent form was signed on November 28, 2006, but the PPV was not given to him until February 22, 2007. CMS Ex. 24

[7] Resident originally signed a consent form on March 6, 2006 and then again on November 30, 2006, but the PPV was not administered until February 22, 2007. CMS Ex. 24

[8] Consent form for resident was signed December 4, 2006, but the PPV was not administered to him until February 22, 2007. CMS Ex. 24

[9] Exhibit indicates that consent for the PPV was given on December 5, 2006, but

(continued...)

Ex. 14, at 6[10]. But, all that the records "prove" is that the residents had signed consent forms to be vaccinated. That says nothing about whether Petitioner was assessing its residents or offering them the vaccine or whether it had a plan in place to manage vaccinations. And, of course, nine of the residents were *not* vaccinated prior to February 22, 2007.

Petitioner argues that some of these residents (Residents #s 3, 6, 10, 12, and 20) had all been vaccinated prior to October 15, 2006 and, therefore, it was not deficient in providing care for them. But, the issue here is not only whether residents were vaccinated but whether Petitioner had in place plans to assure that those residents who needed vaccinating were offered the opportunity in a timely manner. That, in turn, required Petitioner to have a system for assessing the needs of its residents with respect to the PPV. But, the evidence is that Petitioner had neither and it has offered nothing to show that it had such plans. Saying that some of the residents did not really need to be vaccinated begs the question of whether Petitioner had the required systems in place.

Petitioner argues also that Resident #s 13 and 14 had been at the facility for less than 30 days and, therefore, were not required to be vaccinated. Again, this begs the question of whether Petitioner had a system in place designed to address its residents' needs. While the facility may have succeeded in getting a signed consent form, there is nothing to suggest that the PPV had been given or was planned to be offered to these residents. The fact that they left the facility in less than 30 days was merely fortuitous.

Petitioner argues that Resident # 7 would not consent to receiving the vaccine and that two additional residents suffered from aspiration pneumonia and would not have benefitted from the vaccine. Again, these arguments are irrelevant to the issue of whether Petitioner had the requisite systems in place. The entire purpose of the regulation was to decrease the occurrence of disease preventable by vaccine and to mandate that facilities have in place a procedure where by residents are offered the PPV. Just getting consent for the PPV for the resident in and of itself is worthless if the PPV is then not given to the resident in a timely fashion.

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[9](...continued)
there is no indication that it was given to resident. CMS Ex. 13, at 8; CMS Ex. 24.

[10] Consent was given for resident for the PPV on December 11, 2006, but there is no indication that it was given to resident. CMS Ex. 14, at 7; CMS Ex. 24.

c. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.75(o)(1).

This deficiency was originally assessed at immediate jeopardy level of scope and severity and, then, persisted at non-immediate jeopardy level until the facility attained full compliance with participation requirements on March 25, 2007. The regulation that is at issue requires a facility to maintain a quality assessment and assurance committee that would meet at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develop and implement appropriate plans of action to correct identified quality deficiencies. CMS asserts that Petitioner failed to comply with the regulation in that it failed to identify the systematic problem that the facility had in offering and administering the PPV to its residents. CMS premises this assertion on Petitioner's failure to identify a need to offer vaccination to four residents, Resident #s 3, 10, 17, and 20.

Petitioner focuses on whether these residents actually needed to be vaccinated. According to Petitioner, none of these residents needed to be vaccinated because: Resident # 3 suffered from aspiration pneumonia and would not have benefitted by being vaccinated; Resident # 10 suffered from an acute upper respiratory infection that was not pneumonia; Resident # 17 had not consented to administration of the vaccine prior to the survey and had not suffered from pneumonia after October 15, 2006; and Resident # 20 received the PPV in 2004.

Petitioner's assertions, however, do not address the question of whether Petitioner's quality assurance committee was doing what it was required to do. The issue here is not whether individual residents would have benefitted from being vaccinated. The issue is whether Petitioner's quality assurance committee was in a position to evaluate whether residents were receiving appropriate care, and, if not, to take steps to assure that any perceived problems would be corrected. At least two of the residents suffered bouts of pneumonia after October 15, 2006, the date by which all facilities were to have in place policies and procedures for administering a PPV program, and the quality assurance committee failed to address those incidents in order to determine whether there were problems regarding pneumonia prevention that the facility was not addressing but needed to address. The fact that hindsight may prove that these episodes were not pneumococcal pneumonia does not excuse Petitioner's failure to act.

2. CMS's determinations of immediate jeopardy are not 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. CMS's determination as to the level of a facility's noncompliance – which includes its immediate jeopardy finding – must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c).

The Departmental Appeals Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy, 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); *Florence Park Care Center*, DAB No. 1931, at 27-28 (2004), *citing Koester Pavilion*, DAB No. 1750 (2000). Here, the facility has not satisfied its burden.

With all three of the deficiencies discussed above, there was a high probability or likelihood of serious injury, harm, or death to Petitioner's residents. Petitioner's noncompliance with respect to Resident # 19 denied that resident the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being required by 42 C.F.R. § 483.25. It is evident that failure by Petitioner's staff to carry out the hospital's directive regarding dressing changes created a high probability that the resident would become infected. It is not necessary for me to find that the resident's sepsis was caused by Petitioner's deficient care; rather, the fact that Petitioner flagrantly violated professionally recognized standards of care by failing to change this resident's dressing is sufficient to establish immediate jeopardy. Petitioner offered no evidence to prove the finding to be clearly erroneous.

As for the immediate jeopardy findings with respect to Petitioner's deficient compliance with 42 C.F.R. § 483.25(n) and § 483.75(o)(1), there is also a high probability of harm to residents. The regulation was promulgated because of the fact that pneumococcal pneumonia is a serious problem among the aged and in institutions that house aged and debilitated residents. The purpose of the regulation is to require facilities to address this problem systematically and forcefully in order to decrease morbidity and mortality rates for a disease that can be prevented in large part by proper vaccination. By failing to develop such policies, Petitioner greatly increased the risk that some of its residents might succumb to pneumococcal pneumonia. The fact that Petitioner's quality assurance committee failed to address the lack of a policy and the resulting problems because of a lack of such a program created a situation in which Petitioner's noncompliance was likely to cause serious injury, harm, impairment, or death to a resident. Again, Petitioner offered no evidence to prove these findings to be clearly erroneous.

3. Petitioner remained noncompliant, albeit at a level of noncompliance that is less than immediate jeopardy, from February 22, 2007 through March 25, 2007.

Petitioner offered no evidence to show that it corrected its noncompliance with 42 C.F.R. § 483.75(o)(1) prior to March 25, 2007. Therefore, it has not overcome the presumption that its noncompliance continued from the date first established until the date that CMS found it had re-attained compliance.

4. CMS's penalty determinations are reasonable.

a. CMS's determination to impose civil money penalties of $3050 per day during the period of Petitioner's immediate jeopardy level noncompliance is reasonable as a matter of law.

Regulations governing civil money penalty amounts provide for two ranges of penalties. Penalties for deficiencies that are at the immediate jeopardy level fall within a range of between $3050 and $10,000 per day. 42 C.F.R. § 488.438(a)(1)(i). The minimum daily immediate jeopardy level penalty amount is $3050 and that is what CMS imposed against Petitioner for its days of immediate jeopardy level noncompliance. Consequently, if I conclude that immediate jeopardy existed then I must sustain that penalty amount as reasonable as a matter of law.

I note that Petitioner talks about financial hardship as a basis for not imposing the penalties. However, $3050 per day is the minimum immediate jeopardy level CMP and I have no authority to impose a penalty amount that is less than the minimum, Petitioner's hardship argument notwithstanding. I find, moreover, that Petitioner offered no evidence to show that it was unable financially to pay the penalty. There is no credible evidence that describes Petitioner's true financial condition or the financial impact on Petitioner's operations of the civil money penalties that I sustain here.

b. Civil money penalties of $150 per day for the period of Petitioner's non-immediate jeopardy level noncompliance are reasonable.

The range of permissible civil money penalties for non-immediate jeopardy level deficiencies is from $50 to $3000 per day. 42 C.F.R. § 488.438(a)(1)(ii). There are regulatory criteria for deciding what is reasonable within this range. The criteria 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 undisputed material facts of this case provide ample support for a penalty amount of $150 per day. I find that the seriousness of Petitioner's noncompliance is, in and of itself, sufficient to justify the penalty amount. The $150 per day CMP imposed by CMS after Petitioner abated immediate jeopardy but before it attained full compliance is minimal (five percent of the maximum allowable amount) and reasonable given the relative seriousness of Petitioner's noncompliance.

Petitioner's noncompliance continued with respect to the above-discussed deficiencies at a lower level of scope and severity. Therefore, there remained a significant risk to all of Petitioner's residents until Petitioner made certain that their corrective actions were implemented consistent with regulatory requirements and substantial compliance was achieved with respect to those deficiencies.

/s/
Steven T. Kessel
Administrative Law Judge