Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Meridian Nursing Center,	)	Date: February 19, 2009
(CCN: 15-5428),	)	
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-08-531
	)	Decision No. CR1903
Centers for Medicare	)	
& Medicaid Services,	)	
	)	

DECISION GRANTING MOTION FOR SUMMARY DISPOSITION

I grant the motion of the Centers for Medicare & Medicaid Services (CMS) for summary disposition. I sustain imposition of the following remedies against Petitioner, Meridian Nursing Center:

- Civil money penalties of $3,550 per day for a two-day period beginning on March 31 and ending on April 1, 2008;

- Civil money penalties of $100 per day for a two-day period beginning on April 2 and ending on April 3, 2008;

- Loss of authority to conduct a nurse aide training and competency program for a period of two years.

I base my decision on undisputed material facts establishing that Petitioner failed to take all reasonable measures to maintain an environment for one of its residents that was free from accident hazards, and to supervise that resident in order to prevent her from sustaining accidents in contravention of the requirements of 42 C.F.R. § 483.25(h)(1) and (2). The undisputed material facts show also that CMS's determination that this noncompliance was so egregious as to constitute immediate jeopardy was not clearly

erroneous.[1] There is additionally no dispute – and in fact, Petitioner concedes – that it failed to provide care to its residents that met professional standards of quality in contravention of the requirements of 42 C.F.R. § 483.20(k)(3)(i), albeit at a level of noncompliance that is less than immediate jeopardy. Finally, the undisputed material facts establish CMS's remedy determinations to be reasonable.

I. Background

Petitioner is a skilled nursing facility doing business in Indianapolis, Indiana. It participates in the Medicare program. Its Medicare participation is governed by sections 1819 and 1866 of the Social Security Act and by implementing regulations at 42 C.F.R. Parts 483 and 488. Its hearing rights in this case are governed by regulations at 42 C.F.R. Part 498.

CMS notified Petitioner that it had found it not to be complying with Medicare participation requirements and of its intent to impose the remedies which I describe in the opening paragraph of this decision. CMS's noncompliance and remedy determinations emanate from a compliance survey of Petitioner's facility that was completed on April 2, 2008 (April survey).

Petitioner requested a hearing and the case was assigned to me for a hearing and a decision. The parties completed pre-hearing exchanges and I scheduled an in-person hearing. CMS also moved for summary disposition and Petitioner opposed the motion.

CMS filed a total of 19 proposed exhibits which it designated as CMS Ex. 1 - CMS Ex. 19. Petitioner filed a total of 45 proposed exhibits which it designated as P. Ex. 1 - P. Ex. 45. I am receiving them into the record of this case and I cite to some of them, for purposes of illustration, in this decision. However, in deciding to issue summary judgment I rely on the undisputed material facts as averred by the parties.

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[1] The term "immediate jeopardy" is defined at 42 C.F.R. § 488.301 to mean noncompliance that is so egregious as to cause or is likely to cause serious injury, harm, impairment, or death to a resident.

II. Issues, findings of fact and conclusions of law

A. Issues

The issues in this case are whether the undisputed material facts establish that:

1. Petitioner failed to comply substantially with the requirements of 42 C.F.R. §§ 483.20(k)(3)(i) and 483.25(h)(1) and (2);

2. CMS's determination that Petitioner's noncompliance with the requirements of 42 C.F.R. § 483.25(h)(1) and (2) was so egregious as to cause immediate jeopardy for Petitioner's residents is clearly erroneous; and

3. CMS's remedy determinations are reasonable.

B. Findings of fact and conclusions of law

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.

1. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.20(k)(3)(i).

Petitioner has now requested a hearing to challenge CMS's determination that it failed to comply substantially with the requirements of 42 C.F.R. § 483.20(k)(3)(i). It also concedes in its reply to the motion for summary judgment that it has elected not to challenge CMS's deficiency findings concerning its compliance with this regulation. Petitioner's pre-hearing brief at 1. Therefore, I sustain CMS's allegations of noncompliance.

2. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h)(1) and (2).

The standard for compliance with this regulation is well established. A facility must take all reasonable measures to ensure that its resident environment is as free of accident hazards as is possible, and to provide each of its residents with adequate supervision and assistance devices as is possible. In order to fulfill its regulatory obligations a facility must: assess each resident individually in order to ascertain exactly what that resident's foreseeable difficulties and limitations may be; assess its resident environment in order to identify all known and knowable accident hazards; plan the care of each of its residents in a way that establishes reasonable and effective protection of that resident against risks

brought about by the resident's physical or mental condition and against known or knowable accident hazards; and implement all measures that are identified in the plan of care.

The duty to protect residents is never static. A facility has an ongoing responsibility to protect its residents which is not satisfied if the facility opts for protective measures that are revealed not to be effective. That responsibility can only be implemented effectively if a facility is vigilant in its surveillance of residents' needs, and if its staff reacts immediately to evidence that previously developed interventions are not working. A facility may not rest on its past efforts if the measures it implements to protect a resident turn out to be inadequate. Where evidence of inadequate protection is brought to a facility's staff's attention they must immediately reassess the resident, re-plan the resident's care plan based on the new information that the staff has obtained, and implement new measures that are intended to be more effective than those which they supplant.

CMS's allegations of noncompliance with this regulation center around the care that Petitioner provided to a resident who is identified by CMS as Resident B. It has provided facts which show that the resident, who suffered from dysphagia (difficulty in swallowing), was at grave risk for aspiration (inhaling food or liquids into her lungs) if she consumed anything by mouth. CMS Ex. 7, at 8. Indeed, a swallowing assessment of the resident found that aspiration was "certain to occur" even if the resident was given a special diet including pureed foods and thickened liquids. *Id.* Aspiration in the case of a resident such as Resident B could cause choking, pneumonia, or even death. CMS Ex. 19. The risks to Resident B were complicated by the fact that she suffered from mental impairments that affected her ability to understand the nature of the risks posed by consuming food and liquids orally. *See* CMS Ex. 7, at 5. For these reasons her physicians surgically implanted a PEG tube, a device which enabled the resident to be nourished and hydrated without orally consuming food or liquid. CMS Ex. 7, at 12.

CMS offered facts to establish that it was evident to Petitioner's staff immediately upon Resident B's readmission to Petitioner's facility on February 22, 2008, after having her PEG tube implanted, and thereafter that she was noncompliant with orders that she not consume anything by mouth.[2] On the day of her readmission Resident B was observed to be drinking from a water fountain, and her bathroom sink, and she also asked Petitioner's dining staff for food. CMS Ex. 7, at 20, 41, and 42.

[2] The February 22, 2008 readmission was Resident B's second stay at Petitioner's facility.

The facts offered by CMS show that Petitioner's staff prepared a care plan for Resident B on February 22, 2008, the date of her readmission to the facility. CMS Ex. 7, at 58. The staff had assessed the resident's decision making ability as being "severely impaired." *Id.* at 23. Despite the resident's severe cognitive and psychiatric problems the plan initially focused on attempting to give verbal cues to the resident and to redirect her when she was observed attempting to consume food and fluids. *Id.*, at 55, 58. The plan suggested, for example, encouraging the resident not to be in Petitioner's dining area. *Id.* at 55. The staff was told to advise the resident not to consume foods and fluids and to explain to the resident, as simply as possible, that "eating may cause death." *Id.*

CMS provided facts which support a conclusion that these interventions and others were palpably unsuccessful. That conclusion is buttressed by the many occasions over the ensuing two weeks on which the resident was observed to be seeking, and in some instances consuming, food and fluids. CMS Ex. 7, at 28, 30, 31-38, 41-50. But, it was not until March 8, 2008 that Petitioner's staff made a significant change in the resident's care plan. On that date the care plan was revised to require that there be safety checks of Resident B at 15-minute intervals. *Id.* at 58.

The facts averred by CMS establish that it was, or should have been, immediately apparent that even 15-minute safety checks were doing little to protect Resident B from consuming food and fluids by mouth and aspirating. On March 9, 2008, the day after the safety checks were implemented, Resident B was observed drinking water from her roommate's water pitcher, eating leftover food from another resident's tray in Petitioner's dining room, drinking water from her bathroom sink, and attempting to drink water from a water fountain. CMS Ex. 7, at 37-38. On March 10, the resident was observed eating her roommate's food and drinking her beverages. CMS Ex. 9, at 7. On March 11, she was observed drinking from a water fountain and drinking a staff member's beverage. CMS Ex. 7, at 50.

CMS alleged additional facts to show that the manifest failure of the interventions adopted by Petitioner's staff to protect Resident B from the hazards of consuming food and fluid by mouth were exacerbated by the staff's decision to allow Resident B to live in an environment which actually facilitated her food and fluid seeking behavior. Petitioner housed Resident B in a room with another resident who had no dietary restrictions other than being on a low salt diet. CMS Ex. 9, at 3. This resident received all of her meals and snacks while in bed. On several occasions Petitioner's staff observed Resident B consuming fluids and food which had been supplied to her roommate. CMS Ex. 7, at 36, 37- 38. Moreover, the roommate advised Petitioner's staff that she was providing Resident B with food and drink. CMS Ex. 9, at 7.

On the evening of March 11, 2008, a member of Petitioner's staff found Resident B lying non-responsive on the floor of her bathroom. CMS Ex. 7, at 50-51. Attempts to revive the resident were unsuccessful and she was pronounced dead after paramedics arrived at the facility. After the resident's death a nurse at Petitioner's facility discovered an object – described as being white or tan and soft in texture – in the resident's mouth. CMS Ex. 10, at 12-14. The cause of the resident's death was listed on her death certificate as aspiration pneumonia. CMS Ex. 7, at 97.

The facts alleged by CMS are powerful support for a finding that Petitioner failed to discharge its obligations to protect Resident B from accident hazards and to provide this resident with adequate supervision. They show that Petitioner's staff was aware that the resident was at grave risk for causing severe injury to herself, or even death, due to her persistent and determined consumption of food and fluids by mouth. Yet, in spite of its recognition of the problem, Petitioner's staff allowed the resident to engage in behaviors that jeopardized the resident's health and life. Interventions that the staff adopted were ineffective and their ineffectiveness became apparent immediately to Petitioner's staff upon their adoption. But, the obvious failure of those interventions failed to provoke the staff to implement additional, more aggressive interventions that might have protected the resident better, and even spared her life.

The facts adduced by CMS support a conclusion that Petitioner's staff should not have waited more than two full weeks after adopting the initial February 22 care plan to make major adjustments to the resident's care. The resident continued to consume food and fluid by mouth in spite of all of the interventions in that plan. Nor should the staff have rested on the adjustments (safety checks at 15-minute intervals) that they made to the plan on March 8. The ineffectiveness of those checks was immediately apparent to the staff as Resident B continued to consume food and fluids by mouth. Moreover, the staff should have recognized early in the resident's stay that housing this resident with another resident who consumed her meals in her room was a recipe for disaster. Yet, Petitioner's staff never addressed that issue even though they knew that Resident B was consuming food and fluid given to her roommate.

I have considered the facts and arguments offered by Petitioner in response to CMS's motion in light of the following questions. First, has Petitioner offered any facts that create a dispute about the material facts alleged by CMS? Second, has Petitioner offered facts or arguments that suggest that inferences favorable to Petitioner may be drawn from those facts offered by Petitioner or from those offered by CMS that are not in dispute? I find that nothing offered by Petitioner undercuts the facts offered by CMS and the conclusions that I draw from them. The conclusion that Petitioner failed to comply with its regulatory responsibilities in providing care to Resident B is the only reasonable conclusion that one can draw from the undisputed material facts of this case.

Petitioner argues that the benefits of placing Resident B in a room with another resident who took her meals in the room outweighed any hazard that might have been created by that arrangement. Petitioner's brief at 7-8. According to Petitioner, at the time of Resident B's admission to the facility there was no other room in which the resident could have been placed with a female roommate. *Id*. at 7. Also, according to Petitioner, the room in which Petitioner housed Resident B had the advantage of being in proximity to Petitioner's nursing station thereby facilitating observation of Resident B.

For purposes of this decision I will assume it to be true that on February 22, 2008, there was no other room available at Petitioner's facility with a vacant bed in which Resident B could have been housed with a female roommate. But, that fact provides no excuse for Petitioner housing Resident B with her roommate at the level of observation provided by Petitioner's staff. Nothing offered by Petitioner gainsays the fact that Resident B was actively seeking to consume food and fluid by mouth including food and beverages that had been supplied to her roommate, and that Petitioner's staff was aware of this behavior.[3]

Petitioner has not explained why, in light of that, it did not house Resident B in a room with some other female resident who did not require feeding in bed. Nor has it explained why it could not have rearranged its residents' living arrangements – perhaps moving a resident – in order to address Resident B's obvious needs. And, if housing Resident B with a roommate who consumed her food in her bed was the *only* housing arrangement available to Petitioner's staff, then Petitioner has offered no explanation why staff didn't police the room vigilantly to ensure that Resident B was never left alone with her roommate while there was food and beverages available for consumption.

Additionally, Petitioner argues that there was no indication at the time that Resident B was placed with her roommate that she would be able to obtain food from the roommate, asserting that the roommate "almost always" consumed all of her food. Petitioner's brief at 8. I accept for purposes of this decision that it might not have been apparent to Petitioner's staff on February 22, 2008, that Resident B's food seeking behavior would encompass attempting to obtain food and beverages from her roommate. But, the resident's subsequent behavior – including being observed consuming food and liquid

[3] Petitioner questions the credibility of statements given by the roommate concerning her supplying food to Resident B. I do not rely on those statements to make my decision. The uncontroverted facts establish Petitioner's staff observed Resident B eating her roommate's food and drinking fluids supplied to the roommate. CMS Ex. 7, at 36, 37-38.

obtained from her roommate – certainly put Petitioner's staff on notice that their initial assumptions were wrong. CMS Ex. 7, at 36, 37-38. In spite of that knowledge Petitioner's staff did nothing to change Resident B's living arrangement, nor did it provide surveillance necessary to assure that the resident would not have access to her roommate's food and beverages.

According to Petitioner it was not foreseeable at the time of Resident B's death that, even if she obtained food from her roommate or from any other source, she would be in danger of aspirating. Petitioner's brief at 8. I find this assertion to be fanciful. The whole purpose of inserting a PEG tube into Resident B, and precluding any nutrition or hydration by mouth, was the risk of aspiration posed by consuming food and liquids by mouth. It is within the realm of reasonable possibility that the resident might not have aspirated on any given occasion when she consumed food and/or fluids by mouth. But, the *risk of aspiration* was medically established to be very high and the consequences of aspiration, if it occurred, were potentially grave. All of the facts of this case establish that Petitioner was aware of that risk.

Petitioner cites to events occurring on March 10, 2008, which, it claims, support a conclusion that Resident B might, in fact, have been able to consume food and liquid by mouth. Petitioner's brief at 20-21. The inference which Petitioner would have me draw is that protecting Resident B from oral consumption of food and fluids might have been, in fact, unnecessary.

The events cited to by Petitioner involve a brief visit by Resident B on March 10 to a local hospital to investigate the resident's allegation that she had been raped. P. Ex. 26, at 1. Apparently, while at the hospital, the resident was fed by mouth and the hospital staff suggested to Petitioner that the resident be retested to determine whether she actually needed to be fed by PEG tube. CMS Ex. 7, at 46.

For purposes of this decision I am assuming it to be true that the medical staff at the hospital thought that it was possible that Resident B could be fed safely by mouth. But, that fact does not support an inference that Petitioner's treatment of Resident B complied with regulatory requirements because protecting the resident against oral consumption of food and fluids may have been unnecessary.

The regulations do not contain a "no harm no foul" rule which excuses a facility from discharging its obligations to a resident if, judged solely from the perspective of hindsight, those obligations turn out to have been unnecessary. Here, Petitioner's obligations to Resident B were delineated clearly by the orders that had been issued by the resident's treating physicians prior to her February 2008 readmission to the facility, by Petitioner's staff's assessment of the resident in February, and by the care plans that Petitioner created for the resident before her hospital visit. A suggestion that the resident should be

reassessed does not provide a pass to Petitioner for its failure to carry out that which it had been ordered, and which it had planned, to do.

Petitioner's staff had assessed Resident B as being incapable of consuming food and fluids safely by mouth. That assessment was, in turn, based on the orders of the resident's treating physicians. Petitioner was under an obligation to do everything reasonable to protect the resident, consistent with the physicians' orders and its own assessment, until such time as the resident was reassessed and superseding findings were made. At no time during the period when the resident stayed at Petitioner's facility was such reassessment made.

Petitioner criticizes the quality of the surveyor's performance at the April survey, suggesting that cross-examination of the surveyor might show that her findings are inaccurate or inconsistent. Petitioner's brief at 8-11. But, Petitioner has offered nothing to show that the material facts cited by CMS in support of its motion and which I have discussed are incorrect. The possibility that the surveyor may have misinterpreted some information or erred in some respect is irrelevant unless that undercuts a material fact necessary to finding Petitioner to be noncompliant.

The heart of Petitioner's argument, however, is that the measures it adopted to protect Resident B were reasonable, and that there is no basis to find it noncompliant even if the resident was able to obtain and swallow food and liquids, and even if the resident died as a consequence of aspirating something. According to Petitioner, the standard by which I should evaluate the measures it took is whether those measures were reasonable, and not whether they were effective, in protecting the resident. Petitioner's brief at 13.

The standard for complying with 42 C.F.R. § 483.25(h)(1) and (2) is not one of strict liability. There conceivably may be instances where a resident becomes injured despite a facility having taken all reasonable measures to eliminate foreseeable accident hazards and to protect and supervise that resident. But, the undisputed material facts of this case do not support an inference that Petitioner did everything reasonable to protect Resident B. The fact that Petitioner may have implemented some measures to protect the resident does not absolve it from liability if it failed to assess the effectiveness of the measures and to make necessary changes or modifications in the face of evidence showing that the measures were not working.

Petitioner's failure to provide adequate protection to Resident B was glaringly obvious. Even if the measures that it implemented to protect her seemed to be reasonable when they were devised and implemented, Petitioner's staff very quickly learned that they were

ineffective. Yet, the knowledge that these measures were failing did not spur Petitioner's staff to attempt to protect the resident more aggressively. Thus:

> • For a period of more than two weeks after it implemented the February 22 care plan Petitioner's staff *knew* that efforts to cue and redirect the resident were failing abjectly to prevent the resident from seeking and obtaining food and fluid which she consumed orally. Yet, Petitioner's staff failed to modify the care plan and to institute heightened surveillance of the resident during that period.
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> • After Petitioner's staff finally instituted 15-minute safety checks of Resident B on March 8, they very quickly discovered that the resident was continuing to obtain food and fluids which she consumed orally. The staff *knew* that the heightened safety checks were failing to protect the resident yet they failed to implement additional security. The most obvious measure which the staff might have attempted, but which it failed to attempt, was to supervise Resident B continuously.
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> • Petitioner's staff *knew* that Resident B was obtaining food and beverages from her roommate. Yet, despite this knowledge the staff did not change the resident's living arrangement, nor did it implement supervision to ensure that Resident B never had access to her roommate's food and beverages.

Petitioner argues that it, in fact, provided numerous interventions for Resident B besides verbal cues. Petitioner's brief at 15-22. The facts, as described by Petitioner, show that its staff often took food and beverages away from Resident B when she was observed possessing or consuming them, redirected the resident when she was observed to be seeking or consuming food and beverages, and consulted with the resident's physician concerning her behavior.

For purposes of this decision I accept as true Petitioner's chronology of events and the specifics as described in that chronology. But, nothing in that chronology supports a finding that Petitioner or its staff adequately protected Resident B. First, the chronology confirms that there was a period of more than two weeks after Petitioner implemented its initial care plan for Resident B in which the resident was not provided with any enhanced supervision despite her almost constant food and beverage seeking behavior. Second, nothing in that chronology shows that Petitioner's staff ever considered, much less attempted, to provide the resident with continuous supervision or surveillance in order to assure that she did not obtain food and beverages. At no time did Petitioner's staff ever consider the possibility that leaving Resident B alone, even briefly, would facilitate her obtaining and consuming food and liquids.

Petitioner asserts, finally, that it did all that it reasonably could have been expected to do to protect Resident B. It contends:

> The only interventions that were not utilized were physical restraints and isolation, neither of which were medically indicated and both of which would have increased Resident B's risk of injury and/or the intensity and frequency of her aggressive behavior towards staff.

Petitioner's brief at 22. This assertion is simply not supported by the facts. There clearly were things that Petitioner could have done to protect Resident B which did not constitute restraint or isolation, but which might have given the resident greater protection. For example, Petitioner might have considered changing the resident's roommate to an individual who did not consume meals in her room. Or, the staff could have kept Resident B out of her room while her roommate ate, and could have ensured that all leftovers were removed before Resident B returned. The staff could have stepped up its observation of Resident B.

3. The undisputed material facts establish that CMS's determination of immediate jeopardy was not clearly erroneous.

The facts adduced by CMS are ample support for a finding that Petitioner's noncompliance with the requirements of 42 C.F.R. § 483.25(h)(1) and (2) placed residents at immediate jeopardy. Resident B's physicians had diagnosed her dysphagia as putting the resident at a high likelihood for life threatening consequences if she consumed food and liquids by mouth. Not preventing the resident from doing so thus put the resident in the precise jeopardy that her physicians feared and warned against.[4]

Jeopardy is also established by the systemic failure of Petitioner's staff to recognize that the measures that they had adopted to protect Resident B were utterly ineffective. The inference that I draw from the undisputed facts is that the staff were blind to the dangers posed to Resident B by her constantly obtaining and consuming food and fluids by mouth. Nor were the staff sensitive to the risks posed by housing Resident B – with her well-known propensities to seek and consume food and fluids by mouth – with another resident who ate her meals in the residents' shared room.

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[4] I could infer from the facts offered by CMS that failure to supervise and protect Resident B adequately contributed to her death from choking or aspiration. It is unnecessary, however, that I do so. The failure to protect Resident B put this resident at jeopardy even if her death was not a proximate consequence of that failure.

Petitioner argues that any finding of jeopardy based on the facts offered by the parties would be clearly erroneous because:

> Petitioner's staff did not create or exacerbate Resident B's non-compliance with dietary restrictions nor did they passively allow Resident B to remain non-compliant.

Petitioner's brief at 23. But, the issue is not whether Petitioner's staff created or exacerbated the resident's noncompliance nor is it whether the staff passively allowed the resident to remain noncompliant. This case is based on the failure of Petitioner's staff to exhaust *all reasonable measures* to protect Resident B.

Petitioner contends also that any jeopardy that may have existed in this case ceased well before March 31 and April 1, 2008, the dates on which CMS determined to impose immediate jeopardy level civil money penalties against Petitioner. According to Petitioner, on March 12 and 13, all of Petitioner's staff completed compliance training on the following subjects: g-tubes, NPO status, documentation, and physician notification of condition changes. Petitioner's brief at 23; P. Ex. 3. Petitioner asserts also that it reviewed the care plans of other residents with special diets and dietary restrictions and revised them as needed. Petitioner's brief at 24. Finally, Petitioner contends that it placed another resident – Resident C – who, like Resident B, was fed through a tube and was repeatedly noncompliant with orders that he not consume food and fluid orally, on 15-minute checks beginning on March 12, 2008. Petitioner's brief at 24, *see* P. Ex. 32, at 4.[5] Petitioner claims that in spite of CMS's assertion, the evidence as to Resident C is irrelevant allegedly because the resident made no efforts to obtain food or drink for oral consumption after February 24, 2008.

Although I accept the facts alleged by Petitioner as true for purposes of deciding CMS's motion, they are insufficient to establish that CMS's determination of immediate jeopardy was clearly erroneous, either as of March 11 or as of March 31 and ending April 1, 2008. The facts offered by Petitioner show that it implemented *some* corrective actions prior to April 1. They fail to show that Petitioner implemented prior to that date *all* of the

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[5] The decision to check Resident C at 15-minute intervals was not motivated by his noncompliance, but by an allegation that he had slapped another resident. Petitioner objects to my considering facts and evidence about its care of Resident C because the resident's care allegedly was not discussed in the April survey report. However, Petitioner has had ample notice of CMS's intent to raise facts concerning Petitioner's care of the resident. CMS provided notice of its intent to address that care with its pre-hearing exchange. Petitioner had a full month to prepare to defend against any allegations made by CMS about its care of Resident C.

corrective actions that its own staff determined to be necessary. Indeed, Petitioner admitted that it did not complete all necessary corrective actions prior to April 1. CMS Ex. 16, at 2, 5.

4. CMS's remedy determinations are reasonable.

There are two civil money penalties that are at issue here. A civil money penalty of $100 per day for a two-day period was imposed by CMS to remedy non-immediate jeopardy level noncompliance that Petitioner has not challenged. Petitioner has not contended that the penalty amount is unreasonable, nor has it denied that it was noncompliant for the two-day period determined by CMS. Therefore, I find the $100 per day penalty amount and duration to be reasonable as a matter of law.

The second civil money penalty, $3,350 per day, was imposed by CMS to remedy the immediate jeopardy level noncompliance on March 31 and April 1, 2008 which I have discussed at Findings 2 and 3 of this decision. Petitioner has not argued that this penalty amount is unreasonable assuming that I sustain CMS's noncompliance determination. I have done so, and, therefore, the penalty amount and duration are reasonable as a matter of law.

Moreover, the penalty amount is also reasonable when measured against the criteria for determining penalty amounts to remedy immediate jeopardy level deficiencies.

Regulations governing the imposition of civil money penalties provide that penalties of from $3,050 to $10,000 per day of noncompliance may be imposed to remedy an immediate jeopardy level deficiency. 42 C.F.R. § 488.438(a)(1)(i). There are regulatory criteria to be used for deciding where within this range a penalty should fall. 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 immediate jeopardy level civil money penalty that CMS determined to impose – $3,050 per day for two days – is exceedingly modest, being at the low end of the range of permissible immediate jeopardy level civil money penalties. It is amply justified in this case by the seriousness of Petitioner's noncompliance. Petitioner, through its failure to protect adequately Resident B, put that resident at grave risk for life-threatening consequences. Moreover, the failure was blatant considering Petitioner's staff's certain knowledge that the resident was noncompliant with directives that she not consume anything orally and its failure, in the face of that knowledge, to do anything meaningful to address the situation.

There is a third remedy involved in this case, Petitioner's loss of authority to conduct a nurse aide training and competency program for two years. Petitioner has not specifically challenged the imposition of that remedy, which is required given Petitioner's immediate jeopardy level noncompliance.

/s/
Steven T. Kessel
Administrative Law Judge