Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Cogburn Nursing Center – Huntsville (CCN: 01-5440),	)	Date: June 3, 2008
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-07-375
	)	Decision No. CR1798
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

I sustain the determinations by the Centers for Medicare & Medicaid Services (CMS) that Petitioner, Cogburn Health & Rehabilitation – Huntsville failed to comply substantially with Medicare participation requirements. However, I find to be clearly erroneous CMS's determination that Petitioner manifested immediate jeopardy level deficiencies after January 29, 2007. In light of this conclusion I impose the following remedies against Petitioner:

- Civil money penalties of $200 per day for each day of a period that began on January 17, 2007 and which continued through January 28, 2007;

- A civil money penalty of $4000 for one day, January 29, 2007; and

- Civil money penalties of $200 per day for each day of a period that began on January 30, 2007 and which continued through March 1, 2007.

Additionally, I sustain CMS's determination to deny Petitioner payment for new admissions during the period which ran from February 25, 2007 through March 1, 2007.

I. Background

Petitioner is a skilled nursing facility in Huntsville, Alabama. It participates in the Medicare program. Its participation in Medicare 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. Additionally, its right to a hearing in this case is governed by regulations at 42 C.F.R. Part 498.

Petitioner was surveyed for compliance with Medicare participation requirements on January 17, 2007 (January survey) and on February 16, 2007 (February survey). The findings made at the January survey included findings that Petitioner failed to comply substantially with several Medicare participation requirements. None of the findings made at the January survey were of noncompliance so egregious as to qualify as immediate jeopardy level deficiencies. The term "immediate jeopardy" is defined in regulations to mean a situation in which a facility's noncompliance with one or more participation requirements has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. 42 C.F.R. § 488.3.

At the February survey Petitioner was found to be noncompliant with three additional participation requirements and its asserted noncompliance with all three of these requirements allegedly caused immediate jeopardy to Petitioner's residents. CMS concurred with the January and February survey findings and determined to impose remedies consisting of the following:

- Civil money penalties of $200 per day for each day of a period running from January 17 through January 28, 2007;

- Civil money penalties of $4000 per day for each day of a period running from January 29 through March 1, 2007; and

- Denial of payment for new Medicare admissions for each day of a period running from February 25 through March 1, 2007.

See P. Exs. 2, 5, 7.

Petitioner requested a hearing and the case was assigned to me for a hearing and a decision. The parties filed pre-hearing exchanges consisting of their proposed exhibits, the written direct testimony of proposed witnesses, and pre-hearing briefs. Based on the parties' submissions I scheduled this case for an in-person hearing. Petitioner then moved for summary disposition and CMS opposed the motion. I discussed the motion with the

parties at a pre-hearing conference at which the parties agreed that the case could be decided without an in-person hearing and based on their written submissions. I allowed each party to file an additional brief. Order Cancelling In-Person Hearing and Establishing Briefing Schedule (Feb. 14, 2008).

CMS filed a total of 68 exhibits which it designated as CMS Ex. 1 - CMS Ex. 68. Petitioner filed 51 exhibits (including five supplemental exhibits) which it designated as P. Ex. 1 - P. Ex. 51. I receive all of these exhibits into the record of this case.

II. Issues, findings of fact and conclusions of law

A. Issues

The report of the January survey alleges that Petitioner manifested a total of six deficiencies. CMS Ex. 3. Petitioner has not filed any arguments concerning them, either in its pre-hearing brief, its motion for summary judgment, or in its final brief. I conclude Petitioner is not contesting these deficiencies and the remedies imposed by CMS – civil money penalties of $200 per day – and that CMS's determination concerning the January survey is now administratively final. For that reason I do not discuss the January survey findings in this decision.

What remains at issue are the findings of noncompliance that were made at the February survey. Specifically, the issues arising from this survey are whether:

1. As of the February survey Petitioner failed to comply substantially with Medicare participation requirements;

2. Assuming Petitioner's noncompliance as of the February survey, CMS's determination of immediate jeopardy was clearly erroneous;

3. CMS's determination as to duration of immediate jeopardy was clearly erroneous; and

4. CMS's remedy determinations based on the February survey are reasonable.

B. Findings of fact and conclusions of law

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

1. Petitioner failed to comply substantially with Medicare participation requirements as of the February survey.

The allegations of noncompliance in the February survey report relate entirely to the care that Petitioner gave to two of its residents who are identified in the survey report as Residents #s 1 and 2. Resident # 1 became a resident at Petitioner's facility in September 2004. Prior to her admission the resident had suffered a stroke which left her severely limited. She had other medical problems including advanced cardiovascular disease and impaired cognitive skills. The resident required extensive assistance for bed mobility and eating and was dependent on Petitioner's staff for transfers, locomotion, dressing, personal hygiene, and bathing. P. Ex. 44, at 1. In the months prior to late January 2007 the resident declined, losing weight and becoming bedridden. *Id.* at 2. She was difficult to keep clean due to incontinence and was having problems with sustaining nutrition and hydration.

The resident sustained two accidents prior to the February survey. On December 8, 2006 the resident rolled out of her bed, falling to the floor and sustained minor injuries. CMS Ex. 43, at 12. On January 28, 2007, she fell from a shower bed, a device that enabled Petitioner's staff to transfer a bedridden resident such as Resident # 1 from her bed into the facility's shower area, while a nursing assistant attempted to bathe her. CMS Ex. 43, at 1; *see* P. Ex. 45, at 12. The resident sustained a laceration to her forehead and a fractured neck and she died from her injuries two days later.

Resident # 2 was admitted to Petitioner's facility on October 24, 2002. The resident was of Chinese origin and apparently spoke little or no English. Petitioner's staff assessed the resident as being at risk for wandering. P Ex. 44, at 2; P. Ex. 9. The staff implemented a variety of protective measures designed to prevent the resident from escaping Petitioner's premises including the use of a Wanderguard bracelet. Resident # 2 exited Petitioner's facility on two occasions, the first occurring on September 21, 2006, and the second occurring on January 11, 2007. P. Ex. 17, at 1; P. Ex. 19, at 1. On each occasion her Wanderguard triggered an electronic alarm system and Petitioner's staff promptly retrieved the resident and returned her to the facility.

CMS argues that, in providing care to these residents, Petitioner failed to comply with the following participation requirements:

- 42 C.F.R. § 483.20(k)(3)(ii), which requires that a facility provide services to each of its residents in accord with that resident's written plan of care;

• 42 C.F.R. § 483.25(h)(2), which requires a facility ensure that each of its residents receives adequate supervision and assistance devices to prevent accidents; and

• 42 C.F.R. § 483.75 which requires a facility to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each of its residents.

The preponderance of the evidence in this case supports a finding that Petitioner failed to comply substantially with the requirements of 42 C.F.R. §§ 483.20(k)(3)(ii), 483.25(h)(2), and 483.75 in providing care to Resident # 1. The evidence does not support a finding that Petitioner failed to comply substantially with the requirements of these regulations in providing care to Resident # 2.

a. Petitioner was deficient in providing care to Resident # 1.

The evidence in this case proves that Petitioner failed to plan for the needs of Resident # 1 and to implement necessary precautions to protect that resident from sustaining a fall. Petitioner's staff knew that this resident was essentially helpless but it knew also that the resident was vulnerable to rolling over while in bed and falling. However, despite this knowledge the staff failed to take the extra precautions needed to assure the resident's safety. Petitioner's staff assigned insufficient personnel to assist in bathing the resident, given her mental and physical state and her proclivity for rolling over while in bed, and the consequence was that the resident sustained a foreseeable fall.

Petitioner's staff knew about the resident's proclivities and vulnerabilities because on December 8, 2006 the resident rolled out of her bed onto the floor and sustained injuries from the fall. CMS Ex. 43, at 12, 14; CMS Ex. 41, at 3. That accident occurred because Petitioner's staff failed to assure that the side rails on the resident's bed were properly positioned. The accident put the staff on notice that the resident, incapacitated and cognitively impaired as she was, was capable of falling if not adequately protected. And, once put on notice, the staff had the obligation to thoroughly consider all of the ramifications of the fall, to plan the resident's care accordingly, and to implement whatever was planned.

However, there is no evidence of record showing that Petitioner's staff considered or planned for taking additional precautions or protective actions for Resident # 1 after she sustained her December 8, 2008 fall. CMS alleges that Petitioner's care plan failed to address the issue and, in particular, was silent as to special precautions that needed to be taken when bathing the resident. Petitioner does not dispute CMS's assertions about the resident's care plan. It argues that bathing of Resident # 1 was covered by a general

facility policy dealing with bathing of residents. P. Ex. 23. Therefore, according to Petitioner, re-stating this policy or writing down additional instructions in the resident's care plan was not necessary.

I disagree with Petitioner's contention that its policy statement substituted for the particularized planning called for by Resident # 1's unique problems. Petitioner's policy contains no language describing special precautions that needed to be taken in dealing with a resident in the condition manifested by Resident # 1. P. Ex. 23. More importantly it contained nothing in the way of a particularized assessment of the resident's problems nor did it mandate precautions that were unique to the resident's problems. Id.

Implicit in 42 C.F.R. § 483.20(k)(ii) is a requirement that each resident's care plan provide an assessment and interventions that are unique to that resident's individual needs and problems. Adopting a generic policy concerning bathing and showering of residents which did not mandate special precautions for a resident as debilitated as was Resident # 1 hardly addressed that resident's individual needs.

Furthermore, the evidence shows that Petitioner's staff failed adequately to supervise the resident in order to prevent a foreseeable accident as is required by 42 C.F.R. § 483.25(h)(2). The staff knew that the resident could roll out of bed if not closely supervised or otherwise protected. Thus, staff knew or should have known that showering the resident in a shower bed would pose unacceptable risks unless the resident was observed and protected at all times during the procedure of transferring her and showering her. The necessary observation and protection could not be accomplished when the resident was being bathed by only a single staff member because – as is conceded by Petitioner – the staff member would be obligated to turn away from the resident if only momentarily to attach or retrieve necessary equipment. Having the resident bathed by a single staff member simply was inadequate protection given what the staff knew.

Petitioner argues that the staff member who bathed the resident on January 28, 2007 had lengthy prior experience bathing her and was confident that she could take care of the resident's needs. But, if the staff member had such confidence it was false confidence. Whatever procedure had been determined to be safe in the past should have been reconsidered and adjusted in light of the resident's December 8, 2006 fall from her bed. That incident should have put the staff on notice that only one person could not bathe the resident safely.

I also sustain CMS's allegation that Petitioner's failures adequately to plan to address the needs of and to protect Resident # 1 comprised a failure by Petitioner's management to effectively administer the facility in contravention of the requirements of 42 C.F.R. § 483.75. Ultimately, it is the responsibility of a facility's management to assure that its staff execute their obligations under the regulations. That responsibility was particularly important in the case of Resident # 1 because, as Petitioner acknowledges, the shower bed that was involved in the resident's fall and fatal injury was a new piece of equipment that Petitioner purchased in December 2006. P. Ex. 45, at 4. That fact alone should have put management on notice that there was a need to investigate intensively all risks that might be related to using it in the case of a resident prone to rolling over and falling. Moreover, management should have focused on assuring that the facility's staff was trained in addressing any risks that were identified. But, there is no evidence in this case that management either identified the risks or trained the facility's staff prior to the January 28, 2007 fall sustained by Resident # 1.

b. Petitioner was not deficient in providing care to Resident # 2.

Although the evidence amply supports my conclusion that Petitioner's staff was remiss in providing care to Resident # 1 it does not support a similar conclusion as respects the care that the staff gave to Resident # 2. Indeed, the evidence supports the opposite conclusion. In caring for Resident # 2 Petitioner's staff anticipated and planned for the resident's needs and, based on its assessment of the resident, protected her effectively.

The preponderance of the evidence establishes that Petitioner's staff were well aware of Resident # 2's proclivities to wander and planned to address those proclivities. It shows also that, on two occasions when the resident attempted to elope, protective measures worked effectively and the staff promptly and safely retrieved the resident.

The resident's care plan shows that Petitioner's staff was aware of, and took measures to deal with, the resident's propensity to wander. P. Ex. 9. The plan, which is dated June 14, 2006, but which was modified on several occasions subsequently, established as goals that the resident's whereabouts would be known by staff at all times and that the resident would not leave Petitioner's facility unaccompanied without the knowledge of Petitioner's staff. *Id.* at 1. Interventions that were implemented to achieve these goals included, among other things: placement of a Wanderguard bracelet on the resident at all times; checking the operation of the Wanderguard every shift; redirecting the resident when she attempted to leave the facility; photographing the resident and placing her photograph in the front of her chart; monitoring the resident for packing clothing or belongings; listening for cues that the resident may attempt to leave Petitioner's facility; and engaging the resident in diversionary activities. *Id.* at 1-2; P. Ex. 44, at 3.

Petitioner's staff engaged in additional interventions that were designed to minimize the risk that Resident # 2 would elope. The resident was often kept at Petitioner's nurse's station so that staff could keep an eye on her. P. Ex. 45, at 9. The resident was moved to the room closest to the nursing station so that she might be supervised more closely. *Id.* The staff encouraged family visits. *Id.* at 10.

On the two occasions when the resident attempted to elope from Petitioner's facility the staff retrieved the resident promptly without the resident being placed at risk. On September 21, 2006 one of Petitioner's staff responded to an alarm that was triggered by the resident's Wanderguard when the resident exited Petitioner's facility. The resident was observed standing 15 feet from the facility and was retrieved and brought back inside. P. Ex. 45, at 7. Petitioner in-serviced its staff after this incident to make sure that they were instructed as to how to respond appropriately to door alarms. P. Ex. 18. On January 11, 2007 a staff member responded to an alarm and observed Resident # 2 outside of Petitioner's facility, 28 feet from the door. P. Ex. 45, at 7. Again, the resident was retrieved and brought back inside. On January 12, 2007, after the second elopement attempt, Petitioner again in-serviced its staff. *Id.*

The evidence supports the conclusion that Petitioner complied with the requirements of 42 C.F.R. §§ 483.20(k)(ii) and 483.25(h)(2) in providing care to Resident # 2 because it shows that, in providing care to this resident, Petitioner's staff did precisely what the regulations require of it. The staff appropriately assessed the resident for her wandering behavior, planned interventions to deal with it, and implemented those interventions. And, the interventions worked to prevent the resident from eloping Petitioner's premises.

The facts of this case – insofar as they concern Petitioner's care of Resident # 2 – are quite similar to those in *Willow Creek Nursing Center*, DAB No. 2040 (2006). I find the rationale of *Willow Creek* to be persuasive and it clearly applies to the facts of this case. In that case, a resident who, like Resident # 2 was prone to wandering, exited a facility on more than one occasion (four times). On each occasion the facility's alarm system alerted staff to the attempted elopement and on each occasion the resident was retrieved promptly, having progressed no more than several feet from the facility's door. In *Willow Creek* the facility was found to have taken all reasonable efforts to prevent the resident from eloping. Those efforts were essentially identical to those that were employed by Petitioner's staff in providing care to Resident # 2.

All cases involving elopement risks are fact-intensive and, consequently, what might be acceptable in one case would not be in another context. However, CMS has not addressed in any depth the specific facts of this case. CMS's arguments concerning the care that Petitioner's staff gave to Resident # 2 seem to reduce to an assumption that a

facility, even one such as this which is determined to safeguard its residents from wandering, becomes liable if a resident so much as sets foot outside of the facility's doors. The *Willow Creek* decision makes it clear, and I agree, that such an argument is overly simplistic.

A facility whose doors open onto an urban street or a busy highway might be under an obligation to assure that a wandering resident not be exposed to the hazards caused by that environment. In that case, exiting the facility, even for a few seconds, might pose an unacceptable hazard to a resident. But, no such evidence of environmental hazards immediately adjacent to Petitioner's doors exists here. CMS has offered no proof that such hazards were present in this case. Indeed, the evidence suggests otherwise, that there is a relatively secluded area directly in front of Petitioner's premises that is not exposed to the types of risks that would mandate a facility to be, literally, exit-proof. Consequently, the fact that Resident # 2, on two occasions, was able to walk a few feet from Petitioner's facility before being apprehended shortly after leaving the facility and returned indoors is not, in and of itself, sufficient for finding Petitioner noncompliant.

In deciding whether Petitioner was deficient I have looked closely at the timeliness of Petitioner's response to the resident's two elopement attempts. In *Willow Creek* the facility staff responded immediately to the resident's elopement attempts. In this case there is no question that there was at least a short delay on each elopement attempt between the moment when the facility's alarm first sounded and the staff's retrieval of the resident. But, the record is inconclusive as to precisely how long the resident was outside of Petitioner's facility during each attempt and I am not persuaded that it shows a substantial delay in retrieving the resident.

The only evidence respecting the length of time that the resident was outside of Petitioner's facility during the September 21, 2006 attempt appears to be a statement from one of Petitioner's staff that the alarm sounded for about five minutes before she personally retrieved the resident. CMS Ex. 54, at 16. Five minutes is a substantial period of time and, if the resident were indeed out of the facility for that long she would be at risk for harm even if she did not wander far. However, the statement is not precise and it is entirely unclear from the record whether the staff member actually recorded the length of time that the alarm sounded or merely gave an off-the-cuff estimate.

There is no credible evidence as to how long the resident was outside of the facility on January 11, 2007 before the staff retrieved her. Statements concerning this elopement attempt either give no estimate of the amount of time when the resident was outside or say only that it was "minutes" before the alarm was responded to. CMS Ex. 54, at 2, 10, 17.

I am not prepared to conclude that there were significant delays in retrieving Resident # 2 in the absence of convincing evidence establishing the length of time that the resident was outside of Petitioner's facility on the two occasions when she attempted to elope. The evidence which specifically addresses this issue is, as I state, imprecise and not persuasive. I find it more likely that on neither occasion was the resident outside of the premises for very long, based on the fact that on each occasion the resident had wandered only a few feet before she was retrieved.

I note, moreover, that CMS did not determine that Petitioner's residents were at jeopardy at any date *prior to* January 28, 2007, the date of Resident # 1's fatal fall. It is indeed unclear how – or if at all – CMS factored in the two elopement attempts by Resident # 2 in arriving at its immediate jeopardy determination. It is clear, however, that between January 11 and January 28, 2007, Petitioner took substantial steps to assure that its staff was trained properly in responding to alarms. On January 12, 2007 Petitioner in-serviced its staff in order to make certain that alarms would be responded to promptly and efficiently. There is nothing in the record to suggest that Petitioner's staff was inadequately trained in responding to alarms after that date. Thus, I would find no jeopardy emanating from the care Petitioner gave to Resident # 2, as opposed to Resident # 1, beginning on January 28, 2007 even if I were to find Petitioner's care of Resident # 2 to be deficient as of January 11.

I find CMS's allegations that Petitioner failed to comply with the requirements of 42 C.F.R. § 483.75 in providing care to Resident # 2 to be without merit. As I have discussed, Petitioner's staff acted appropriately in planning for the resident's needs and protecting the resident against foreseeable hazards. The evidence does not support a finding that Petitioner's management failed to direct the staff appropriately in its care of the resident.

2. CMS's determination that Petitioner's deficient care of Resident # 1 was at the immediate jeopardy level of noncompliance was not clearly erroneous.

There is ample and persuasive evidence that Petitioner's deficient care of Resident # 1 was at the immediate jeopardy level of noncompliance. The staff's failure to anticipate that the resident would be at risk for rolling out of a shower bed while being bathed and its failure to implement necessary precautions caused that resident to sustain an injury that resulted in her death. Management's failure to anticipate and to deal with the risks resulting from using the shower bed with a resident as incapacitated as was Resident # 1 plainly put the resident – and, potentially, any other resident similarly situated – in a state of immediate jeopardy.

3. CMS's determination that immediate jeopardy continued after January 28, 2007 is clearly erroneous.

However, although immediate jeopardy plainly existed as of January 28, 2007 that ended when Petitioner's management and staff took effective measures to eliminate it. The overwhelming evidence is that Petitioner implemented such measures on January 29, 2007. I find CMS's determination that immediate jeopardy persisted after January 28 to be clearly erroneous given the measures that Petitioner's staff took.

The evidence establishes that, effective January 29, 2007, Petitioner implemented a policy requiring two staff members to be present at all times during transfer, transportation, and bathing of residents. P. Ex. 22, at 4-6; P. Ex. 45; at 3. The effect of this policy was that a staff member could observe and, if necessary support, a resident at all times. On January 29, 2007 Petitioner in-serviced its staff regarding this new policy. P. Ex. 22, at 4-6; P. Ex. 45, at 3. Petitioner also immediately removed from service the shower bed that was involved in the accident sustained by Resident # 1 and it never used it again. P. Ex. 45, at 4. It ordered a new shower bed to replace the one taken out of service but, also, immediately suspended the use of shower beds for bathing residents. Finally, Petitioner limited the shifts on which showers were given to residents.

These measures, although simple and rather obvious, went to the heart of the immediate jeopardy caused by Petitioner's noncompliance. The probability of harm or worse to Petitioner's residents exposed by Petitioner's care of Resident # 1 was that residents were not being supervised and assisted adequately while being bathed. That risk was eliminated by Petitioner when it assigned two of its staff to assist residents at all times during the bathing process. Indeed, CMS notes that assigning two staff members to assist residents while being bathed was a "reasonable" approach to dealing with risks such as those encountered by Resident # 1. CMS's brief in lieu of hearing at 12.

CMS argues that immediate jeopardy was not abated immediately because Petitioner did not review and revise the care plans of residents who needed assistance with bathing until the end of February 2007. CMS's brief in lieu of hearing at 25. According to CMS:

> Immediate jeopardy could only be removed by facility-wide re-training as to the use/purpose of care plans, updating the care plans of affected residents with the two-person bathing policy, and staff training in the proper technique for bathing facility residents who required the use of a shower bed.

Id. I find this assertion to be unpersuasive because, in fact, Petitioner took effective steps immediately after the accident on January 28 to assure that all of its vulnerable residents – those needing assistance with bathing – were protected. The critical action taken by

Petitioner, the action that CMS has identified as "reasonable", was to assure that *all* of these residents were bathed by two staff members. Also Petitioner removed from service the shower bed that was implicated in the January 28 accident. Updating residents' care plans certainly was necessary to attain *full* compliance with participation requirements. But, elimination of immediate jeopardy was accomplished by taking the simple step of assuring that all residents needing assistance received adequate assistance and supervision when they were bathed.

The purpose of updating residents' care plans was to assure that each resident received the individualized care that he or she was entitled to and to assure that all foreseeable risks to that resident were identified and planned for. As I have discussed every resident in a facility is entitled to such individualized assessment and planning and a facility is deficient if it fails to provide that to each of its residents. But, in terms of *eliminating jeopardy* to residents what is important is that a facility implement policies that assure that its residents are adequately protected against hazards and risks. Here, requiring that all residents be supervised by two members of Petitioner's staff while being bathed was targeted precisely at the risk that became apparent with the accident to Resident # 1. Giving all of Petitioner's residents the benefit of this change in policy – whether each of them needed two-person supervision and assistance or not – eliminated the jeopardy that was present in this case.

4. Petitioner did not attain full compliance with participation requirements before March 1, 2007.

Petitioner has not argued that it attained full compliance with participation requirements prior to March 1, 2007 and, indeed, the evidence supports a finding that it did not complete all corrective actions prior to that date. As CMS notes, Petitioner did not complete its review of residents' care plans prior to that date.

5. A one-day civil money penalty of $4000 is a reasonable remedy for Petitioner's immediate jeopardy level noncompliance. Penalties of $200 per day are a reasonable remedy for Petitioner's non-immediate jeopardy level noncompliance through March 1, 2007.

Regulations governing imposition of civil money penalties provide that daily penalties for immediate jeopardy level noncompliance may fall within a range of from $3050 to $10,000 for each day of noncompliance. 42 C.F.R. § 488.438(a)(1)(i). Penalties for non-immediate jeopardy level noncompliance may fall within a range of from $50 to $3000 per day. 42 C.F.R. § 488.438(a)(1)(ii). The regulations establish criteria for deciding the appropriate daily civil money penalty amount within each of these ranges. 42 C.F.R. §§

488.438(f)(1)-(4), 488.404 (incorporated by reference within 42 C.F.R. § 488.438(f)(3)). These factors include: the seriousness of a facility's noncompliance; its compliance history; its culpability; and its financial condition.

CMS has provided no argument as to what is reasonable in this case aside from asserting that immediate jeopardy continued from January 29 through March 1, 2007. Petitioner asserted that the penalty amounts determined by CMS are unreasonable but, like CMS, provided no argument as the reasonableness of these amounts in the context of the applicable regulatory factors for deciding penalty amounts.

I decide that an immediate jeopardy level penalty for January 28, 2007 of $4000 is reasonable based on the application of the regulatory factors to the evidence. The seriousness of Petitioner's noncompliance in providing care to Resident # 1 and Petitioner's culpability for the resident's fatal accident are sufficient to justify a penalty of $4000. The failure of Petitioner's staff to assess and plan for the risk that the resident might roll out of a shower bed caused this resident to sustain a fatal accident. This was a risk that was foreseeable in light of a previous incident in which the resident fell out of her bed.

The one-day civil money penalty of $4000 that I impose for Petitioner's immediate jeopardy level noncompliance is considerably less than the aggregate that CMS determined to impose for this noncompliance. That is because CMS's determination as to duration is clearly erroneous. I note, however, that the penalty I impose also is predicated on CMS's apparent determination that Petitioner's immediate jeopardy level noncompliance *commenced* on January 28, 2007, the date that Resident # 1 sustained her fall from the shower bed. That is obviously an incorrect assessment as to the beginning point of immediate jeopardy. In this case immediate jeopardy commenced when Petitioner failed to assess and care for Resident # 1's propensity to fall. That, in fact, began at least weeks prior to the date when the resident actually fell (indeed, the resident sustained an initial fall on September 21, 2006). Had CMS determined to impose immediate jeopardy level civil money penalties beginning at an earlier date than January 28, 2007, a date commensurate with the actual date of Petitioner's failure adequately to assess Resident # 1 and plan for her care, I would have sustained them.

I decide that penalties of $200 per day are adequate to remedy the noncompliance that persisted after January 28 and which continued up through March 1, 2007. Petitioner eliminated the most egregious elements of its noncompliance by requiring that two staff members supervise and assist residents during bathing, by removing from service the shower bed that was implicated in the January 28 accident, and by limiting the hours during which bathing took place. But, there were still unresolved – albeit relatively low

level – elements of noncompliance which Petitioner had to correct in order to eliminate all possibility of harm to its residents. These included a systematic review of all residents' plans of care. Civil money penalties of $200 per day during the period when these corrective actions took place are, in my judgment, commensurate with the noncompliance that remained after January 28, 2007.

6. CMS is authorized to deny Petitioner payment for new Medicare admissions for the period that ran from February 25 through March 1, 2007.

CMS has discretion to deny a facility payment for new Medicare admissions at any time when the facility is not complying substantially with Medicare participation requirements. 42 C.F.R. § 488.417(a). Denial of payment is authorized in this case during the period that ran from February 25 through March 1, 2007 because Petitioner was not complying substantially with Medicare participation requirements during this period.

/s/
Steven T. Kessel
Administrative Law Judge