Department of Health and Human Services

**DEPARTMENTAL APPEALS BOARD**

Civil Remedies Division

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| In the Case of: | ) | |
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| Care Center of Opelika, | ) | Date: January 23, 2007 |
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| Petitioner, | ) | |
| | ) | Docket Nos. C-06-63; C-06-138 |
| | ) | |
| | ) | Consolidated Docket No. C-06-138 |
| - v. - | ) | Decision No. CR1556 |
| | ) | |
| Centers for Medicare & Medicaid Services. | ) | |
| | ) | |

## DECISION

Petitioner, Care Center of Opelika (Petitioner or facility), is a long-term care facility certified to participate in the Medicare program as a provider of services. Surveyors from the Alabama Department of Public Health (State Agency) completed a survey on October 6, 2005, and discovered that, for more than two months, the facility lacked a functioning call light system. As a result of this and other survey findings, the Centers for Medicare & Medicaid Services (CMS) determined that the facility was not in substantial compliance with program participation requirements, and, from July 27 through October 5, 2005, the facility's deficiencies posed immediate jeopardy to resident health and safety. CMS imposed civil money penalties (CMPs) of $3,050 per day for 71 days of immediate jeopardy, and $100 per day for the remaining days of noncompliance that was not immediate jeopardy. Petitioner here challenges those determinations.

For the reasons set forth below, I find that the facility was not in substantial compliance with program requirements for the period in question, and that, from July 27 through October 5, 2005, its deficiencies posed immediate jeopardy to resident health and safety. Since CMS imposes the statutory minimum CMP for the period of immediate jeopardy, the question of its reasonableness is not before me. I find reasonable the $100 per day CMP for the remaining period of noncompliance.

## I. Background

Following a complaint investigation completed July 7, 2005, and a certification survey completed October 6, 2005, CMS determined that the facility was not in substantial compliance with federal requirements for nursing homes participating in the Medicare program.[1] Most significantly, CMS asserts that the facility did not meet federal requirements under 42 C.F.R. § 483.70(f) (Tag F-463 – Physical Environment) because it did not have a functioning call light system, and the absence of a functioning call light system posed immediate jeopardy to resident health and safety. CMS Exhibit (Ex.) 1, at 9-12. CMS also claims that the facility was not in substantial compliance with 42 C.F.R. § 483.15(e)(1) (Tag F-246 – Quality of Life) and 42 C.F.R. § 483.25(h)(1) (Tag F-323 – Quality of Care). *Id.* at 1-9.

After a follow-up visit on December 8, 2005, CMS determined that the facility achieved substantial compliance. CMS Exs. 2, 15, 21, at 11; P. Exs. 6, 8. CMS has imposed CMPs in the amount of $3,050 per day for 71 days ($216,550) of immediate jeopardy, and $100 per day for the remaining days of noncompliance that was not immediate jeopardy. CMS Ex. 2.[2]

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[1] CMS sent two separate notice letters addressing these surveys; Petitioner filed separate hearing requests; and this office opened two case files (C-06-63 and C-06-138). By motion dated March 6, 2006, the parties asked that the matters be consolidated because they concern the same facility and the same survey cycle. By order dated March 9, 2006, I granted the motion and consolidated the cases as C-06-138.

[2] The record is confusing as to the date Petitioner achieved substantial compliance. In its preliminary brief (CMS Br.), CMS asserts that the facility achieved substantial compliance on November 4, 2005. CMS Br. at 11. However, in CMS's closing brief (CMS Cl. Br.), it sets the date of substantial compliance as December 8, 2005. CMS Cl. Br. at 1-2. Inexplicably, Petitioner has not challenged this December date. According to the state surveyor, Wayne DuBose, the surveyors accepted the November 4, 2005 date. CMS Ex. 21, at 11 (DuBose Decl. ¶ 19). However, the record is silent as to whether CMS accepted the surveyor recommendation. Since neither party has briefed the issue, I consider that duration is not before me, and I decline to resolve the question. However, if the parties, in fact, disagree about the date the facility achieved substantial compliance, they may ask that the case be reopened pursuant to 42 C.F.R. § 498.100, for the limited purpose of resolving that issue.

The facility timely requested a hearing, and the matter was assigned to me. The parties have agreed that this matter may be decided on the written record, without an in-person hearing. Summary of 7/19/2006 Prehearing Conference; Petitioner's correspondence (July 21, 2006). The parties have filed preliminary and closing briefs. (CMS Br., CMS Cl. Br., P. Br., P. Cl. Br.). Petitioner also filed a letter brief in reply to CMS's closing brief. (P. Reply). CMS submitted 25 exhibits (CMS Exs. 1-25), and Petitioner submitted 46 exhibits (P. Exs. 1-46). I have admitted CMS Exs. 1-25 and P. Exs. 1-46. Summary of 7/19/2006 Prehearing Conference.[3]

## II. Issues

The case presents the following questions:

1. Was the facility in substantial compliance with requirements for facilities participating in the Medicare program, specifically 42 C.F.R. §§ 483.70(f), 483.15(e)(1), and 483.25(h)(1)?

2. If the facility was not in substantial compliance from July 27 through October 5, 2005, did its deficiencies then pose immediate jeopardy to resident health and safety?

3. If the facility was not in substantial compliance after October 5, 2005, is the amount of the CMP imposed, $100 per day, reasonable?

## III. Discussion

The Social Security Act (Act) sets forth 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, section 1819. The Secretary's regulations governing nursing facility participation in the Medicare program are found at 42 C.F.R. Part 483. Facilities must maintain substantial

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[3] My summary of the July 19, 2006 prehearing conference reflected that Petitioner had submitted 47 exhibits. In fact, Petitioner only submitted 46 exhibits. Petitioner's list of exhibits indicated that it would be submitting a 47th exhibit which was to consist of relevant sections of the Code of Federal Regulations; it is not necessary to submit copies of federal regulations as exhibits

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

***A. Because its call light system was essentially inoperable from July 27 through October 5, 2005, the facility was not in substantial compliance with the program participation requirement set forth at 42 C.F.R. § 483.70(f), and that deficiency posed immediate jeopardy to resident health and safety.***[4]

Section 483.70 requires that the facility be equipped and maintained "to protect the health and safety of residents, personnel and the public." Among other specific requirements, the nurse's station must be equipped to receive resident calls through a communication system from both the resident rooms and from toilet and bathing facilities. 42 C.F.R. § 483.70(f).

The facility has a total of 225 beds in four sections. The largest section, called Section One, consists of 73 beds in 47 rooms. CMS Exs. 6, 7; P. Ex. 9. Section One's electronic call light system was installed in 1975, and, by 2002, was apparently showing its age. CMS Ex. 3, at 3; P. Ex. 36, at 1. In March 2002, the facility had to replace the system's malfunctioning "main panel," located at the nurse's desk. The "main control unit" had to be replaced twice, once in 2003, and again in 2005. On March 24, 2005, the entire system went down, leaving the 73 beds in Section One without an electronic call system. CMS Ex. 3, at 3; P. Ex. 36, at 1. With some difficulty – the distributor did not have the necessary part in stock so it had to be back-ordered – the facility managed to restore the system to "normal operation" on March 30, 2005. P. Ex. 22; CMS Ex. 3, at 3; P. Ex. 36, at 1.[5]

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[4] I make Findings of Fact and Conclusions of Law (Findings) to support my decision in this case. I set forth each Finding, in italics and bold, as a separate heading.

[5] The state investigated complaints of system malfunction in a facility visit ending July 7, 2005, but, at that time, the system was functional, and no penalties were imposed. P. Ex. 36, at 2. Neither party has provided a complete Statement of Deficiencies for the July 7 survey, so the record does not specify the deficiencies cited at that time, nor the facility's plan of correction. Petitioner claims that the State Agency cited no deficiencies, at least with respect to the call light system. P. Ex. 44, at 1 (Hornsby Decl. ¶ 3). According to CMS's notice letters, however, the State Agency found significant deficiencies but suspended its recommendation for enforcement action because the facility had submitted a plan of correction and the State Agency presumed that it had corrected its deficiencies. CMS Ex. 2, at 2. When the October 6 survey revealed that the

Thereafter, however, the system was intermittently beset with malfunctions. P. Exs. 23, 34, 36, 37, 44; CMS Ex. 4. On June 22, 2005, problems with the control panel disabled the call lights in three rooms, but the malfunction could not be corrected because, according to maintenance staff, "system old – bad wiring." P. Ex. 23, at 5; CMS Ex. 4, at 5. Then, on July 27, 2005, the system broke down, and was never more than partially functional thereafter. Petitioner attempted repairs; it ordered a new control unit, and subsequently ordered additional parts. But the system kept shorting out. P. Ex. 23, at 8, 9; P. Ex. 34, at 4; P. Exs. 36, 42 (Cook Decl.); P. Ex. 44 (Hornsby Decl.). The system was simply "antiquated" and parts were no longer available; the system's manufacturer no longer serviced it, and Petitioner had difficulty finding service people willing to attempt the repairs. P. Ex. 32, at 1; P. Ex. 37; P. Ex. 44, at 2 (Hornsby Decl. ¶ 5).

Finally, in a requisition request dated September 6, 2005, the facility sought from its corporate office approval for replacing the system. P. Ex. 32, at 1; P. Ex. 37, at 2, P. Ex. 44, at 3 (Hornsby Decl. ¶ 13). The expenditure was approved, and installation of a new call system began on September 19, 2005. The work was completed on October 6, 2005. P. Exs. 33, 35, 37, 44, at 3-4 (Hornsby Decl. ¶ 13).

The uncontroverted evidence thus establishes that from July 27 through October 5, 2005, the facility had no reliable call light system. During that time, the nurse's station was simply not "equipped to receive resident calls through a communication system" from both resident rooms and from toilet and bathing facilities. *See* 42 C.F.R. § 483.70(f). On its face, this finding seems to resolve, without further discussion, the question of the facility's substantial compliance with the physical environment regulation.

I recognize, however, that extraordinary and unforeseeable circumstances might nevertheless preclude a finding of substantial noncompliance (which no doubt explains CMS's unwillingness to impose a remedy in March 2005, even though the facility was then without a working system for a week). Here, Petitioner suggests that the system failure was not foreseeable, and claims that it took "all reasonable steps to keep its electronic call light system in working order." P. Cl. Br. at 5. I disagree.

The circumstances surrounding the July 2005 failure of the call light system were neither extraordinary nor unforeseeable. No one can reasonably expect an electrical system to last forever, and this system was quite old. I do not doubt that the facility's maintenance staff did its best to keep the system functioning. *See, e.g.*, P. Ex. 42. The many

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facility had not corrected and had not achieved substantial compliance, CMS made deficiency findings and imposed penalties.

maintenance documents show that these individuals were making significant efforts, but those documents also establish that the facility knew that it had an old, unreliable system – broken down more often than it was operational. P. Ex. 42, at 2 (Cook Decl. ¶ 8); P. Exs. 22-35. By March, Petitioner should have known that the system was on its way out and that it needed to start planning for a replacement system. In early June, maintenance staff reported that they were unable to repair the system because it was old and the wiring was bad. P. Ex. 23, at 5. And when the system broke down in July, the technician told the facility's maintenance director that he needed to replace all of the rooms' old call stations with a new series. P. Ex. 23, at 8.

Petitioner should also have known that replacing the system would be complicated and time-consuming. Jim Williams, from Columbus Fire & Safety (the company that ultimately installed the new system), described the difficulties in replacing a call light system:

> There is not a one-size-fits-all call light system for a nursing facility, so providing a quote for a new call light system is not something that can just be recited upon request. Our company has to generate drawings for the facility before it can design the system to be installed and provide a quote.

P. Ex. 43, at 1 (Williams Decl. ¶ 5); *see also* P. Ex. 44, at 2 (Hornsby Decl. ¶¶ 5, 6). These steps should and could have been taken months earlier, probably in March, when the broken-down system took a week to repair, and no later than June, when staff acknowledged that malfunctions could not be repaired because of the system's age. Yet, the facility did not even contact vendors to discuss the system's replacement until September 2005. I therefore do not agree that Petitioner took "all reasonable steps" to maintain an effective call light system.

Petitioner also argues that it had in place an adequate back-up system. Initially, this "system" consisted of distributing hand bells to some, but not all, of the Section One residents. On August 24, about a month after the system broke down, the facility added "bell monitors," who, for twelve hours per day (from 7:00 pm to 7:00 am) walked the halls listening for ringing bells. P. Ex. 12, at 1, 7, 9, 23; P. Ex. 44, at 3 (Hornsby Decl. ¶ 12).[6] It appears that bell monitors were occasionally not assigned, and sometimes were "pulled" from that assignment due to staffing shortages. P. Ex. 12, at 1, 7, 9, 23.

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[6] It appears that, between July 27 and August 24, no special efforts were made to assist the regular nursing staff in hearing and responding to the hand bells.

With or without bell monitors, the hand bell system was not an effective substitute for an electronic call light system, and the record in this case demonstrates its inadequacies.

First, not all residents were even capable of using hand bells. The Assistant Director of Nursing identified the residents of rooms 104A, 111A-B, 114A, 138A, 140, and 141 as incapable of using the hand bells, so none were provided. CMS Ex. 21, at 10 (DuBose Decl. ¶ 17). Second, the bells were not available in all of the rooms, even for residents capable of using them. Surveyor DuBose saw no bells for the residents in rooms 102A, 103A-B, 105, 126A, 127A-B, 128A, 130A-B, 132A-B, 133B, 135B, 136A-B, and 137A-B. CMS Ex. 21, at 10 (DuBose Decl. ¶ 17). In her declaration, the facility's administrator, Jane Hornsby, acknowledges that, during his initial walk-through of the facility, Surveyor DuBose complained about not finding bells in certain resident rooms. She claims, however, that three of her staff subsequently located the bells in all but three of the resident rooms. P. Ex. 44, at 4 (Hornsby Decl. ¶16). Petitioner provides no additional details about where the bells were found. The uncontroverted evidence thus establishes that three capable residents had no bells in their rooms at the time of the survey, and fifteen other capable residents did not have bells readily available to them.

Third, the hand-bell "system" provided no coverage for toilets and bathing areas. Rosemary Wilder is a registered nurse with many years of state and federal survey and certification experience. CMS Ex. 23. She correctly points out that bathrooms can be especially dangerous for nursing home residents; bathroom injuries are common among the elderly, and it is therefore imperative that they have a means of communicating with staff while in the bathroom. CMS Ex. 22, at 3 (Wilder Decl. ¶ 6). Petitioner suggests that it provided such a system because hand bells are portable, and the residents could have carried them into the bathroom. P. Reply at 3. I find this completely insufficient. Aged and infirm residents cannot be relied upon to carry bells around. They may reasonably decline to do so because they do not anticipate any emergencies, or they may simply forget. Moreover, those with difficulty ambulating, requiring canes or walkers, should not be expected to carry with them any additional items.

Finally, the hand-bell "system" just did not work effectively. Several residents complained to Surveyor DuBose that staff could not hear the bells, heard them but did not respond, or took a long time to respond. CMS Ex. 21, at 10 (DuBose Decl. ¶ 18). Surveyor DuBose tested the system by ringing several residents' hand bells, and, in fact, staff did not respond. *Id.* Surveyor DuBose's experience is consistent with statements from the facility's designated bell monitors. They reported that bells "on the far end" could not be heard, and residents would stop ringing before their bells could be answered. P. Ex. 38, at 1. If the resident was not in the act of ringing, staff would not know where to go to respond. Most monitors reported that they could not hear the bell if the resident's

door was closed, particularly on the back hall. P. Ex. 38, at 2, 3, 4, 6, 8, 11, 12, 15, 16, 17, 18. A couple of monitors said that they simply kept all the doors open in order to hear the bells. P. Ex. 38, at 1, 14.[7] One monitor reported that she had problems responding if more than one bell was ringing at the same time. P. Ex. 38, at 9.

Petitioner claims to have addressed some of these problem by checking on residents "frequently." Sick residents and those whose doors were closed were checked every 30 minutes; others were checked every hour. P. Ex. 21, at 2; P. Br. at 6. Checking on a resident hourly, or even every 30 minutes, does not adequately address emergency situations. Much damage can occur in that time when an aged or infirm resident is effectively out of contact with facility staff. Moreover, one bell monitor admitted that she did not check on residents whose doors were closed. P. Ex. 38, at 16.

For these reasons, I find that, from July 27 through October 5, 2005, the facility had no effective call light system, and was thus not in substantial compliance with 42 C.F.R. § 483.70(f).

With respect to the immediate jeopardy finding, Petitioner notes that no actual harm occurred to any resident. The absence of actual harm is fortuitous, but not the standard for determining immediate jeopardy. 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).

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[7] According to Petitioner, staff were instructed to "encourage" residents to leave their doors open so that nurses could hear the bells. P. Ex. 21, at 2; P. Br. at 6. By their own admission, however, some staff apparently interpreted this as a requirement and kept all the doors open, potentially infringing on the residents' privacy. P. Ex. 38, at 1, 14.

Nursing home residents include a highly vulnerable population, who often need immediate assistance. Nurse Wilder correctly points out that residents use call systems for mundane matters, but also to remind nursing staff to bring them medication or to request assistance in going to the bathroom. The system is also a critical part of the facility's emergency system since it immediately alerts staff of a resident's acute symptoms or accident, and allows staff to summon additional help in an emergency.[8] CMS Ex. 22, at 2 (Wilder Decl. ¶ 3).

To protect their health and safety the regulation requires that residents and those caring for them be able to communicate expeditiously with the nurse's station from the resident rooms as well as from toilet and bathing facilities. CMS's conclusion that the extended absence of such a communication system is likely to cause serious harm is therefore not clearly erroneous.

***B. The facility was not in substantial compliance with the quality of life regulation, 42 C.F.R. § 483.15(e)(1), nor the quality of care regulation, 42 C.F.R. § 483.25(h)(1).***

Quality of Life. Under the "quality of life" regulation, a resident has the right to receive services in the facility "with reasonable accommodation" of his/her individual needs and preferences, except when resident health or safety would be endangered. 42 C.F.R. § 483.15(e)(1).

Resident (R) 8 was 5'6" tall, and weighed almost 200 pounds. She was paralyzed on one side, and could not turn or reposition herself. Her bed was wider than normal, and Surveyor DuBose observed that she had no mattress cover. Instead of one appropriately sized and fitted bottom sheet, the facility had covered her mattress with two overlapping smaller sheets. These had separated, exposing her to the bare mattress. Surveyor DuBose, who is an experienced registered nurse, noted that lying on a bare mattress increases a resident's risk of skin breakdown. CMS Ex. 1, at 3; CMS Ex. 21, at 5 (DuBose Decl. ¶ 8).

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[8] Petitioner dismisses the need for a call light system where staff might need assistance in an emergency, arguing that staff can simply call for help. I do not consider yelling an adequate substitute for an effective call light system.

Citing its Plan of Correction, Petitioner claims that R8 preferred ill-fitting sheets. P. Br. at 19. This is incorrect. According to the Plan of Correction, after the survey, the facility provided R8 with a mattress cover and properly fitting bed sheets. R8 informed the facility "that she wants to use the full size fitted sheet on her bed, but wants to continue to use the twin bed flat sheet to cover up." P. Ex. 4, at 1. The deficiency here involved the absence of a mattress cover and suitable bottom sheet. No problems were cited regarding R8's top sheet.

Surveyor DuBose also observed that water was not within reach of several residents, including R6 and R7, even though their care plans called for "water pitcher in easy reach." According to Surveyor DuBose, R6 was "begging for water." R7 showed signs of dehydration (dry lips, thick mucus in his mouth). CMS Ex. 1, at 4-5; CMS Ex. 21, at 6-7 (DuBose Decl. ¶¶ 10, 11).

R11 was diabetic. Surveyor DuBose observed that her feet were dark and scaley, and her toenails had not been trimmed; they extended beyond the end of her toes. CMS Ex. 1, at 6; CMS Ex. 21, at 8 (DuBose Decl. ¶ 13). For diabetics, proper foot care is essential to prevent injury caused by toenails scratching feet or legs, and to prevent diabetic foot ulcers. CMS Ex. 21, at 8 (DuBose Decl. ¶ 13).

Because any one of these deficiencies presents the potential for causing more than minimal harm, the facility was not in substantial compliance with 42 C.F.R. § 483.15(e)(1).

Quality of Care. Under the statute and "quality of care" regulation, each resident must receive and the facility must provide the necessary care and services to attain or maintain for each resident the highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. Act, section 1819(b); 42 C.F.R. § 483.25. Among other requirements, the facility must ensure that the resident environment remains as free of accident hazards as possible. 42 C.F.R. § 483.25(h)(1).

Surveyor DuBose observed an unattended maintenance cart in an unlocked room on the Alzheimer's ward. The cart contained a hammer, metal snips, a wire stripper, thermometer, screw drivers, screws, wrenches, drill bits, and light bulbs. CMS Ex. 1, at 7-8. The responsible maintenance employee was not in the vicinity, and the cart sat there for about 25 minutes until removed by another maintenance worker. CMS Ex. 1, at 7-8; CMS Ex. 21, at 8-9 (DuBose Decl. ¶ 14).

On his tour of the facility, Surveyor DuBose also observed an unattended needle and syringe lying on a bed table. After about ten minutes, the Resident Care Manager was summoned to the room. When she picked up the syringe, the sheath covering the needle fell to the floor. CMS Ex. 1, at 8; CMS Ex. 21, at 9 (DuBose Decl. ¶ 15). Leaving prepared medications and needles unattended violates good nursing practice. CMS Ex. 25.

The unattended cart and the unattended needle and syringe posed hazards to facility residents that had the potential for causing more than minimal harm. The facility was therefore not in substantial compliance with 42 C.F.R. § 483.25(h)(1).

***C. I find reasonable the $100 per day CMP, which is at the low end of the CMP range for non-immediate jeopardy situations.***

Aside from its claims regarding compliance, Petitioner offers little argument as to the reasonableness of the $100 per day CMP. In any event, the penalty is at the low end of the range, and is justified by the relevant criteria.

If CMS determines that a facility is not in substantial compliance with program requirements, it may impose a CMP for each day of substantial noncompliance. Act, section 1819(h); 42 C.F.R. §§ 488.402, 488.408. Where the deficiencies do not pose immediate jeopardy to resident health and safety, but have either caused actual harm or have the potential for causing more than minimal harm, the penalty will be in the range of $50 to $3,000 per day. 42 C.F.R. §§ 488.408(d), 488.438(a). At $100 per day, the penalty here is at the very low end of the range.

I determine whether the amount of a CMP is reasonable by applying the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of noncompliance; 2) the facility's financial condition; 3) factors specified in 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. The absence of culpability is not a mitigating factor. 42 C.F.R. § 488.438(f). The factors in 42 C.F.R. § 488.404 include: 1) the scope and severity of the deficiency; 2) the relationship of the deficiency to other deficiencies resulting in noncompliance; 3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

Aside from some unhelpful references to the July survey, the record says nothing about the facility's history, and Petitioner has not claimed that its financial condition prevents it from paying this small penalty. However, the remaining factors support this CMP. The deficiencies cited were not trivial, and affected resident comfort, health and safety. Failure to provide easily accessible water to thirsty residents suggests a level of neglect or indifference. Leaving a syringe unattended is irresponsible and neglectful.

## IV. Conclusion

For all of the reasons discussed above, I uphold CMS's determination that Petitioner was not in substantial compliance with program participation requirements. I find that from July 27 through October 5, 2005, its deficiencies posed immediate jeopardy to resident health and safety. I must therefore sustain the $3,050 per day CMP imposed for the period of immediate jeopardy, since that is the statutory minimum. Finally, I sustain as reasonable the $100 per day CMP imposed for the period of noncompliance that was not immediate jeopardy.

/s/

Carolyn Cozad Hughes
Administrative Law Judge