Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Jewish Home of Eastern Pennsylvania
(CCN: 39-5103),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket Nos. C-08-280, C-08-281, and C-08-346

Decision No. CR2242

Date: September 17, 2010

DECISION

Petitioner, Jewish Home of Eastern Pennsylvania, was not in substantial compliance with program participation requirements from November 2, 2007 through January 17, 2008. There is a basis for the imposition of an enforcement remedy. A civil money penalty (CMP) of $600 per day from November 2, 2007 through January 17, 2008, totaling $46,200, is a reasonable enforcement remedy.

I. Background

Petitioner is located in Scranton, Pennsylvania and participates in Medicare as a skilled nursing facility (SNF) and the state Medicaid program as a nursing facility (NF). On November 2, 2007, Petitioner was surveyed by the Pennsylvania Department of Health (state agency) and found not in substantial compliance with program participation requirements. The Centers for Medicare and Medicaid Services (CMS) notified Petitioner by letter dated December 6, 2007, that it was imposing the following enforcement remedy: a CMP of $600 per day effective November 2, 2007, continuing until Petitioner returned to substantial compliance or its participation in Medicare was terminated. A revisit survey was conducted by the state agency on January 4, 2008, and it was determined that Petitioner had not returned to substantial compliance. CMS notified Petitioner by letter dated January 23, 2008, that it was imposing a denial of payments for new admissions (DPNA) effective February 8, 2008, if Petitioner did not

return to substantial compliance before that date; and that Petitioner's provider agreement would be terminated on May 2, 2008, if Petitioner did not return to substantial compliance before that date. CMS advised Petitioner by letter dated March 5, 2008, that the state agency determined based on a revisit survey conducted on February 22, 2008, that Petitioner returned to substantial compliance with program participation requirements on January 18, 2008, and the DPNA and termination were cancelled. CMS also advised Petitioner that the total CMP was $46,200, based upon a daily CMP of $600 for the period from November 2, 2007 through January 17, 2008.

Petitioner requested a hearing before an administrative law judge (ALJ) by letters dated February 4, 2008 (docketed as C-08-280 and C-08-281)[1] and March 11, 2008 (docketed as C-08-346). The cases were assigned to Judge Jose Anglada for hearing and decision and an Acknowledgement and Initial Pre-Hearing Order was issued in each case. Judge Anglada ordered the consolidation of C-08-280 and C-08-281 on April 2, 2008. Judge Anglada consolidated C-08-280 and C-08-346 by "Ruling and Consolidation" dated January 30, 2009. Judge Anglada also denied a CMS motion for dismissal or partial summary disposition by ruling issued January 30, 2009.

On February 13, 2009, the consolidated cases were reassigned to me for hearing and decision due to Judge Anglada's departure from the Civil Remedies Division. On March 18, 2009, I issued a supplemental prehearing order. On August 25, 2009, a hearing was convened in Scranton, Pennsylvania and a 313-page transcript (Tr.) of the proceedings was prepared. CMS offered CMS exhibits (CMS Exs.) 1 through 37 that were admitted as evidence. Tr. at 62. Petitioner offered Petitioner exhibits (P. Exs.) 6 through 10 that were admitted as evidence. Tr. at 65. CMS called the following witnesses: Surveyor Darin Ambosie; Daniel Haimowitz, MD; and Beryl Goldman, PhD. Petitioner called as a witness, Mary Rose Applegate, Petitioner's Administrator. CMS filed its post-hearing brief (CMS Br.) on October 23, 2009, and its post-hearing reply brief (CMS Reply) on November 23, 2009. Petitioner filed its post-hearing brief (P. Br.) on October 26, 2009,[2] and waived filing a reply brief on November 24, 2009.

II. Discussion

A. Issues

The issues in this case are:

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[1] Docketing the February 4, 2008 request for hearing twice was an administrative error.

[2] Petitioner's motion for leave to file its post-hearing brief out-of-time, was not opposed, and the motion is granted.

Whether there is a basis for the imposition of an enforcement remedy; and,

Whether the remedy imposed is reasonable.

B. Applicable Law

The statutory and regulatory requirements for participation by a long-term care facility are found at sections 1819 (SNF) and 1919 (NF) of the Act and at 42 C.F.R. Part 483. Section 1819(h)(2) of the Act vests the Secretary of Health and Human Services (Secretary) with authority to impose enforcement remedies against a SNF for failure to comply substantially with the federal participation requirements established by sections 1819(b), (c), and (d) of the Act.[3] Pursuant to 1819(h)(2)(C), the Secretary may continue Medicare payments to a SNF not longer than six months after the date the facility is first found not in compliance with participation requirements. Pursuant to 1819(h)(2)(D), if a SNF does not return to compliance with participation requirements within three months, the Secretary must deny payments for all individuals admitted to the facility after that date – commonly referred to as the mandatory or statutory DPNA. In addition to the authority to terminate a noncompliant SNF's participation in Medicare, the Act grants the Secretary authority to impose other enforcement remedies, including a discretionary DPNA, CMPs, appointment of temporary management, and other remedies such as a directed plan of correction. Act § 1819(h)(2)(B).

The Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility that is not complying substantially with federal participation requirements. "*Substantial compliance* means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301 (emphasis in original). A deficiency is a violation of a participation requirement established by sections 1819(b), (c), and (d) of the Act or the Secretary's regulations at 42 C.F.R. Part 483, Subpart B. State survey agencies survey facilities that participate in Medicare on behalf of CMS to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-.28, 488.300-.335. The regulations specify the enforcement remedies that CMS may impose if a facility is not in substantial compliance with Medicare requirements. 42 C.F.R. § 488.406.

The regulations specify that a CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper

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[3] Section 1919(h)(2) of the Act gives similar enforcement authority to the states to ensure that NFs comply with their participation requirements established by sections 1919(b), (c), and (d) of the Act.

range of a CMP, $3,050 per day to $10,000 per day, is reserved for deficiencies that pose immediate jeopardy to a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. § 488.438(a)(1)(i), (d)(2). "*Immediate jeopardy* means a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301 (emphasis in original). The lower range of a CMP, $50 per day to $3,000 per day, is reserved for deficiencies that do not constitute immediate jeopardy but either cause actual harm to residents, or cause no actual harm but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii).

The Act and regulations make a hearing before an administrative law judge (ALJ) available to a long-term care facility against which CMS has determined to impose an enforcement remedy. Act §§ 1128A(c)(2), 1866(h); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *Cal Turner Extended Care*, DAB No. 2030 (2006); *The Residence at Salem Woods*, DAB No. 2052 (2006); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Emerald Oaks*, DAB No. 1800 at 11 (2001); *Anesthesiologists Affiliated*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); 42 C.F.R. §§ 488.330(e), 498.3. However, the choice of remedies or the factors considered by CMS when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance determined by CMS if a successful challenge would affect the range of the CMP that may be imposed or impact the facility's authority to conduct a NATCEP. 42 C.F.R. § 498.3(b)(14), (d)(10)(i). The CMS determination as to the level of noncompliance, including the finding of immediate jeopardy, "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). *Woodstock Care Ctr.*, DAB No. 1726 at 9, 38 (2000), *aff'd*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g.*, *Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). ALJ Review of a CMP is subject to 42 C.F.R. § 488.438(e).

The standard of proof or quantum of evidence required is a preponderance of the evidence. CMS has the burden of coming forward with the evidence and making a *prima facie* showing of a basis for imposition of an enforcement remedy. Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense. *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 F. App'x. 181 (6th Cir. 2005); *Batavia Nursing & Convalescent Inn*, DAB No. 1911 (2004); *Emerald Oaks*, DAB No. 1800; *Cross Creek Health Care Ctr.*, DAB No. 1665 (1998); *see Hillman Rehab. Ctr.*, DAB No. 1611 (1997), No. 98-3789, 1999 WL 34813783 (D.N.J. May 13, 1999).

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold text followed by my findings of fact and analysis. Based upon the survey that ended November 2, 2007, CMS alleges that Petitioner was not in substantial compliance with program participation requirements beginning November 2, 2007, based upon violations of 42 C.F.R. §§ 483.10(f)(2) (Tag F166, scope and severity (s/s) E); 483.13(c) (Tag F224, s/s D); 483.13(c)(1)(ii)-(iii), (c)(2)-(4) (Tag F225, s/s D); 483.13(c) (Tag F226, s/s D); 483.15(e)(1) (Tag F246, s/s E); 483.15(g)(1) (Tag F250, s/s D); 483.25(c) (Tag F314, s/s G); 483.25(d) (Tag F315, s/s G); 483.25(h) (Tag F323, s/s G); 483.25(m)(2) (Tag F333, s/s E); 483.30(a) (Tag F353, s/s D); 483.35(f) (Tag F368, s/s E); 483.35(i)(2) (Tag F371, s/s E); and 483.75(m)(2) (2007)[4] (Tag F518, s/s E). CMS Ex. 2. Based upon the survey that ended on January 4, 2008, CMS alleges that Petitioner continued to be in violation of 42 C.F.R. §§ 483.25(h) (Tag F323, s/s G) and 483.75(o)(1) (Tag F520, s/s D). CMS Ex. 25.

Petitioner stipulated at hearing that the exhibits offered by CMS and admitted as evidence are sufficient for a *prima facie* showing of the deficiencies alleged by the November 2, 2008 survey. Petitioner stated that it would not introduce any rebuttal evidence. Petitioner asserted that it preserved its right to proceed on certain alleged "equal protection issues" and privilege issues related to the surveys. Petitioner alleges before me that it returned to substantial compliance with program participation requirements on November 30, 2007, and that it was not in violation of 42 C.F.R. §§ 483.25(h) (Tag F323) and 483.75(o)(1) (Tag F520) as alleged by the revisit survey completed on January 4, 2008. Tr. at 18-28. By stipulating that the CMS evidence constitutes a *prima facie* showing as to the November deficiencies and by not presenting a case in rebuttal, Petitioner has conceded that CMS had a basis for imposing a $600 per day CMP beginning November 2, 2007 and continuing to the date that Petitioner returned to substantial compliance. The issues remaining for adjudication are whether Petitioner returned to substantial compliance prior to January 18, 2007 (including whether Petitioner violated 42 C.F.R. §§ 483.25(h) (Tag F323) and 483.75(o)(1) (Tag F520) as alleged by the revisit survey completed on January 4, 2008) and whether the CMP proposed is a reasonable enforcement remedy.

I have carefully considered all the evidence, including the documents and the testimony at hearing, and the arguments of both parties, though not all may be specifically discussed in this decision.[5] I discuss in this decision the credible evidence given the greatest weight

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[4] References are to the version of the Code of Federal Regulations (C.F.R.) in effect at the time of the survey, unless otherwise indicated.

[5] "Credible evidence" is evidence that is worthy of belief. *Black's Law Dictionary* 596 (18th ed. 2004). The "weight of evidence" is the persuasiveness of some evidence compared to other evidence. *Id*. at 1625.

in my decision-making. The fact that evidence is not specifically discussed should not be considered sufficient to rebut the presumption that I considered all the evidence and assigned such weight or probative value to the credible evidence that I determined appropriate within my discretion as an ALJ. There is no requirement for me to discuss the weight given every piece of evidence considered in this case, nor would it be consistent with notions of judicial economy to do so.

1. Petitioner violated 42 C.F.R. § 483.25(h) and the violation caused actual harm.

a. Facts

Resident 164 suffered from osteoporosis, degenerative joint disease (DJD), peripheral vascular disease (PVD), atherosclerotic coronary disease (ASCD), glaucoma, urge incontinence, urinary retention, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), hypertension, restless leg syndrome, anxiety, and depression. CMS Ex. 27, at 24, 57. Petitioner had assessed the resident as at risk for fall five times between October 2006 and September 2007. CMS Ex. 27, at 7. Resident 164 had a care plan dated July 10, 2006, that addressed her history of falls; the fact that she liked to be at the sink in her room for personal hygiene, including make-up and she did not like staff assistance; her diagnoses that contributed to her risk for falls including hypertension, PVD, osteoarthritis, osteoporosis, CVA (cardio-vascular accident), and her anti-anxiety medication. Hand written entries list other risk factors including her poor balance, the fact she fatigues easily, and her propensity to self-transfer to a bedside commode. CMS Ex. 27, at 9, 37, 50.

There is no dispute that in roughly six weeks Resident 164 fell four times on November 5, 2007 (CMS Ex. 27, at 20), November 27, 2007 (CMS Ex. 27, at 35), December 2, 2007 (CMS Ex. 2, at 5), and December 22, 2007 (CMS Ex. 27, at 45). There is no dispute that the last comprehensive fall risk assessment of Resident 164 was done on September 10, 2007. CMS Ex. 27, at 7. It is undisputed that no comprehensive fall risk assessment of Resident 164 was performed between September 10, 2007 and the survey on January 4, 2008, even though Resident 164 fell four times. Petitioner's Administrator, Mary Rose Applegate, admitted that no fall risk assessment was done after any of the four falls but that one should have been done. Tr. at 296. Resident 164 received a score of eighteen on the September 10, 2007 Fall Risk Assessment, with a risk for falls being indicated by a score above 10. The assessment indicated that Resident 164 was confused; she required nursing assistance with elimination; she had three or more falls within the last six months; she was taking medication that increased her risk for falls, including Lasix, Zoloft, Ativan, Lopressor, Imdur; she needed an assistive device for ambulation; and she had balance problems when walking. CMS Ex. 27 at 7.

Resident 164's care plan in effect at the time of the November 5, 2007 fall, included the following interventions: place personal items and water in easy reach; refer to physical therapy and treatment as indicated; administer medication as ordered; ophthalmology

follow-up as necessary; eyeglasses as appropriate; no side-rails; blood pressure monthly and as necessary; encourage use of comfortable, non-skid shoes; non-skid mat both sides of bed and bathroom; gripper socks at night when in bed; restorative nursing program as ordered; and encourage use of wheelchair when off the unit and the roller walker when on the unit. An undated hand-written entry at the end of the list of interventions that I infer was added in response to the November 5, 2007 fall, states "PT screen." CMS Ex. 27, at 19, 22-23; Tr. at 234-35, 298-302. Although not listed on the care plan, Administrator Applegate testified that Resident 164 also had a low bed with no side rails in place prior to her fall on November 5, 2007. Tr. at 234.

The facts related to each un-witnessed fall are undisputed as they are reported in Petitioner's records that have been admitted as evidence.

A fall occurred on November 5, 2007, at approximately 9:30 p.m. Resident 164 was found on her buttocks on the non-skid mat next to her bed. Upon investigation, it was determined that Resident 164 bent down in front of her dresser to get a shirt out of a low drawer. When Resident 164 pulled the dresser drawer, the entire drawer came out and she fell. Resident 164 was not injured except for reddened areas on her left elbow and mid-spine. She had been last observed at 9:15 p.m. in bed. It is noted that the resident does not always use the call bell and ask for assistance, the call bell was within reach, but the call bell was not activated. It was noted that the resident had independently toileted herself within the past two hours even though she was supposed to transfer only with the assistance of one staff. CMS Ex. 27, at 20-21, 24, 25, 28, 29. The facility devised and implemented the following interventions in response to the fall: Resident 164 was educated not to reach for low items without ringing and asking for assistance; maintenance worked on all the dresser drawers in the facility so that the drawers would work properly and could not be pulled completely out; a PT screen was added to her care plan. CMS Ex. 27 at 21, 23, 28. A fall screen on November 8, 2007 by occupational therapy found that Resident 164 continued to require supervision with all transfers due to safety and balance deficits. CMS Ex. 27, at 31. A Social Services Progress Notes entry dated November 6, 2007, indicates that the resident was counseled regarding the danger of not using her call bell. An entry dated November 8, 2007 reveals that the Falls Committee felt that Resident 164's bedside commode should be removed to avoid dangers of self transferring but the resident asked to keep the commode. The resident reportedly stated that if the commode was taken and staff did not respond quickly enough to the call bell, she would attempt to walk to the bathroom on her own. The note indicates that it was decided to keep the bedside commode but "a contract will be drawn to inform" the resident of the dangers of non-compliance. CMS Ex. 27, at 33-34. The "contract" dated and signed on November 9, 2007, includes a list of interventions with spaces for the resident to indicate by her initials whether she would comply with the listed interventions. Resident 164 indicated that she would comply with the assistance of one staff member for transfers but only if she did not have to wait for assistance. She indicated that she would not use the wheelchair when out of bed to go to the bathroom, and she indicated that she would not use the call bell and wait for assistance. CMS Ex. 27, at 43.

A second fall occurred on November 27, 2007 at approximately 9:00 p.m. Resident 164 was found sitting on the floor in her room. Resident 164 reported that she fell while straightening the blankets on her bed. No injury is noted. She was last observed prior to the incident at 8:15 p.m. lying in bed. A nurse had seen her at 8:00 p.m. in bed with her gripper socks on but when the resident was found on the floor she had on her dress shoes. CMS Ex. 27, at 35, 41, 42. A Social Service Progress Notes entry dated November 28, 2007 shows that the resident was counseled regarding what shoes she should wear and reminded to use the call bell for assistance and, it is noted, the resident agreed. CMS Ex. 27, at 42. The facility added to Resident 164's care plan under "Problem/Need" that Resident 164 had poor balance and fatigues easily. Under "Goal" Petitioner added that the goal for the resident to ring the call bell for assistance and accept the assistance of one staff member for transfers. An intervention to encourage use of the call bell was added to the copy of the care plan filed with the event report but it is dated September 7, 2007. A second new intervention was to post visual clues to remind Resident 164 that she should ring for assistance. A previously listed intervention to encourage the resident to use her wheelchair when off the unit and her walker when on the unit was discontinued with the note that her wheelchair was her primary mode of transportation. CMS Ex. 27, at 37-38, 40; Tr. at 88.

A third fall occurred on December 2, 2007 at approximately 8:00 a.m. Resident 164 was found on the floor beside her bed. Resident 164 reported that she was getting off the bedside commode and fell pulling up her pants. Resident 164 reported that she rang the call bell but does not want to wait for assistance and so transferred herself to the bedside commode. She was last seen before the event at 7:50 a.m. sleeping in bed. Staff assessment at the time revealed no apparent injury but the resident complained of right arm pain. Petitioner's investigation report form records that the resident was not compliant with instruction to use her call bell to call for assistance; but the call bell was in reach and activated; the resident had self-toileted within the past two hours; the resident's unsteady gait, impaired cognition, psychoactive medication, frequent need to toilet, attempts to self-transfer, and noncompliance with visual cues to call for assistance may have contributed to the event. The facility intervened by removing the bedside commode from Resident 164's room and offering the bedside commode between 7:00 a.m. and 8:00 a.m. and during rounds. Facility staff was to continue to encourage Resident 164 to request assistance with transfers. CMS Ex. 27, at 5-6, 8. The resident's care plan was updated to reflect that the bedside commode was to be removed from her room and offered between 7:00 and 8:00 a.m. and during rounds. CMS Ex. 27, at 10, 13. Resident 164 subsequently requested the return of the bedside commode and the request was granted on December 4, 2007, with the plan to offer assistance with use between 7:00 and 8:00 a.m. CMS Ex. 27, at 15, 51.

The fourth fall occurred on December 22, 2007 at approximately 2:30 a.m. Resident 164 was found sitting on the floor beside her bed on the non-skid mat with her legs extended in front of her. Resident 164 stated that she was walking to the bathroom to get a glass of water and slipped, fell, and banged her head.[6] The resident was last observed prior to the event at 1:30 a.m. awake in bed. She was assessed as having abrasions and contusions to her forehead, above both eyes, and on top of her head.[7] Petitioner's investigation report shows that the call bell was in reach and activated at the time of the event (but by the resident's roommate after the fall (CMS Ex. 27, at 48-49)); the resident had self-toileted within the two hours preceding the event using her bedside commode; there was an incontinent pad on the anti-skid mat to the right of the bed; the resident's unsteady gait, impaired cognition, hypertension, psychoactive drugs, steroids, cardiovascular drugs, analgesics, and narcotics may have contributed to the event. The resident was noted to be noncompliant because she self-transfers without the assistance of staff, and it is noted that she had not liked to ask for assistance since August 21, 2006. CMS Ex. 27, at 45-46, 48. Petitioner added the following interventions: use of a winged mattress, thirty-minute checks, offering assistance if awake, and a bed and chair alarm. CMS Ex. 27, at 46, 47, 51, 53, 57-58. Subsequently the alarms were removed as they were distressing to the resident. CMS Ex. 27, at 59, 60. However, the effectiveness of the alarm was clearly demonstrated as evidenced by the Alarm Assessment Tool which shows that on December 24, 2007 there were four instances between 4:00 p.m. and 8:45 p.m. when the alarm sounded when the resident attempted to self-transfer. CMS Ex. 27, at 60. The effectiveness of the thirty minute checks is shown by the assessment tool which shows three instances between Noon and 10:30 p.m. on December 22, 2007, when the resident self-transferred without calling for assistance. CMS Ex. 27, at 62-64.

b. Analysis

The question before me is whether Petitioner was in substantial compliance with the requirement of 42 C.F.R. § 483.25(h), which requires that a resident receive adequate supervision and assistive devices to prevent accidents.

The general quality of care regulation, 42 C.F.R. § 483.25, requires that a facility ensure that each resident receives necessary care and services to attain or maintain the resident's

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[6] Administrator Applegate testified that Resident 164 later recanted her statement that she was on the way to the bathroom to get a glass of water. Tr. at 275. Testimony was presented that a glass of water was already at Resident 164's bedside. Ms. Applegate testified that the facility never determined the circumstances of the December 22, 2007 fall. Tr. at 276.

[7] Resident 164 subsequently became confused and was transferred to the hospital where she was found to have a scalp hematoma and a questionable non-displaced fracture of the nose. CMS Ex. 27, at 54-57.

highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care developed by the resident's care planning team in accordance with 42 C.F.R. § 483.20. The quality of care regulations impose specific obligations upon a facility related to accident hazards and accidents.

> The facility must ensure that –
>
> (1) The resident environment remains as free of accident hazards as is possible; and
>
> (2) Each resident receives adequate supervision and assistance devices to prevent accidents

42 C.F.R. § 483.25(h). The State Operations Manual (SOM), CMS's guidance to surveyors, instructs surveyors that the intent of 42 C.F.R. § 483.25(h)(1) and (2) is "to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents." The facility is expected to identify, evaluate, and analyze hazards and risks; implement interventions to reduce hazards and risks; and monitor the effectiveness of interventions and modify them when necessary. SOM, app. PP, Guidance to Surveyors Long Term Care Facilities, F323, Quality of Care (Rev. 27; eff. Aug. 17, 2007).

The Board has provided interpretative guidance for adjudicating alleged violations of 42 C.F.R. § 483.25(h)(1):

> The standard in section 483.25(h)(1) itself - that a facility "ensure that the environment is as free of accident hazards as possible" in order to meet the quality of care goal in section 483.25 -- places a continuum of affirmative duties on a facility. A facility must determine whether any condition exists in the environment that could endanger a resident's safety. If so, the facility must remove that condition if possible, and, when not possible, it must take action to protect residents from the danger posed by that condition. [Footnote omitted.] **If a facility has identified and planned for a hazard and then failed to follow its own plan, that may be sufficient to show a lack of compliance with [the] regulatory requirement.** In other cases, an ALJ may need to consider the actions the facility took to identify, remove, or protect residents from the hazard. Where a facility alleges (or shows) that it did not know that a hazard existed, the facility cannot prevail if it could have reasonably foreseen that an endangering condition existed either generally or for a particular resident or residents.

Maine Veterans' Home – Scarborough, DAB No. 1975, at 6-7 (2005) (emphasis added).

The Board has also explained the requirements of 42 C.F.R. § 483.25(h)(2) in numerous decisions. *Golden Living Ctr. – Riverchase*, DAB No. 2314, at 6-7 (2010); *Eastwood Convalescent Ctr.*, DAB No. 2088 (2007); *Liberty Commons Nursing and Rehab. - Alamance*, DAB No. 2070 (2007); *Century Care of Crystal Coast*, DAB No. 2076 (2007), *aff'd*, 281 F. App'x 180 (4th Cir. 2008); *Golden Age Skilled Nursing & Rehab. Ctr.*, DAB No. 2026 (2006); *Estes Nursing Facility Civic Ctr.*, DAB No. 2000 (2005); *Northeastern Ohio Alzheimer's Research Ctr.*, DAB No. 1935 (2004); *Woodstock Care Ctr.*, DAB No. 1726 (2000), *aff'd*, *Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 (6th Cir. 2003). Section 483.25(h)(2) does not make a facility strictly liable for accidents that occur, but it does require that a facility take all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigates foreseeable risks of harm from accidents. *Woodstock Care Ctr. v. Thompson*, 363 F.3d at 589 (a SNF must take "all reasonable precautions against residents' accidents"). A facility is permitted the flexibility to choose the methods of supervision it uses to prevent accidents, but the chosen methods must be adequate under the circumstances. Whether supervision is "adequate" depends in part upon the resident's ability to protect himself or herself from harm. *Id*. Based on the regulation and the cases in this area, CMS meets its burden to show a *prima facie* case if the evidence demonstrates that the facility failed to provide adequate supervision and assistance devices to prevent accidents, given what was reasonably foreseeable. *Alden Town Manor Rehab. & HCC*, DAB No. 2054, at 5-6, 7-12 (2006). An "accident" is an unexpected, unintended event that can cause a resident bodily injury, excluding adverse outcomes associated as a direct consequence of treatment or care (e.g., drug side effects or reactions). SOM, app. PP, Tag F323; *Woodstock Care Ctr.*, DAB No. 1726, at 4.

The surveyors allege in the Statement of Deficiencies (SOD) based upon a review of the clinical record of Resident 164 that Petitioner failed to provide adequate supervision to prevent repeated falls and that Resident 164 suffered actual harm as a result. CMS Ex. 25, at 1. The surveyors allege violation of this regulation based on the four falls of Resident 164 between November 5, 2007 and December 22, 2007 and Petitioner's failure to implement adequate interventions to minimize the risk for harm to the resident due to accidental injury related to the falls.

Based upon my review of the evidence as summarized above, I conclude that CMS has made a *prima facie* showing that Petitioner was in violation of 42 C.F.R. § 483.25(h) with regard to Resident 3 as early as November 9, 2007. November 9, 2007 is the date on which Resident 164 refused to agree to use the call light and wait for the assistance of staff with transferring. CMS Ex. 27, at 43. On November 9, 2007, the evidence shows that Petitioner had assessed Resident 164 as at risk for falls (CMS Ex. 27, at 7, 31); Petitioner knew that Resident 164 required assistance with transfers; and Resident 164 was capable of using the call bell and would do so but refused to wait for staff to respond to provide assistance. Resident 164's refusal to use the call bell and then wait for assistance was the accident hazard with the potential for accidental injury that Petitioner needed to mitigate or eliminate. Resident 164's refusal to use the call bell and wait for

assistance was clearly foreseeable as of November 9, 2007. Petitioner was clearly on notice by Resident 164's responses to the contract and her continued self-transfers and self-toileting. Resident 164's express refusal to use the call bell and wait for assistance rendered ineffective Petitioner's inventions of reminders and encouragement to use the call bell as of November 9, 2007. Therefore, Petitioner clearly was on notice as early as November 9, 2007, that the care planning team needed to develop and implement interventions to provide closer supervision of Resident 164 to ensure that she did not engage in unassisted transfers or, when she attempted to do so, staff was alerted to render assistance to reduce the potential for accidental injury of the resident. Petitioner failed to develop adequate interventions to ensure adequate supervision as early as November 9, 2007, and thereby violated 42 C.F.R. § 483.25. When Petitioner finally implemented the use of alarms and thirty-minute checks after the fourth fall, the evidence shows they were effective.[8] I conclude that Petitioner has failed to rebut the *prima facie* showing or to establish an affirmative defense. I further conclude that Petitioner has not presented evidence to show that it returned to substantial compliance with 42 C.F.R. § 483.25 until January 18, 2008.

Petitioner argues that Resident 164 had the cognitive ability to understand and comply with instructions and visual reminders to use her call bell. P. Br. at 7. I do not have the entire clinical record to assess whether Petitioner's assertion is supported by the resident's medical records. However, even if I accept that Resident 164's cognitive ability was intact, it simply supports my conclusion that Resident 164 was clear in her communication to staff that she would not comply with requests to use her call bell and that Petitioner had notice that Resident 164 required increased supervision to prevent accidental injury due to self-transfers. I note however, that if Resident 164 was cognitively intact, there is nevertheless a significant question about her safety awareness and ability to exercise judgment for her own protection that is not addressed by either CMS or Petitioner. Whether Resident 164's refusal to comply with the request that she use the call bell and wait for staff assistance is due to some cognitive impairment or a lack of safety awareness, is not an issue I need resolve. Petitioner does not dispute that the resident was assessed as a fall risk, that she had poor balance, that she fatigued easily, and that she continued to self-transfer after November 9, 2007, demonstrating that mere requests and visual cues not to transfer without assistance were not effective interventions.

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[8] There was testimony at hearing that other interventions might also have been effective to ensure adequate supervision such as moving the resident to a room closer to the nurse's station. I do not have sufficient evidence to evaluate the feasibility or potential effectiveness of all the possible interventions that the care plan team might have devised and implemented. In this case, it is sufficient that there is evidence of two interventions that could have been effective.

Petitioner argues that use of an alarm was not appropriate because Resident 164 was competent and did not want an alarm; and because the standard of care and the right to self-determination support Petitioner's decision not to use an alarm. P. Br. at 7-8. Resident 164 refused to comply with Petitioner's request that she use the call bell and wait for staff assistance for any transfers. I am not convinced on these facts that balancing a resident's rights against a resident's safety does not tip the scale in favor of using an alarm. However, as the evidence shows Petitioner had alternative interventions such as increasing direct visual observation to every thirty minutes or every fifteen minutes or imposing one-on-one supervision. Petitioner does not address why it did not implement increased observation on November 9, 2007, when it was on notice Resident 164 was going to continue to be noncompliant.

Petitioner argues that its safety interventions were effective for the first three falls because there were no injuries. Petitioner also argues that the falls were not really accidents because they were not unplanned as the facility planned to safely accommodate the possibility the resident would fall. P. Br. at 8-9. The regulation obliges Petitioner to provide supervision and assistive devices to prevent accidents, such as falls, not just prevent injuries from accidents. As already discussed, I conclude Petitioner violated the regulation because Petitioner did not take all reasonable steps to ensure that Resident 164 had the supervision necessary to prevent her from falling. The fact that Petitioner implemented interventions to minimize the risk of injury in the event of a fall is good, but not a defense to a violation of the regulation in this case.

Petitioner argues that the use of the bedside commode for toileting, blood pressure monitoring, and medication monitoring were all appropriate interventions. P. Br. at 9-10. Whether or not these were appropriate interventions, does not address why Petitioner did not increase supervision of Resident 164 after November 9, 2007. Petitioner also argues that the surveyor cited the deficiency, at least partly, due to call bell response times. P. Br. at 10-11. My review is *de novo*. Whether the surveyor considered call bell response times as a fact in support of citing the deficiency does not impact my decision in this case. Rather, my decision turns upon the facts that show that: (1) Petitioner was on notice on November 9, 2007 that Resident 164 was going to continue to be noncompliant with requests that she use her call bell and wait for assistance with transfers; and (2) Petitioner failed to increase supervision to minimize the risk for falls.

Accordingly, I conclude that Petitioner violated 42 C.F.R. § 483.25(h) and the violation caused actual harm to Resident 164.

2. Petitioner did not violate 42 C.F.R. § 483.75(o) (Tag F520).

Every long-term care facility is required to establish a functioning quality assessment and assurance (QA) committee. The regulation requires:

> (1) A facility must maintain a quality assessment and assurance committee consisting of—

> (i) The director of nursing services;
> (ii) A physician designated by the facility; and
> (iii) At least 3 other members of the facility's staff.
>
> (2) The quality assessment and assurance committee—
>
> (i) Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and
> (ii) Develops and implements appropriate plans of action to correct identified quality deficiencies.

42 C.F.R. § 483.75(o).

Surveyor Darin Ambosie admitted that Petitioner had established a QA committee but cited the facility on the theory that the committee was not effective based upon the deficiency under Tag F323 related to Resident 164. Tr. at 108-12. Mary Rose Applegate, Petitioner's Administrator, testified that the facility had a QA committee that included the Administrator, Medical Director, and Director of Nursing and that the committee met quarterly to consider problems and solutions. Tr. at 226-33.

I find that Petitioner had the required committee and that the committee met as required for the required purpose. I will not infer that the QA committee was not effective in fulfilling its regulatory purpose based upon the facts related to the deficiency I have found under Tag F323. I further note that the allegations related to Resident 164 and Tag F323 relate to the plan of care for the resident and not to the development and implementation of a plan of action to correct identified quality deficiencies as required by the regulation.

Accordingly, I conclude that Petitioner did not violate 42 C.F.R. § 483.75(o) (Tag F520).

3. Petitioner did not return to substantial compliance on November 30, 2007.

4. Petitioner returned to substantial compliance on January 18, 2008.

Based on the violation of 42 C.F.R. § 483.25(h) as discussed above, I conclude Petitioner did not return to substantial compliance on November 30, 2007, the date Petitioner alleged it returned to substantial compliance on the Plan of Correction after the November 2, 2007 survey. CMS Exs. 2, at 1; 23, at 1. The date reflected on the Plan of Correction to the January 4, 2008 revisit survey by the facility is January 18, 2008. CMS Ex. 25, at 1. I determined above that Petitioner remained out of compliance during the January 4, 2008 revisit survey. Petitioner has the burden to demonstrate by a preponderance of the evidence that it returned to substantial compliance on a date earlier

than the completion date alleged in the Plan of Correction that Petitioner prepared and submitted to the agency. Petitioner has not offered evidence to show it corrected by November 30, 2007, the noncompliance cited by the November 2, 2007 survey and admitted in open court by Petitioner. Petitioner has also not offered evidence that it corrected before January 18, 2008, the deficiency under Tag F323 cited by the survey completed on January 4, 2008.

Petitioner was not in substantial compliance with the requirements of 42 C.F.R. § 483.25(h) in the case of Resident 164 as of November 9, 2007. Petitioner did not correct the deficiency related to Resident 164 prior to January 18, 2007, the date alleged by Petitioner in its plan of correction and the date of substantial compliance found by CMS. CMS Ex. 5; CMS Ex. 25, at 1.

5. Petitioner's objections to my consideration of evidence based upon a "Quality Assurance Privilege" are without merit.

6. Petitioner's objection to my consideration of evidence based upon Equal Protection principals is without merit in this forum.

CMS offered as evidence CMS exhibits 1 through 37. Tr. at 30. Petitioner objected to CMS Ex. 25, pages 2-6; CMS Ex. 27, pages 5-8, 14, 15, 20, 21, 25-27, 29, 30, 32, 35, 39, 41, 45, 46, 48, 49, 53, 59; and CMS Ex. 28.[9] Petitioner reasserts its objections to pages from CMS Exs. 25 and 27 in its post-hearing brief. P. Br. at 1-2.

CMS Ex. 25 is the Statement of Deficiencies (CMS form 2567) (SOD) for the January 4, 2008 revisit survey. In CMS Ex. 25, Petitioner specifically objected to my consideration

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[9] Petitioner objected to CMS Ex. 28 on grounds that it is an Informal Dispute Resolution (IDR) document, IDR is similar to a settlement discussion, and evidence related to settlement discussions is not admissible under the Federal Rules of Evidence. I overruled the objection and admitted CMS Ex. 28 for reasons stated on the record. Tr. at 31-40. Petitioner did not renew the objection in post-hearing briefing and my prior ruling stands. The regulations require that a state agency offer a facility an opportunity for IDR to dispute survey findings upon receipt of the SOD. If a provider successfully shows that a deficiency should not have been cited, the regulation requires that the deficiency and any related enforcement remedy be rescinded. 42 C.F.R. § 488.331. IDR is more akin to an informal adjudication than a settlement process. I further note that the Federal Rules of Evidence do not apply in this proceeding but are referred to for guidance. Authentic and relevant evidence is generally admissible and there is no question that CMS Ex. 28 is both authentic and relevant.

of the plan of correction (POC)[10] prepared by Petitioner that appears in the right column on pages two through six of the document and the last three paragraphs on the left side of CMS Ex. 25, page 2. Petitioner objected to my consideration of any part of the pages of CMS Ex. 27 to which it objected. Petitioner's objection is based upon the theory that the POC, the documents summarized in the SOD on page 2 of CMS Ex. 25, and the documents reflected by the pages of CMS Ex. 27, are all subject to a "Quality Assurance Privileges" that Petitioner argues is created by 42 C.F.R. § 483.75(o). Petitioner argues that the regulation precludes the Secretary from requiring disclosure of quality assurance documents or from using a facility's good faith efforts to correct deficiencies as the basis for imposing sanctions. Tr. at 26, 40-43. I denied the objection and admitted the evidence for the reasons stated on the record at hearing. Tr. at 48-61.

Petitioner offers no new argument in its post-hearing brief and my ruling at hearing is not disturbed. In *Jewish Home of Eastern Pennsylvania,* DAB No. 2254 (2009), another case involving the same Petitioner, an appellate panel of the Board commented that the Act and regulations do not create an evidentiary privilege rather, they establish disclosure and use restrictions applicable to records of a QA committee. *Id*. at 6 n. 3. The Board analyzed the documents to which the objection was interposed in that case to determine whether they were subject to the disclosure and use restrictions under 42 C.F.R. § 483.75(o). The Board considered whether a particular document appeared to be in the "nature of records of a QA Committee." *Id*. at 9. The Board concluded that event reports and interview statements that appear on their face to be of the type normally generated by a facility incident investigation are not subject to 42 C.F.R. § 493.75(o). The Board discussed that the fact that incident reports and patient care records may be considered by a QA committee as part of its function, does not cause such records to become QA records subject to the restrictions of 42 C.F.R. § 493.75(o). *Id*. at 11-12; 42 C.F.R. § 483.13(c)(2), (3), and (4).

Applying the Board's approach to the documents before me, my conclusion that Petitioner's objection was unfounded is unchanged. The POC is required by 42 C.F.R. § 488.402(d) as a response to an alleged deficiency and it is not a document prepared by or for the QA committee as part of its function but rather a required response to the state agency and CMS allegations of deficiencies. The investigation reports to which Petitioner objects are required by 42 C.F.R. §§ 483.13(c)(3) and (4) (investigations of alleged abuse, neglect, mistreatment, and injuries of unknown source), 483.20(k) (documentation to show the care plan was executed and that care meets professional standards of care), 483.25 (to establish delivery of necessary care and services), and/or

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[10] A facility notified that it has deficiencies with respect to program participation requirements must submit a plan of correct for approval by either CMS or the state agency, unless the deficiency is isolated and has no potential for causing more than minimal harm. 42 C.F.R. § 488.402(d).

483.75(l) (required clinical records). The documents to which Petitioner objects were not prepared for the QA committee to fulfill a QA function but rather were necessary for Petitioner to document that it delivered necessary care and services in compliance with participation requirements.[11] Indeed, if Petitioner was successful with its objection, it would deprive itself of the evidence it needs to satisfy its burden of persuasion in a case of this type. Finally, I consider no action of Petitioner's QA committee as evidence of a deficiency or as the basis for an enforcement remedy.

Petitioner objected to my consideration of any evidence offered by CMS on grounds that I may not receive or consider evidence gathered by the government in violation of equal protection principles. Tr. at 66-67. Petitioner renewed its objection in its post-hearing brief. P. Br. at 1-2. Petitioner's theory is that the state survey agency gathered documents, conducted the survey and found deficiencies in this case in violation of the Petitioner's right to equal protection. Petitioner argues that this case involves selective enforcement. Petitioner claims that Petitioner was treated differently than similarly situated facilities because of religious bias in that factually similar behavior in other facilities led to citation of a scope and severity level that was lower than the scope and severity level cited for Petitioner's facility. In short, Petitioner argues that it was cited for no reason other than that it is a Jewish facility. Tr. at 66-76.

The level of noncompliance assigned to a particular deficiency by CMS and the choice of remedies imposed by CMS, when there is a basis for imposition of a remedy, are matters that are not subject to my review. 42 C.F.R. §§ 488.438(e)(2), 488.408(g)(2), 498.3(b)(14) and (d)(10)(ii); *Jewish Home*, DAB No. 2254 at 14. I do not have the authority to conduct investigations of the conduct of state or federal agencies. I do not have the authority to adjudicate constitutional questions. I do not have authority to fashion a remedy for a constitutional violation or resulting harm. My narrow authority is limited to adjudicating matters subject to applicable statutes and regulations and determining whether Petitioner was in substantial compliance with the applicable law. Further, the hearing before an ALJ is a de novo proceeding on the issues of whether there is a basis for imposition of an enforcement remedy and whether the remedy is reasonable. My de novo evaluation of the evidence related to both issues, insulates a facility from the effect of any perceived disparate treatment or bias on the part of the state survey agency or CMS. I also ascertained at the hearing that Petitioner does not have any specific

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[11] I have carefully considered the opinion of Barry Fogel, MD, that Petitioner's event reports are Quality Assurance documents in their entirety and confidential because they are used by the QA Committee. CMS Ex. 6. I find his opinion is not weighty as it is based upon the false legal premise that the regulations establish an evidentiary privilege that extends to all QA documents. I also find his opinion is not persuasive as he fails to address the apparent inconsistency between the alleged privilege and the requirement for the facility to show that it is in substantial compliance with program participation requirements and for CMS to ensure compliance by program participants.

evidence of bias on the part of the surveyor that participated in the January 4, 2008 survey that would impact the credibility of the surveyor's testimony. Tr. at 69-70.

7. A CMP of $600 per day from November 2, 2007 through January 17, 2008 is reasonable.

The only enforcement remedy at issue is the CMP of $600 per day from November 2, 2007 through January 17, 2008. The issue is whether the CMP is reasonable considering 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 regulation provides that the absence of culpability is not a mitigating factor. The factors of 42 C.F.R. § 488.404 are: (1) the scope and severity of the deficiency; (2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and (3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

In reaching a decision on the reasonableness of the CMP, I consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found, and in light of the above factors. I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Ctr.*, DAB No. 1848, at 21 (2002); *Cmty. Nursing Home*, DAB No. 1807, at 22 (2002); *Emerald Oaks*, DAB No. 1800, at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1638, at 8 (1999).

Petitioner has a history of noncompliance in the area of accidents, particularly falls. Petitioner was previously found to have violated 42 C.F.R. § 483.25(h) from December 9, 2005 through January 26, 2006 and a CMP of $350 per day was imposed and affirmed on review through the Board. Petitioner was also found in violation of 42 C.F.R. § 483.25(h) from October 16, 2006 through November 16, 2006 and a CMP of $400 per day was imposed and approved on review through the Board. *Jewish Home of Eastern Pennsylvania*, DAB No. 2254, at 1. Petitioner also conceded the violation of 42 C.F.R. § 483.25(h) cited by the November 2, 2007 survey that resulted in actual harm. Petitioner has not offered evidence to show it is unable to pay the CMP. Petitioner was culpable in the case of Resident 164. The violation of 42 C.F.R. § 483.25(h) was a serious deficiency that resulted in actual harm to the resident. I also note that a CMP of $600 per day is in the lower third of authorized CMPs for non-immediate jeopardy level deficiencies. I conclude that a CMP of $600 per day from November 2, 2007 through January 17, 2008 is reasonable based upon the violation of 42 C.F.R. § 483.25(h) and the admitted deficiencies from the November 2007 survey.

Petitioner argues that the Secretary could not impose a CMP against Petitioner without authority of the Attorney General, citing section 1128A(c)(1) of the Act (42 U.S.C. § 1320a-7a(c)(1). P. Br. at 2. Section 1128A(c)(1) of the Act requires that the Attorney

General and the Secretary agree upon procedures for the imposition of CMPs, assessments, and exclusions. Section 1128A(c)(1) of the Act is applicable to CMPs that the Secretary and her delegate, CMS, may impose as an enforcement remedy against a SNF pursuant to section 1819(h)(2)(B)(ii) of the Act. Pursuant to sections 1102 and 1871 of the Act, the Secretary has promulgated regulations governing the imposition of CMPs pursuant to the authority of the Act. Contrary to the suggestion of Petitioner in this case, section 1128A(c)(1) does not require that the Attorney General authorize the imposition of CMPs against SNFs in individual cases. Furthermore, the provisions of the Act authorizing the imposition of CMPs against individual SNFs, as implemented by the Secretary's regulations, do not require that the Attorney General authorize the imposition of CMPs in individual cases. 42 C.F.R. Part 402; 63 Fed. Reg. 68,690 (Dec. 14, 1998). Thus, I conclude that Petitioner's argument is without merit.

Petitioner argues that the Secretary erred by imposing a CMP without considering mitigating factors in arriving at the reasonable CMP. P. Br. at 3. I conclude that Petitioner's argument is without merit. Petitioner misconstrues the application of the language of 42 C.F.R. § 488.438(f)(4), which provides that the "absence of culpability is not a mitigating circumstance in reducing the amount of the penalty." The provision has no application in this case as Petitioner was clearly culpable in its failure to develop and implement appropriate interventions to fulfill its regulatory obligation to ensure that Resident 164 had adequate supervision to prevent falls. However, in assessing the reasonableness of the $600 per day CMP, I have specifically considered Petitioner's culpability. I have specifically considered the degree or amount of Petitioner's culpability given Petitioner's failing or neglect of its regulatory obligation vis-à-vis the efforts made toward care planning actually undertaken and implemented, i.e. there was not a complete failure to care plan for falls as evidenced by the placement of mats, the use of a low bed, and the other interventions listed on Resident 164's care plan. My review of the reasonableness of the CMP is *de novo* and I do not review whether or how CMS considered the regulatory factors when selecting the amount of the CMP.

III. Conclusion

For the foregoing reasons, Petitioner was not in substantial compliance with program participation requirements from November 2, 2007 through January 17, 2008. There is a basis for the imposition of an enforcement remedy. A CMP of $600 per day from November 2, 2007 through January 17, 2008 is reasonable.

/s/
Keith W. Sickendick
Administrative Law Judge