Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Autumn Ridge Rehabilitation Centre,

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-296

Decision No. CR2467

Date: November 23, 2011

DECISION

I sustain the determination of the Centers for Medicare and Medicaid Services (CMS) to impose the following remedies against Petitioner, Autumn Ridge Rehabilitation Centre:

- Civil money penalties of $3,550 per day for each day of a period beginning on November 4, 2010 and running through December 13, 2010;
- Civil money penalties of $100 per day for each day of a period beginning on December 14, 2010 and continuing through January 6, 2011;
- Denial of payment for new admissions for each day of a period beginning on December 23, 2010 and running through January 6, 2011;
- Loss of authority to conduct a nurse aide training and certification program (NATCEP); and
- Directed in-service training.

I premise my decision on findings that Petitioner failed to comply substantially with Medicare participation requirements throughout the periods of time during which remedies are imposed. In particular, I find that Petitioner manifested immediate jeopardy level noncompliance with the requirements of 42 C.F.R. § 483.25(k) from November 4, 2010 through December 13, 2010. This regulation requires, among other things, that a facility assure that each resident who has a tracheostomy receive proper management and care of that condition and that each resident in need of tracheal suctioning receives it.

I. Background

Petitioner is a skilled nursing facility in Wabash, Indiana. It participates in the Medicare program. Its participation is governed by sections 1819 and 1866 of the Social Security Act (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.

Petitioner requested hearings to challenge the remedy determinations that I describe in the opening paragraph of this decision. The requests were consolidated at my direction. The parties filed pre-hearing briefs and proposed exhibits that included the written direct testimony of their proposed witnesses. CMS then moved for summary judgment. I denied that motion, finding that there were disputed issues of material fact. I subsequently held a hearing by video conference, on September 22, 2011, and by telephone, on September 27, 2011. The parties filed post-hearing briefs.

I received into evidence from CMS exhibits consisting of: CMS Exhibits (Ex.) 1 – 18; 21 – 23; 30 – 32; 35 – 37; 39- 42; 46 and 47; 55 – 68; and 73 – 96. I received into evidence from Petitioner exhibits consisting of P. Ex. 1 – 3. Petitioner attached two additional documents that it styled "exhibits" to its post-hearing brief. Exhibit A consists of excerpts from CMS's State Operations Manual. It is part of the public record, and it is, therefore, unnecessary that I decide whether to receive it into evidence. Exhibit B is a notice letter that CMS sent to another skilled nursing facility in February 2011. This exhibit is irrelevant, and, moreover, Petitioner filed it untimely if it is offering the exhibit as evidence. I exclude it for these reasons.

II. Issues, Findings of Fact, and Conclusions of Law

A. Issues

The issues in this case are whether:

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

2. CMS's determination of immediate jeopardy noncompliance is clearly erroneous; and

3. CMS's remedy determinations are reasonable.

In addressing these issues, I note that there were multiple surveys of Petitioner's facility in the latter part of 2010 and the early part of 2011. These included surveys that were completed on September 23, 2010 (September Survey), November 16, 2010 (November Survey), December 14, 2010 (December Survey), and January 7, 2011 (January Survey). Noncompliance findings were made at all of these surveys except at the January Survey, at which Petitioner was found to have attained compliance with Medicare participation requirements.

Petitioner opted not to offer evidence or argument challenging the noncompliance findings made at the September and November Surveys and challenged only one of the findings of noncompliance made at the December Survey, the finding of immediate jeopardy level noncompliance with 42 C.F.R. § 483.25(k). The other findings of noncompliance made at the September, November, and December surveys are, therefore, administratively final.

I find it unnecessary to address these administratively final findings of noncompliance except to the extent that they support the imposition of remedies by CMS. Moreover, the immediate jeopardy level noncompliance with the requirements of 42 C.F.R. § 483.25(k) found at the December Survey is, by itself, sufficient to justify all of the remedies that are at issue here.

B. Findings of Fact and Conclusions of Law

I make the following findings of fact and conclusions of law (Findings).

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

The evidence unequivocally establishes that Petitioner failed to give three of its residents – identified as Residents B, C, and D – necessary care to address problems related to the residents' tracheostomies. In particular, Petitioner's staff failed to suction the residents' tracheostomies to prevent them from becoming occluded or to remove mucus.

There was systemic noncompliance by Petitioner's staff with requirements for basic tracheostomy care. Each of the three residents whose care is at issue had tracheostomies. At least two of these residents, Residents B and C, had serious and recurring complications related to their tracheostomies. These residents suffered from occlusions and mucus plugs that required suctioning to make it possible for the residents to breathe

freely. Petitioner's staff failed consistently to provide these residents and Resident D, as well, with the care and suctioning that they needed.

Resident B lived at Petitioner's facility for a two-month period, from September 25, 2010 until November 25, 2010, when he was transferred to a hospital and then, to another nursing facility. During these two months, the resident was hospitalized four times for problems related to breathing and/or obstruction of his tracheostomy site. CMS Ex. 84, CMS Ex. 96 at 5 – 9. This resident obviously had severe problems associated with his tracheostomy, and these problems were clearly well known to Petitioner's staff. But, the staff never prepared a care plan to address the resident's tracheostomy or to define measures that the staff would take to make sure that the resident's airway remained patent. Thus, the resident's care plan directed Petitioner's staff to observe the resident's tracheostomy stoma site for possible congestion and to observe the resident for symptoms of infection. CMS Ex. 84 at 73. But, it recited neither prophylactic treatments nor interventions in the event that problems developed, except to say that that the resident should receive medications and oxygen as ordered. *Id.*

On more than one occasion, physicians outside of Petitioner's facility ordered that the resident receive suctioning to keep his air passage clear. On each of these occasions, Petitioner's medical director ordered that the suctioning order be discontinued. The consequence was that Resident B almost never received suctioning, despite orders from outside physicians that he receive it, and Petitioner never evaluated or addressed the implications of this failure to provide care to the resident. Thus:

- In September 2010, as of his admission to Petitioner's facility, Resident B had an order for suctioning on a PRN basis. CMS Ex. 84 at 61. On September 29, 2010, Petitioner's staff suctioned the resident. *Id.* at 62. Then, and without explanation, the order for suctioning was discontinued. *Id.* at 61.[1]

- The resident was brought to the emergency room on October 7, 2010, suffering from acute pneumonia and acute hypoxia (shortness of breath). CMS Ex. 84 at 1-2. The treatments he received included suctioning of his trachea. *Id.* at 5.

- On October 31, 2010, Resident B was brought to the emergency room at a local hospital suffering from shortness of breath. It was determined that his breathing was impaired by a large mucus plug. CMS Ex. 84 at 3. The resident was later discharged with orders that he be suctioned four times daily. *Id.* at 37. On November 1, 2010, just one day later, Petitioner's medical director, James P. McCann, M.D., ordered that the suctioning be discontinued. His order provides no explanation for discontinuing the resident's suctioning. *Id.* at 31.

[1] The order to discontinue suctioning is memorialized by the expression "D/C" in the resident's medication administration record. CMS Ex. 84 at 61.

- Resident B was again admitted to the hospital on November 7, 2011, suffering from acute exacerbation of his chronic breathing problems. CMS Ex. 84 at 8-9. He was treated and released back to Petitioner's facility on November 10, 2011. His discharge orders included a directive that he receive tracheal suction on a PRN basis. *Id.* at 32. But, on that date, Dr. McCann ordered that suctioning be discontinued "due to facility policy." *Id.* at 33. The next day, November 11, 2010, he wrote a progress note that contained this statement:

  > The nurses are restricted by nursing home policies and are not allowed to suction . . . [Resident B's] pharynx. He has a tracheostomy. Unfortunately, they can't directly clean it out.

  Id. at 40.

So, Resident B's orders for suctioning his tracheostomy were discontinued for unarticulated policy reasons. A consequence was that the resident, despite being assessed repeatedly as *needing* suctioning, never *received* it. No one at Petitioner's facility, neither Dr. McCann nor the staff, ever really explained the clinical reasons for countermanding the orders issued by hospital based physicians for suctioning. Petitioner's records are devoid of any explanation for Petitioners' policy not to provide suctioning to residents who had been assessed outside of the facility as needing that service.

This pattern of consistently failing to provide residents with suctioning or countermanding orders that residents receive suctioning, and consistently failing to explain why suctioning was not provided, repeats with Residents C and D. Resident C, like Resident B, had a tracheostomy but had no plan of care that addressed how to assure that the resident's airway remain open and free of mucus. CMS Ex. 96 at 3-4. And, also like Resident B, Resident C suffered from breathing problems related to congestion that required her to be treated at a local hospital. She was discharged back to Petitioner's facility with orders that she receive routine tracheal care and suctioning. CMS Ex. 86 at 1-3, 26, 32, 36. Not only were these orders not complied with by Petitioner's staff but Dr. McCann countermanded an order that the resident receive suctioning. *Id.* at 19. He provided no explanation for countermanding the suctioning order, and, in fact, Petitioner's staff performed no assessment of Resident C showing that she did not need suctioning.

Resident D also had a tracheostomy. The resident had an order in her records for suctioning but, as with Residents B and C, had no care plan addressing her tracheostomy or the means by which Petitioner's staff would attempt to keep her airway open. CMS Ex. 96 at 4-5. The resident's record is devoid of any evidence showing either that she ever received suctioning or that the staff assessed her and determined that suctioning was not needed.

The picture presented of all three residents is of individuals with medical conditions that demanded that Petitioner and its staff either provide specified medical care (tracheal suctioning) or to explain, in the course of assessing these residents and planning for their care, why such care was not necessary. Petitioner and its staff did neither. The inescapable conclusion is that these residents' needs were simply ignored by Petitioner and its staff. Moreover, in revoking explicit physicians' orders that residents receive tracheal suctioning, Petitioner's medical director, Dr. McCann, went beyond ignoring these residents' needs, he actively countermanded treatment that had been ordered for the residents without offering a coherent explanation for doing so.

In addressing the issue of noncompliance Petitioner attempts to reduce this case to a contest between Dr. McCann and Deann Mankell, R.N., the surveyor who was responsible for reviewing Petitioner's records and making on-site observations relevant to the finding of noncompliance with the requirements of 42 C.F.R. § 483.25(k). Petitioner asserts that Dr. McCann's qualifications as a physician, and his personal knowledge of the residents whose care is at issue, trump Ms. Mankell's findings and observations. Essentially, Petitioner contends that any opinion that Ms. Mankell might have about the inadequacy of care that Petitioner gave to its residents with tracheostomies is overwhelmed by Dr. McCann's allegedly far more authoritative opinion.

But, this case is not a case that depends on the conclusions of dueling medical professionals. There is a regulatory requirement stated in 42 C.F.R. § 483.25(k) that residents of skilled nursing facilities who have tracheostomies receive necessary care to address any problems that they might encounter. All three of these residents were diagnosed as having tracheostomies that were susceptible to occlusion, and, in fact, two of them had repeated problems that were at least in part related to occluded tracheostomies. Under those circumstances, Petitioner had an absolute duty to these residents to provide tracheostomy care including suctioning as was necessary. And, Petitioner's medical director and professional staff had a duty to explain and to justify any decision on their part not to suction residents with tracheostomies.

Suctioning was presumptively necessary in the case of all three residents because each of them came to the facility with a physician's order that he or she receive suctioning, either according to a schedule or as needed. Certainly, it is possible that, after careful assessment and review of a resident's condition, Dr. McCann and Petitioner's staff could decide that in an individual case suctioning was not needed, even if another physician thought that suctioning was needed. But, there is no evidence here that Dr. McCann or Petitioner's professional staff did *any* – much less careful – assessment of these resident's conditions. The clinical records for these residents are devoid of such assessments. The residents have no care plans addressing their tracheostomies. There is no commentary concerning the problems that these residents were or might be encountering. And, Dr. McCann provided no clinical analysis whatsoever for his orders countermanding other physicians' orders that the residents be suctioned.

Dr. McCann's only contemporary explanation for countermanding orders that residents be suctioned was that, "unfortunately," Petitioner's professional staff was not allowed to perform suctioning due to some inchoate facility policy. CMS Ex. 84 at 40. That is hardly a justification for countermanding orders issued by physicians outside of the facility based on the clinical conditions of the residents in question.

Now, Dr. McCann contends that he erred in concluding that suctioning was prohibited by facility policy. P. Ex. 1 at 3-4. He contends that he erred as a consequence of receiving incorrect information from Petitioner's former director of nursing. *Id.* But, Dr. McCann has been Petitioner's medical director for about 29 years. Tr. at 6-7 (Sept. 27, 2011). Dr. McCann is personally responsible in his role of medical director for implementation of resident care policies and the coordination of medical care for residents of the facility. 42 C.F.R. § 483.75(i). Dr. McCann also is personally responsible in his capacity as medical director for assuring that each resident receives the medical care that he or she needs. Moreover, he served as the treating physician for Residents B, C, and D. In that capacity, he also bore personal responsibility for assuring that these residents received needed care.

Given that, I cannot comprehend why Dr. McCann simply would accept the statement of a nurse on Petitioner's staff that there was a facility policy barring suctioning of residents. He was certainly derelict in performing his duties to these residents if he simply accepted that statement and, based on his acceptance, countermanded orders that these residents be suctioned.

More likely, however, there *was* a facility policy not to suction residents. That is the inference that I draw. The existence of such a policy plausibly explains why: none of the residents received suctioning, despite orders that they be suctioned; Dr. McCann countermanded orders for suctioning from physicians from outside the facility almost as soon as residents were admitted; and no analysis, assessment, or care planning was done by Dr. McCann or Petitioner's professional staff concerning whether these residents needed suctioning. Above all, the existence of a policy barring suctioning explains why at least one Resident, Resident B, was not suctioned despite experiencing multiple incidences of congestion requiring hospital care, and despite receiving multiple physicians' orders that he be suctioned while at Petitioner's facility. [2]

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[2] My conclusion that Petitioner's policy was not to suction its residents also finds support in the comments of clinicians who dealt with Petitioner. A hospital treatment note made during Resident B's hospital stay in the first week of October, during which suctioning was performed at the hospital, reads:

> He has had a tracheostomy for cancer of larynx in the past; occasionally needed suctioning *which the nursing home is not able to provide*.

CMS Ex. 84 at 14 (emphasis added).

In fact, Petitioner was derelict whether or not there was a policy not to suction residents. Petitioner owed a duty of care to each resident with a tracheostomy to assure that the resident received necessary care. Failure to provide such care to Residents B, C, and D, either as a consequence of facility policy, or as a consequence of neglect, is a regulatory violation.

Dr. McCann also testified that none of the residents whose care is at issue actually needed suctioning. For example, Dr. McCann asserts that Resident B would not have benefited from suctioning. P. Ex. 1 at 2-3. His thesis is that the conditions that the resident suffered from were not ameliorated by suctioning. *Id.* He asserts also that Petitioner's then-director of nursing "deemed it unsafe – in her professional judgment – to continue suctioning given . . . [Resident B's] numerous complex diagnoses." *Id.* But, Dr. McCann does not point to even one contemporaneous clinical assessment that would arguably support these assertions. He references no assessments, no physicians' orders, no plans of care. He does not cite any written assessment by the former director of nursing addressing the costs and benefits of suctioning Resident B. Nor does he point to any record of communications between himself and the former director of nursing. So, Dr. McCann's testimony consists entirely of *post hoc* rationalizations and naked assertions that are unsupported by clinical evidence. I find it to be not credible and obviously self-serving.

I also find it to be not credible because it is belied by clinical evidence that *does* exist. Resident B was treated at the hospital several times during his stay at Petitioner's facility. The treatments that Resident B received while at the hospital included suctioning. CMS Ex. 84 at 5. There is, thus, credible clinical evidence that the resident not only needed suctioning but that he benefited from it. And, consistent with that evidence are the several orders from hospital-based physicians that the resident be suctioned after his discharge from the hospital.

2. CMS's determination of immediate jeopardy level noncompliance is not clearly erroneous.

The term "immediate jeopardy" is defined to mean noncompliance that is so grave as to cause, or to be likely to cause, serious injury, harm, impairment, or death to a resident. 42 C.F.R. § 488.301. Where there is noncompliance and a determination of immediate jeopardy, the facility has the burden of proving that determination to be clearly erroneous.

Here, there is overwhelming evidence to support CMS's determination that Petitioner's noncompliance with the requirements of 42 C.F.R. § 483.25(k) was so egregious as to constitute immediate jeopardy for Petitioner's residents. And, even if that were not so, Petitioner plainly did not prove CMS's determination of immediate jeopardy to be clearly erroneous.

Residents B, C, and D are individuals who were found by physicians who are independent of Petitioner's facility to need suctioning of their tracheostomies. Yet, none of these residents had care plans that provided interventions for protecting them from problems that might arise respecting their tracheostomies, or for treating any problems that did arise. On numerous occasions, the orders for suctioning of these residents were countermanded without any coherent explanation for doing so. As a consequence, these residents were at risk for developing obstructions to their tracheostomies and for compromised breathing. CMS Ex. 96 at 5. The likelihood of harm to these residents from such complications and from lack of tracheostomy care was substantial. Indeed, that is why regulations *explicitly require* a facility to provide tracheostomy care to any resident who has a tracheostomy. 42 C.F.R. § 483.25(k).

Moreover, the evidence supports a conclusion that at least one Resident, Resident B, was seriously harmed by Petitioner's failure to provide prophylactic care and treatment of his tracheostomy. Resident B was sent to the hospital to address respiratory issues four times during his brief stay at Petitioner's facility. On one occasion, hospital staff found it necessary to suction the resident, performing the precise treatment that Petitioner refused to perform. CMS Ex. 84 at 5.

Petitioner argues that the determination of immediate jeopardy ignores several critical facts that mitigate in favor of a finding that the determination is clearly erroneous. First, Petitioner argues that Resident B had frequently gone on leave from the facility without receiving humidified oxygen while off-premises. It contends that the respiratory problems that the resident experienced in October and November 2010 were not the consequence of deficient care by Petitioner but, rather, were caused by the resident's frequent off-premises trips and his lack of access to humidified oxygen. Petitioner's Post-Hearing Brief at 5-6.

That argument is no defense. While it is certainly possible that the resident's respiratory problems were exacerbated by his off-premises trips, that does not relieve Petitioner of its responsibility to provide care for him. Petitioner's obligation to provide tracheostomy care to the resident is undiminished by the possibility that the resident's off-premises trips were making his problems worse. The failure by Petitioner's staff to suction the resident meant that the adverse consequences of the resident's trips, including increased congestion, occlusion, and breathing difficulties, were not addressed. The likelihood of harm, therefore, was exacerbated not only by the resident's stays away from the premises but Petitioner's failure to address the consequences of those stays.

Petitioner also asserts that Resident B suffered from other conditions – such as gastric reflux disease – that could have caused the resident to suffer from increased secretions and resulting problems associated with his tracheostomy. Assuming that to be true, I can identify no basis for this argument to refute CMS's determination of immediate jeopardy. Petitioner's obligations to provide appropriate tracheostomy care to the resident were

only heightened by the resident's medical conditions that put him at risk for tracheostomy-associated complications. The failure of Petitioner to provide tracheostomy care to Resident B in the face of complicating conditions does not mitigate against a finding of immediate jeopardy; rather, it supports such a finding.

Petitioner next argues that Dr. McCann's testimony stands unimpeached, in light of the failure of CMS's counsel to cross examine him extensively. Petitioner's Post-Hearing Brief at 7-9. I disagree. I have explained at Finding 1 why I find Dr. McCann's testimony to be self-serving and not credible.

Petitioner also attempts to rebut a survey finding that Petitioner had failed to provide Resident D with access to suctioning equipment. I find it unnecessary to address this issue. As I have stated, evidence showing immediate jeopardy level noncompliance is very strong. Whether or not Resident D had access to suctioning equipment would not change my finding as to the issue of immediate jeopardy.

Next, Petitioner attempts to attack the surveyor who conducted the December Survey for relying too heavily on documents and facility records. It contends that the survey results were flawed fatally because the surveyor did not attempt to interview or observe Resident B. According to Petitioner, the surveyor relied too heavily "on hearsay evidence – Resident B's records – without observing the resident's physical condition." Petitioner's Post-Hearing Brief at 10-11.

I find this argument to be without merit. The clinical records relied on by the surveyor and offered by CMS as evidence are more than sufficient proof, both of noncompliance by Petitioner and of the likelihood of serious harm or worse that was caused by that noncompliance. I have discussed that evidence in detail in this decision; it is more than enough to shift the burden to Petitioner to rebut it with affirmative proof of its own. For the reasons I have discussed, Petitioner failed to rebut that evidence. Furthermore, the records that CMS offered were not, Petitioner's contention notwithstanding, mere "hearsay," they were records generated by Petitioner's own staff of the care that they provided (or failed to provide) to its residents, including Resident B. Petitioner had it within its power to explain those records, if there was any explanation for them other than the one that CMS advocated. It failed to do so.

Finally, Petitioner has offered nothing to show that observation of Resident B would have changed the outcome of this case in the slightest.

3. CMS's remedy determinations are reasonable.

The remedies that CMS determined to impose consist of civil money penalties and other remedies that are authorized for noncompliance with participation requirements. The non-monetary remedies that CMS determined to impose include directed in-service

training of staff, denial of payment for new Medicare admissions, and loss of authority to conduct NATCEP. Petitioner has challenged none of these non-monetary remedies. Consequently, I find no need to address them here, except to find that Petitioner's noncompliance with the requirements at 42 C.F.R. § 483.25 at the immediate jeopardy level beginning on November 4, 2010 and continuing through December 13, 2010, its non-immediate jeopardy level noncompliance with that regulation from December 14, 2010 through January 6, 2011, and its non-immediate jeopardy level noncompliance with other regulations beginning prior to November 4, 2010 and running through January 6, 2011 are grounds to sustain all of the non-monetary remedies that CMS imposed.

There is also ample basis to sustain the amount and duration of the civil money penalties.

a. Civil money penalties of $3,550 for each day of the November 4 through December 13, 2010 period are reasonable.

Daily civil money penalties to remedy immediate jeopardy level noncompliance must fall within a range of from $3,000 to $10,000 per day. 42 C.F.R. § 488.438(a)(1)(i). Any decision as to where within that range a penalty amount ought to fall depends on evidence that relates to regulatory factors that are specified at 42 C.F.R. §§ 488.438(f)(1) – (4) and 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)). These factors may include: the seriousness of a facility's noncompliance; its compliance history; its culpability; and its financial condition.

The immediate jeopardy level civil money penalties of $3,550 per day that CMS determined to impose are reasonable. The penalty amount lies close to the bottom of the immediate jeopardy level civil money penalty range. That penalty amount is amply justified by the seriousness of Petitioner's noncompliance and also by its culpability. As I have discussed, there was dereliction by Petitioner of its duty to provide tracheostomy care to Residents B, C, and D, thereby creating a likelihood of serious harm for these residents. That dereliction was either a consequence of Petitioner's policy not to provide such care or a consequence of Petitioner's staff's indifference to the needs of the residents. In either case, Petitioner's culpability for its noncompliance was high.

Petitioner has not challenged the duration of its immediate jeopardy level noncompliance by offering proof that it abated that noncompliance on a date that is earlier than December 13, 2010. Rather, it contends that CMS's determination of duration of immediate jeopardy is "arbitrary" and "capricious." Petitioner's Post-Hearing Brief at 14-15. To support this contention, Petitioner argues that there was no direct surveyor observation of Petitioner's facility during the 40-day period that CMS determined immediate jeopardy to persist.

This argument is incorrect as a matter of law because it improperly attempts to shift the burden of proof of correction of noncompliance from Petitioner to CMS. The burden is

not on CMS to prove that immediate jeopardy was ongoing during this 40-day period. Rather, the burden lies entirely on Petitioner to prove that it abated its immediate jeopardy level noncompliance at an earlier date than that which was determined by CMS.

Petitioner failed to offer any evidence proving that it abated immediate jeopardy prior to December 13. It did not, for example, offer evidence showing that it had reformed its care procedures for residents with tracheostomies during this period.

Petitioner argues that the civil money penalties are unreasonable because it has no history of repeated deficiencies relating to tracheostomy care. That may be so, but, as I have discussed, the seriousness of Petitioner's noncompliance and its culpability, coupled with the fact that the penalties are at the low end of the immediate jeopardy range, is sufficient basis to sustain the penalties that CMS determined to impose. Petitioner argues also that imposing civil money penalties of $3,550 per day against it for a 40 day period would have a severe financial impact on it. Petitioner has offered no evidence to substantiate this claim.

Petitioner also asserts that the immediate jeopardy level penalties are unreasonable because, at an informal dispute resolution proceeding, the penalties were cut to one-half of that which were originally determined to be imposed. That may be so, but it is no basis for me to infer that the penalties of $3,550 per day are unreasonable.

Finally, Petitioner contends that CMS uses an "arbitrary, capricious, and unreasonable double standard" in calculating civil money penalties. Petitioner's Post-Hearing Brief at 14-16. Petitioner argues, essentially, that the penalties imposed against it are disproportionately high when compared with penalties imposed against other, similarly situated, facilities.

Nothing in the regulations governing civil money penalties suggests that a comparative standard may or ought to be used in deciding civil money penalty amounts. Each case is to be judged on its own merits, and my decision is made de novo, without regard to what CMS may have determined to do in other cases. I have explained already why the civil money penalty amount at issue here is reasonable based on the merits of *this case,* and it is unnecessary for me to readdress those factors.

Moreover, Petitioner's argument that the immediate jeopardy level penalties are unreasonably high is premised, in large measure, on the fact that in some other cases the *total amount* of civil money penalties (daily amount multiplied by the days of noncompliance) was arguably lower than the total amount of penalties that are at issue here. But, I may not reduce a daily penalty amount in consideration of the number of days of a facility's noncompliance. The regulations simply do not permit such adjustments.

b. Civil money penalties of $100 per day for each day of the December 14, 2010 – January 6, 2011 period, are reasonable.

Civil money penalties for non-immediate jeopardy level deficiencies must fall within a range of from $50 to $3,000 per day. 42 C.F.R. § 488.438(a)(1)(ii). A decision of where within that range a penalty amount should fall is based on the same regulatory criteria as are used for deciding daily penalty amounts of immediate jeopardy level civil money penalties.

The penalties of $100 per day that CMS imposed for each day of the December 14, 2010 – January 6, 2011 period are minimal, coming close to the bottom of the non-immediate jeopardy range and consisting of only three percent of the maximum allowable daily amount for non-immediate jeopardy level penalties. Petitioner has not offered evidence or argument to challenge these penalties, and I find them to be reasonable.

/s/
Steven T. Kessel
Administrative Law Judge