Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: April 7, 2008
SunBridge Care and Rehabilitation for Pembroke,	
Petitioner,	Civil Remedies CR1636 App. Div. Docket No. A-08-7
- v. -	Decision No. 2170
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

SunBridge Care and Rehabilitation for Pembroke (SunBridge or Petitioner), a skilled nursing facility located in Pembroke, North Carolina, appeals the August 13, 2007, decision of Administrative Law Judge (ALJ) Steven T. Kessel. SunBridge Care and Rehabilitation for Pembroke, CR1636 (2007)(ALJ Decision). The ALJ sustained a determination by the Centers for Medicare & Medicaid Services (CMS), based on survey findings by the North Carolina State Survey Agency (state agency), that SunBridge failed to comply substantially with requirements governing the participation of long-term care facilities in the Medicare and Medicaid programs during a period that began on March 6, 2006 and ended on June 19, 2006. CMS found, and the ALJ agreed, that SunBridge was not in substantial compliance with (1) the requirement that the resident environment remain as free of accident hazards as possible, 42 C.F.R. § 483.25(h)(1)[Tag F323]; and (2) the requirement that the facility 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 resident, 42 C.F.R. § 483.75 [Tag F490]. CMS determined that the noncompliance that began on March 6, 2006 and ended on May 11, 2006 posed immediate jeopardy to the facility's residents and imposed a civil money penalty (CMP) of $4,000 per day for that period. The ALJ upheld the immediate jeopardy determination as not clearly erroneous and also found that the CMP amount for the immediate jeopardy period was reasonable. CMS found that noncompliance continued at less than the immediate jeopardy level beginning on May 12, 2006 and ending on June 19, 2006 and imposed a CMP of $50 per day for that period of time. The ALJ upheld the finding of noncompliance for that period, determining that the CMP was reasonable as a matter of law since $50 is the lowest per day amount CMS may impose for noncompliance that is not immediate jeopardy.

For the reasons discussed below, we uphold the ALJ's findings of fact and conclusions of law (FFCLs) 1-5.

Applicable Legal Provisions

The participation requirements for skilled nursing and other long-term care facilities that participate in Medicare and Medicaid are set forth at 42 C.F.R. Part 483, Subpart B. State agencies under contract with CMS perform surveys to verify whether the facilities are complying with the participation requirements. The procedures for survey and certification of long-term care facilities are set out at 42 C.F.R. Part 488, subparts A and E, and in the State Operations Manual (SOM) issued by CMS. The state agency reports any "deficiencies," or failures to meet participation requirements, on a standard form called a "Statement of Deficiencies" (SOD). See 42 C.F.R. §§ 488.301, 488.325(a); SOM Appendix (App.) P, sec. III.

A facility becomes subject to various enforcement remedies, including per day or per instance CMPs, when it is found not to be in "substantial compliance" with one or more participation requirement. See 42 C.F.R. §§ 488.400, 488.402(c), 488.406, 488.408. "Substantial compliance" means a level of compliance 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. ("Noncompliance" is defined at 42 C.F.R. § 488.301 as "any deficiency that causes a facility to not be in substantial compliance.") CMS may impose per day CMPs ranging from $3,050 - $10,000 per day for one or more deficiencies constituting immediate jeopardy and from $50 -

$3,000 per day for deficiencies that do not constitute immediate jeopardy but that either cause actual harm or create the potential for more than minimal harm. 42 C.F.R. § 488.438(a). "Immediate jeopardy" is defined in the regulations as a situation in which a provider's noncompliance "has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301.

The regulations set out a number of factors that CMS considers in determining the amount of a CMP. 42 C.F.R. §§ 488.438(f), 488.404. These factors are the facility's history of noncompliance (including repeated deficiencies), its financial condition, its degree of culpability for the cited deficiencies, the seriousness of the noncompliance, and the relationship of one deficiency to the other deficiencies resulting in noncompliance. Id. A CMP accrues until either the facility achieves substantial compliance or its provider agreement is terminated. 42 C.F.R. § 488.454(a). CMS's choice of remedy is not subject to appeal, but the facility may appeal the noncompliance findings leading to the imposition of a remedy specified in 42 C.F.R. § 488.406, except the state monitoring remedy. See 42 C.F.R. §§ 498.3(b)(13), 498.3(d)(11). On review of the amount of the penalty, an ALJ may not consider any factors other than those specified at 42 C.F.R. § 488.438(f). 42 C.F.R. § 488.438(e)(3).

The regulation at 42 C.F.R. § 483.25(h)(1), which governs the first finding of noncompliance in this appeal, provides:

> *Accidents*. The facility must ensure that –
>
> (1) The resident environment remains as free of accident hazards as is possible.

The regulation at 42 C.F.R. § 483.75, which governs the second finding of noncompliance, reads:

> *Administration.* A facility must 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 resident.

Standard of Review

Our standard of review on a disputed conclusion of law is whether the ALJ Decision is erroneous. Our standard of review on a disputed finding of fact is whether the ALJ Decision is supported by substantial evidence in the record as a whole. Guidelines for

Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs; see also Batavia Nursing & Convalescent Inn, DAB No. 1911, at 7 (2004), aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson, 143 Fed.Appx. 664 (6th Cir. 2005).

Case Background[1]

The noncompliance found in this case involves SunBridge's transportation of wheelchair-bound residents to and from off-site dialysis and other appointments. SunBridge owns and operates a van and employs drivers for this purpose. ALJ Decision at 3. The van's equipment includes "tie down" devices to hold the wheelchairs in place and separate, safety belts (also referred to as "occupant restraints", "seat belts" or "harnesses") for the passengers in wheelchairs. ALJ Decision at 3-4. Each harness is permanently anchored to a point at the side of the van and to a point at the ceiling of the van; the harness is secured when in use by attaching it to an anchor point on the van floor. ALJ Decision at 4.

Two separate incidents occurred wherein wheelchair-bound residents were injured while being transported in SunBridge's van. ALJ Decision at 3-4. First, on August 8, 2005, a resident (identified for privacy reasons as Resident #1) sustained abrasions and shoulder pain while being transported when the van, driven by a SunBridge employee identified in the record as Driver #3, made a sudden stop, and the resident slid down or out of his wheelchair.[2] ALJ Decision at 3. On March 6, 2006, a different resident (identified for privacy reasons as Resident #3) slid out of her wheelchair and sustained a broken femur while being transported in SunBridge's van, at that time driven by an

[1] The information in this section is drawn from the ALJ Decision and the record before the ALJ and is presented to provide a context for the discussion of the issues raised on appeal. Nothing in this section is intended to replace, modify, or supplement the ALJ's findings of fact.

[2] The ALJ noted that the parties disputed whether Resident #1 completely fell out of, or merely slipped down in, the wheelchair but found it unnecessary to resolve that factual dispute. ALJ Decision at 3, n.2. However, the ALJ also noted that SunBridge's own investigation report of the accident states that the resident slid out of the chair and fell to the floor. Id., citing P. Ex. 11, at 1.

individual identified in the record as Driver #1.[3] ALJ Decision at 3, 12. The driver stated that when she became aware that Resident #3 was sliding out of the wheelchair, she stopped the van at the side of the road, attempted unsuccessfully to return the resident to her wheelchair, and called the facility by cell phone for further instructions. CMS Ex. 4, at 2-3. The Director of Nursing (DON) instructed the driver to return to the facility with the resident lying on the floor of the van. ALJ Decision at 12; Tr. at 86-90. Upon return, Resident #3 was assessed as having a broken leg; SunBridge employees called 911, and an ambulance subsequently transported Resident #3 to the hospital, where she expired. CMS Ex. 4, at 2-3.

The state agency conducted a complaint survey at SunBridge from May 10, 2006 through May 12, 2006. CMS Ex. 1. Based on the surveyor's review of relevant records, observations, staff interviews and demonstrations of the van's wheelchair and occupant restraint systems by SunBridge employees, the state agency and CMS concluded that SunBridge was out of compliance with the program requirements at 42 C.F.R. §§ 483.25(h)(1) and 483.75.[4] CMS Exs. 1, 2, 4. According to the state agency and CMS, immediate jeopardy started on August 8, 2005 and was removed on May 12, 2006, when SunBridge provided a credible allegation of compliance. CMS Ex. 4, at 1. The state agency and CMS determined that SunBridge would remain out of compliance at less than the immediate jeopardy level "until a method to use to safely secure residents for transport is implemented and facility drivers can be in-serviced regarding changes in the method to safely secure residents for transportation [and] . . . until drivers can be in-serviced on procedures to follow at the time of an emergency." CMS Ex. 4, at 1, 19-20. On June 5, 2006, CMS issued its determination that it would impose a CMP of $4,000 per

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[3] In describing Resident #3's accident, we use the terminology in the ALJ's finding that Resident #3 "slid out of her wheelchair." ALJ Decision at 3. In its brief, Petitioner variously refers to what happened as the resident's slipping, sliding or falling out of her wheelchair, see P. Br. at 2, 7, 33, but does not dispute that she came out of the chair completely and ended up on the floor.

[4] The surveyor was unable to interview Driver #1, whose employment had been terminated following the second accident. The surveyor did, however, interview Driver #3 and also observed a demonstration of the van's safety equipment by a different driver, identified as "Driver #2," on May 11, 2006. CMS Ex. 4, at 3, 6, 13-14.

day for the period beginning on March 6, 2006 and ending on May 11, 2006 and $50 per day effective May 12, 2006 and continuing until the facility either achieved substantial compliance or was terminated.[5] CMS Ex. 2. CMS later determined that the noncompliance period ended on June 19, 2006. ALJ Decision at 13.

SunBridge timely appealed CMS's determination and received an in-person hearing by ALJ Kessel on June 5, 2007. ALJ Decision at 2. Following the hearing and briefing by the parties, the ALJ issued a decision setting forth five FFCLs: 1) Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h)(1); 2) Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.75; 3) Petitioner failed to prove that CMS's determination of immediate jeopardy was clearly erroneous; 4) Petitioner failed to prove that the duration of its noncompliance was for a shorter period than was determined by CMS; and 5) CMS's civil money penalty determinations were reasonable.

Issues on Appeal

The ALJ concluded that the case fundamentally involved improper use of the van safety belt systems by SunBridge staff. ALJ Decision at 10. Specifically, the ALJ found that when a harness is properly anchored to the van floor at a point behind the wheelchair-bound passenger, the seat belt portion of the belt system "fits snugly across a resident's hips." ALJ Decision at 4. If, however, the harness is attached incorrectly, to an anchor point in front of the wheelchair, the system "fails to provide any pelvic restraint." Id. The ALJ determined that the evidence submitted by CMS supported the conclusion that SunBridge staff did not "understand the need to attach passenger harnesses to floor anchors that were located behind the wheelchairs." Id. The ALJ also concluded that the staff "routinely" attached the harnesses to anchors located in front of the chairs," thereby "fail[ing] to provide the residents with the protection that the harnesses were designed to provide," and putting residents at risk of serious injury, harm, impairment or death. ALJ Decision at 4-5. Further, the ALJ concluded, SunBridge management failed to assure that staff would use the van's safety belt systems

[5] The ALJ noted that CMS imposed no remedy for the period between the first accident on August 8, 2005, and the second accident on March 6, 2006 and that, consequently, he did not need to address whether immediate jeopardy existed before March 6, 2006. ALJ Decision at 13, n.6. Likewise, we do not address whether immediate jeopardy began before March 6, 2006.

properly and to assure that staff followed prescribed emergency procedures for responding to accidents. Id. at 10-12.

SunBridge argues on appeal that the ALJ's findings and conclusions are erroneous and contrary to the record evidence. SunBridge also argues that the ALJ exceeded his authority by sustaining the CMPs on a theory different from that cited by the state agency and CMS, and that the ALJ denied SunBridge any opportunity to address that theory. SunBridge further contends that the ALJ Decision is inconsistent with the Board's recent decision in the case of Liberty Nursing and Rehabilitation Center - Mecklenberg County, DAB No. 2095 (2007)(Liberty – Mecklenberg), appeal docketed, No. 07-1667 (4th Cir. 2007). In addition, SunBridge submits that CMS is attempting to regulate the use of motor vehicles under section 483.25(h)(1), but lacks authority to do so.

Analysis[6]

1. The ALJ's finding of noncompliance with 42 C.F.R. § 483.25(h)(1) beginning on March 6, 2006 and ending on June 19, 2006, is supported by substantial evidence and free of legal error.

A. Substantial evidence supports the ALJ's findings that there is a proper way to fasten the harnesses but that SunBridge failed to understand this and routinely fastened them improperly.

SunBridge argues that the record does not contain substantial evidence to support the ALJ's conclusion that SunBridge failed to comply with 42 C.F.R. § 483.25(h)(1). Specifically SunBridge asserts that there is no evidence to support the ALJ's finding that the safety belts must be anchored to the van floor behind the wheelchairs in order to provide the proper restraint, that anchoring the belts in front of the wheelchairs is incorrect or ineffective, or that staff in fact fastened any passengers' safety belts in front of the wheelchairs. Petitioner Brief (P. Br.) at 3-4, 14, 16, 41.

We disagree.

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[6] Although some specific points SunBridge made may not be discussed in detail in this decision, all of the arguments in its brief were considered in reaching the conclusions set forth below.

(1) Substantial evidence shows that the harnesses provide the proper restraint only when anchored to the floor behind, not in front of, the wheelchair.

SunBridge asserts that there is no evidence in the record to support the ALJ's conclusion that there are correct and incorrect methods of securing the harnesses. P. Br. at 3-4, 13-17. However, that assertion is belied by multiple sources of evidence in the record.

To begin with, several technical publications that SunBridge itself submitted, including a Department of Veterans Affairs (VA) publication, depict the importance of properly securing the harnesses. P. Ex. 40. As noted by the ALJ, Figure 1 in the VA publication shows that the preferred and optimal angles for pelvic restraints depend on fastening the restraints behind the wheelchair.[7] ALJ Decision at 7, n.4; see also P. Exs. 31, 34, 38, 39 (all indicating that the proper location to anchor the harness is behind the chair). Together, these publications support the ALJ's conclusion that there is a correct way to fasten occupant safety harnesses, behind the wheelchairs, and that anchoring harnesses in front of wheelchairs poses a foreseeable hazard that endangers passengers.[8]

The state agency surveyor's testimony relied on by the ALJ further supports the ALJ's conclusion that for purposes of providing the necessary restraint (pelvic as well as shoulder and chest) there is a correct way to fasten the harnesses to the floor (attaching them to an anchor point behind the wheelchair)

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[7] The ALJ also cited Figure 3 in this publication, which shows the safety belt being attached behind the chair. Figure 3 also shows the belt passing over the armrest, and a caption to the figure indicates that this aspect of the figure is unsafe. However, this aspect is not at issue here, and the ALJ correctly cited the Figure for what is at issue, that is, that fastening the seat belt to the floor behind the chair is the correct method.

[8] SunBridge argues that the ALJ misinterpreted the VA diagram at page 3 of Petitioner Exhibit 40 (figure 1) which, SunBridge states, "actually portrays the optimal angle for a lap belt *to cross the pelvis*, not where *on the floor* the end of the lap belt should be secured." P. Br. at 17 (emphasis in original). However, it is obvious from the diagram that the optimal angle cannot be achieved by fastening the safety belt to the floor in front of the wheelchair.

and an incorrect way (attaching the harness to an anchor point in front of the wheelchair). Tr. at 42, 44, 45-46, cited in ALJ Decision at 4. We note, as did the ALJ, that the surveyor's testimony is consistent with her statements on the SOD about a demonstration in which she participated on May 11, 2006. The surveyor stated that during the demonstration she sat in the wheelchair and Driver #2 "put [the harness] through the armrests in front of the wheelchair" and then fastened the harness to "a metal groove" on the floor in front of the chair. CMS Ex. 4, at 6. When fastened this way, the surveyor stated, the harness did not provide proper pelvic restraint, slipped away as she leaned forward, and "at that point a resident could slip under the belt that went through the armrests."[9] Id. Conversely, she stated on the SOD that when the Maintenance Director then demonstrated how the harness could be fastened into the anchor point behind the wheelchair, the passenger could not lean forward. Id. at 6-7.

We conclude that the publications and/or the surveyor testimony would in themselves suffice for us to uphold the ALJ's finding that there is a correct location to attach the harness (an anchor point on the floor behind the wheelchair) and an incorrect location (an anchor point in front of the wheelchair), given the absence of contradictory evidence in the record. We conclude that this evidence also supports the ALJ's conclusion that when attached correctly, the harness "fits snugly across a resident's hips and prevents the resident from sliding out of the wheelchair or lurching forward in the event of a sudden stop or accident" but that when attached incorrectly, the harness "fails to provide any pelvic restraint" and, accordingly, "a wheelchair bound resident could slip out of the harness." ALJ Decision at 5.

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[9] SunBridge objected that while the surveyor "suggested" that she was able to slide under the harness when it was attached in front but would not have been able to slide out if it had been attached behind the wheelchair, she "never actually directly said" this. P. Posthearing Br. at 10. The ALJ viewed this objection as an attempt to characterize the record as vague or inconclusive. See ALJ Decision at 8. The ALJ disagreed with that characterization and so do we. The clear thrust of the surveyor's statements on the SOD and at the hearing was that an occupant of the wheelchair (whether herself or a resident) could slip out when the harness was attached in front of the chair because that method did not provide proper pelvic restraint whereas anchoring the harness behind the wheelchair did provide the proper pelvic restraint.

Furthermore, the ALJ did not rely on this evidence alone. He also cited two photographs introduced by SunBridge that showed SunBridge employees strapped into wheelchairs in the van with the safety belts attached to anchor points behind the wheelchairs. ALJ Decision at 4, citing P. Ex. 25, at 3 (images at top and lower right portion of page). The photographs were taken at the direction of SunBridge's Administrator. P. Ex. 43, at 2-3 (pre-filed testimony of Administrator Brenda Erskine). The ALJ contrasted these photos to a third one that he found showed the safety belt attached to an anchor point in front of the wheelchair. Id., citing P. Ex. 25, at 3 (image at lower left portion of page). The ALJ found in these photos further evidence that, when attached behind the wheelchair, the harness provided the hip restraint needed to keep a resident from sliding out of the chair and, when attached in front of the chair, the harness did not provide that necessary restraint.

On appeal neither party challenges the ALJ's findings with regard to where each of the three photographs shows the safety belt to be anchored to the floor. In addition, as the ALJ noted, SunBridge "did not offer any evidence supporting an argument that the harnesses were intended to be fastened in front of residents or that they would function properly if fastened that way." ALJ Decision at 7, n.4. SunBridge questions whether the ALJ could conclude that the occupant of the wheelchair in the third photo (showing the safety belt attached to an anchor point in front of the wheelchair) is any less secure than occupants of the wheelchairs in the other two photos since, SunBridge contends, the third photo "also shows the shoulder/lap portion of the belt tightly fastened around the passenger's waist ... ."[10] P. Br. at

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[10] Sunbridge argues that the ALJ erroneously concluded that staff "could adjust . . . where the lower belts were secured to the floor." P. Br. at 14. SunBridge asserts that the photos "make . . . clear that all of the wheel clamps and the seat belt tracks are fixed to the floor, and are *not* adjustable." P. Br. at 15 (emphasis in original). SunBridge seems to be implying that because the tracks were fixed, anchor points behind the wheelchairs would not be available. However, this assertion is undercut by SunBridge's own photographs, at least two of which SunBridge does not dispute show the harnesses fastened behind the wheelchairs. It is also undercut by the demonstration in which the Maintenance Director was able to fasten the harness behind the wheelchair. Driver #2 stated that it was not possible to fasten the belts behind the wheelchairs when transporting multiple wheelchair-bound residents at the same time, as on

(continued...)

18, n.12. However, SunBridge's conclusion as to what the photo "also shows" is conjecture since the occupant's waist area is not fully visible. Furthermore, any conclusion that a portion of the belt actually encircles the occupant's waist, which appears to be what SunBridge is suggesting, is contrary to testimony about the design of the belts as being in one piece, albeit with two portions, a shoulder portion and a pelvic portion, like a car seat belt. See Tr. at 42-46.

SunBridge argues that "vehicular safety belts are designed and intended to assure that passengers are not ejected from their seats or wheelchairs in collisions or sudden stops, and are *not* designed or intended to prevent a passenger from sliding out of a seat or wheelchair." P. Br. at 27 (emphasis in original). Accordingly, SunBridge argues, the ALJ erred in describing van safety belts for wheelchairs as designed to "hold passengers securely in their wheelchairs." P. Br. at 3, citing ALJ Decision at 4. This argument misses the point. The ALJ did not uphold CMS's finding of noncompliance based on any design or functional shortcoming of the seat belt itself but, rather, based on staff failure to fasten the seat belts properly. As discussed above, substantial evidence supports the ALJ's finding that when the seat belt is properly fastened to the anchor behind the wheelchair, it does prevent the passenger from sliding out; conversely, when the seat belt is improperly fastened to an anchor in front of the chair, the passenger can slide out. Furthermore, SunBridge itself notes, "[m]anufacturer-supplied safety belts are carefully designed to fit over the collarbone and ribs, and across the hips, which are the strongest parts of the human skeleton, and are crash-tested to assure not only that they are strong enough to withstand crash stresses, but also to assure that they remain in place during collisions, and do not shift up or down which could cause greater injuries to internal organs." P. Br. at 26-27.

In addition, SunBridge relies on this assertion about the design of the safety belts as part of its argument that the real basis for the noncompliance finding was that staff failed to use supplemental restraints, such as the lap or waist belts sometimes

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[10](...continued)
Mondays, Wednesdays and Fridays when she took four wheelchair-bound residents to dialysis. CMS Ex. 4, at 7. However, as we discuss later, that would present a logistical problem based on van space, not the fixed nature of the anchors, that the facility was required to address, not a defense to its violation of its duty to safely transport residents.

prescribed to position or restrain a resident in a wheelchair and that attach directly to the wheelchair. We agree with the ALJ that this argument is a "straw man and does not in any sense reflect the true nature of Petitioner's noncompliance ... *improper use* of safety harnesses by Petitioner's staff [which] made residents vulnerable to precisely the type of accident that Petitioner contends that the harnesses were designed to protect against." ALJ Decision at 10 (emphasis in original). SunBridge also quoted the ALJ out of context as saying that the van's safety belts were "designed to hold passengers securely in their wheelchairs," implying that the ALJ erroneously equated the purpose of the vehicle safety belts with the intended function of supplemental wheelchair restraints. P. Br. at 3, quoting ALJ Decision at 4-5. The ALJ's full comment on page 4 was: "The van also contains harnesses that are designed to hold passengers securely in their wheelchairs and to prevent residents from coming out of their chairs in the event of an accident." The sentence as a whole, as well as the ALJ's extended discussion related to this sentence, clearly show that when he used the phrase "securely in their wheelchairs," the ALJ was referring to the function of van safety belts as distinct from the function of the supplemental restraints which SunBridge mistakenly asserts are the issue in this case.

Furthermore, the technical publications SunBridge put into evidence do not support its constrained view of the design purpose of wheelchair seat belts as not intended to prevent passengers from sliding out of wheelchairs during transit. The publication entitled "Ride Safe[:] Information to help you travel more safely in motor vehicles while seated in your wheelchair" defines "[o]ccupant restraint" as "[a] system or device designed to restrain a motor vehicle occupant in a crash <u>by keeping the occupant in the vehicle seat</u> ... ." P. Ex. 34 at 8 (emphasis added). The underscored language is sufficiently broad to encompasses any form of coming out of a wheelchair, not just being forcefully ejected. The same publication defines "[w]heelchair tiedown and occupant-restraint system (WTORS)" as "[a] complete system for use by wheelchair-seated occupants comprised of a system or device for securing the wheelchair and a belt-type restraint system <u>for limiting occupant movement</u> in a motor vehicle crash." <u>Id.</u> (emphasis added). Another publication, "Wheelchair rider risk in motor vehicles: A technical note," states that anecdotal reports from school transportation sources "suggest that most of the injuries ... occur when the occupant either falls out of the wheelchair or the wheelchair tips over during vehicle maneuvers" and that "[m]ost of the injuries have been attributed to the improper use or maintenance of the vehicles' WTORS." P. Ex. 31, at 5; <u>see also</u>

P. Ex. 42, at 13 (another publication discussing injuries from non-crash scenarios such as falling out of wheelchairs or the wheelchair tipping over due to vehicle maneuvering). A resident can fall out of a wheelchair without being ejected (a term that connotes force), and sliding out of a wheelchair is reasonably considered a type of fall, as evidenced by the fact that SunBridge itself investigated the incidents involving Residents #1 and #3 as falls. See P. Exs. 11, at 2, and 18, at 2.

(2) Substantial evidence supports the ALJ's finding that SunBridge staff failed to comprehend that the seat belts must be fastened behind the wheelchair and instead routinely fastened them in front of the wheelchair.

As discussed above, the surveyor participated in a demonstration in which a SunBridge van driver fastened the seat belt to the anchor in front of the wheelchair, which did not provide the pelvic restraint necessary to secure the surveyor in the wheelchair. The ALJ relied on this demonstration by a SunBridge driver, documented on the SOD and described in the surveyor's testimony, as evidence that the drivers responsible for fastening the safety belts did not understand that the safety belts must be fastened behind the wheelchairs in order to provide proper restraint and, instead, routinely attached the seat belts in front of the wheelchairs. ALJ Decision at 4-5. The ALJ also relied on the driver's statement to the surveyor (after the Maintenance Director demonstrated the proper way to fasten the belt, behind the chair) that it was not possible to anchor the belts behind the wheelchairs when there were four wheelchairs in the van, as was the case three days each week, she said. Id., citing CMS Ex. 4, at 7; Tr. at 46. The ALJ concluded that this evidence, if unrebutted, "strongly supports a finding that Petitioner routinely was transporting its wheelchair bound residents unsafely and in a manner that made serious injury, harm or even death likely." ALJ Decision at 5.[11]

[11] The surveyor also said on the SOD that during an interview SunBridge's Administrator admitted, "We know it can happen that way[;] residents can slip out of the chair under the current belting arrangement. I could slip out. I did it." CMS Ex. 4, at 7. The surveyor also testified to this effect at the hearing. Tr. at 29-31. The Administrator denied that this conversation took place. Tr. at 101, 103. The ALJ did not rely on the surveyor's statements about this alleged conversation and neither do we.

SunBridge takes exception to the ALJ's reliance on the May 11, 2006 survey demonstration, pointing out that the employee who anchored the safety belt in front of the wheelchair at the demonstration was not the driver of the van at the time of either of the two accidents.[12] P. Br. at 15-16. Consequently, SunBridge submits, the demonstration evidences neither that the method demonstrated was in fact the way Residents #1 and #3 were secured at the time of the accidents nor the way in which SunBridge drivers routinely secured the harnesses. Id. However, we agree with the ALJ's conclusion that this evidence made a prima facie showing that SunBridge's drivers, including Drivers #1 and #3, did not even understand that the safety belts should be anchored behind the wheelchairs and routinely anchored the harnesses in front of the wheelchairs. ALJ Decision at 4-5. We also agree with the ALJ that SunBridge did not effectively rebut that showing with affirmative evidence to the contrary. See e.g. Batavia at 8-21 (holding that once CMS has made a prima facie showing that a nursing home was not in substantial compliance with a relevant statutory or regulatory provision, a facility must prove by a preponderance of the evidence that it was in substantial compliance with the provision in order to prevail).

In particular, Driver #2's statement that it was not possible to fasten the safety belts behind the wheelchairs when she transported multiple residents strongly supports the ALJ's finding that the facility staff neither understood nor complied with proper methods of using the harnesses. The driver stated that she could not anchor all of the belts behind the wheelchairs when, three days each week, she transported four wheelchair-bound passengers at the same time. In effect, this statement is an admission by Driver #2 that she routinely (at least three days every week) transported residents without properly securing the safety belts. SunBridge did not show, or even contend, that Drivers #1 and #3 did not also transport multiple wheelchair

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[12] The driver at the May 11, 2006 demonstration is referred to in the record as "the current van driver" or "Driver #2." CMS Ex. 4, at 6-7, 14-15. The driver at the time of the August 8, 2005 incident involving Resident #1 was identified as "Driver #3," whom the surveyor interviewed by phone on May 11, 2006. Id. at 14. The surveyor further interviewed both Drivers #2 and #3 on May 12, 2006, the day after the first safety belt demonstration. Id. at 11. The driver at the time of Resident #3's accident is identified as "Driver #1." Id. at 3. SunBridge dismissed Driver #1 immediately after the March 6, 2006 accident. Consequently, Driver #1 was unavailable for interview. Id. at 3-4.

bound residents at times. SunBridge did not dispute that the van used in the demonstration was the same van used at the time of the accidents involving Residents #1 and #3. CMS Ex. 4, at 3-8. Thus, it was reasonable for the ALJ to infer from Driver #2's statement, at least in the absence of any evidence to the contrary, that what she described as her routine practice was also the routine practice of Drivers #1 and #3 at the time of the accidents.

SunBridge has not presented any evidence that shows this inference to be unreasonable. SunBridge's DON testified at the hearing that its drivers underwent in-service training in the use of the van's safety equipment, including use of safety belts. Tr. at 105. She said that the training in loading and unloading and how to belt in the residents is "all part of the road testing." Id. In her prefiled testimony submitted in January 2007, the DON stated that training that included proper use of safety belts was given in 2005 to the driver at the time of the incident involving Resident #3 (elsewhere identified as Driver #1). P. Ex. 43, at 2. She also stated that the "Maintenance Director has informed me that he does not permit anyone to operate the van unless the operator demonstrates to him that they can safely secure a wheelchair and passenger using the safety belts in the van." Id. at 3.

The DON's testimony is clearly based solely on her understanding that the "road testing" performed by the Maintenance Director included proper use of seat belts, since she does not claim any personal knowledge of how the drivers in question were trained or the content of the training. Sunbridge's own evidence, however, indicates that the "road testing" performed as late as June 15, 2006, did not include the training the DON thought it did. A statement by the Maintenance Director signed on that date states, "I personally in-service all new drivers on policy and procedure related to driving company vehicles. Attached is the record of road test which is the tool used with new drivers and the copy of road test certification that I sign after a driver gives a return demonstration." P. Ex. 23. The attached "record of road test" is a checklist which contains no mention of any test related to proper use of safety belts or even of any test related to loading residents into the van, and the attached certification form is blank. This statement by the Maintenance Director and its attachments are certainly better evidence of what was included as part of any "road testing" received by the drivers in question than the DON's hearing testimony. That the Maintenance Director may have informed the DON at some point in time that he "does not permit anyone to operate the van unless the operator demonstrates to him that they can safely secure a wheelchair and passenger

using the safety belts in the van" does not evidence that this represented his practice throughout the relevant time periods.

Moreover, the Maintenance Director's June 2006 statement merely says that the attached tool is used with "new drivers" and does not specify that it was used with any of the three drivers in question. If it had been, one would have expected SunBridge to have submitted the training certifications for those drivers, rather than just a blank form.

Finally, we note that SunBridge offered no proof that there were differences in the way Drivers #1, #2 or #3 were trained or in how they were using the equipment prior to the survey. Tr. at 105-106; P. Exs. 23, 43. Thus, there is no reason to believe that the training for any of the drivers, even if it included some mention of the proper use of seatbelts (which SunBridge has not proved with convincing evidence), was adequate to impress on them the importance of fastening the seatbelts behind the wheelchairs, rather than in front.

Although not specifically discussed in the ALJ Decision, the surveyor's interviews with the Maintenance Director and Administrator also revealed that SunBridge had no instruction manual or guidelines specifically showing or describing where or how the safety belts should be anchored. CMS Ex. 4, at 6-7, 15. The record contains a document entitled "Sun Healthcare Group, Inc. Fleet Safety and Vehicle Operating Manual." P. Ex. 27. This document states, "All drivers operating and passengers riding in company owned, leased, or authorized motor vehicles must wear safety belts and shoulder harnesses while the vehicle is being operated, even if the vehicle is equipped with a supplemental restraint system such as air bags." Id., at 14. However, there is no specific mention of seat belts for wheelchair bound residents or how to attach them.

As for the alleged "impossibility" of securing the harnesses behind the wheelchairs when multiple, *e.g.*, more than three, wheelchairs were in the van, this is not a defense to the finding of noncompliance. It was SunBridge's responsibility to identify any problems involving the safe transport of its residents and to determine how to resolve them. As the Board stated in Maine Veterans' Home - Scarborough, DAB No. 1975, at 6-7 (2005): "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." See also Liberty – Mecklenberg, DAB No. 2095, at 9-15 (fact that van was missing two wheelchair

safety harnesses did not excuse SNF's transporting residents without harnesses and using unsafe soft lap belts instead). SunBridge has not produced evidence that at any time prior to the survey it recognized the alleged problem with the manner in which it secured wheelchair-bound residents when transporting multiple residents at one time or that it tried to overcome this problem, such as by obtaining alternate safe transport for the times in question or rearranging transportation schedules to assure that it was not carrying more wheelchair-bound residents than could be transported using the safety belts properly at any given time.

SunBridge cites testimony by its DON as evidence that Drivers #1 and #3 fastened the seatbelts for Residents #1 and #3 correctly, behind the wheelchairs. P. Br. at 17. The DON testified that following each of the accidents, she took part in investigations of the incidents. Tr. at 75-83, 93-95. The DON says that as part of her investigations, she interviewed Drivers #1 and #3 and that they explained to her and showed her how the safety belt systems had been used to secure the residents. SunBridge argues that the DON "clearly testified that she determined during her investigation that both Residents had been positioned in the van so that the lap portions of the belts had been fastened *behind* them." P. Br. at 17, citing Tr. at 79, 81, 94 (emphasis in original). SunBridge further argues that the ALJ "simply disregarded this testimony . . . ." Id.

While the ALJ Decision does not directly address this testimony, his acknowledgment of SunBridge's assertion in its post-hearing brief "that there was a 'dispute at the hearing' regarding how the harnesses were attached to the floor" indicates that he considered the DON's testimony along with the other evidence on that issue. ALJ Decision at 8, citing Petitioner's posthearing brief at 10. The ALJ rejected SunBridge's characterization of the surveyor's statements in the survey report and/or in her testimony concerning how the harnesses were attached as "vague and inconclusive," indicating that the ALJ found the surveyor's statements on this issue clear and conclusive. Id. Also, while the DON's testimony was based on her allegedly thorough investigations, the ALJ apparently rejected that testimony when he concluded that the evidence SunBridge offered did not satisfy him "that it conducted the thorough and intensive investigation that it contends it conducted." ALJ Decision at 7. The ALJ correctly noted that the investigation report on Resident #1's accident states that the resident slid out of the wheelchair but does not contain any analysis of why he did so and, in particular, contains no analysis of how the van's safety features functioned. Id. He also noted that a written statement taken from the Maintenance Director after Resident #3's accident

indicates that while the Maintenance Director examined the van's safety equipment, including the seat belts, and found no defects in that equipment due to improper use, the statement "does not suggest that [the Maintenance Director] queried the van's drivers to determine whether they were attaching the harnesses properly." ALJ Decision at 8.

We add, from our own review of the record, that the investigation report on Resident #3's accident also contains no analysis as to whether the seat belt was properly attached, and there are no notes by the DON from the time of either accident to corroborate her later testimony about what the drivers told or showed her.[13]

As the Board has previously stated, absent clear error, we defer to the findings of the ALJ on weight and credibility of testimony since the ALJ had the opportunity to observe the demeanor of the witnesses. Lakeridge Villa Health Care Center, DAB No. 1988, at 19 n.14 (2005); Koester Pavilion, DAB No. 1750, at 15 (2000). Nonetheless, since the ALJ Decision does not directly address the DON's testimony, we have reviewed that testimony and have determined that it does not detract from the ALJ's conclusion that SunBridge staff routinely fastened safety harnesses in front of the wheelchairs. See Universal Camera Corp. v. NLRB, 340 U.S. 474, 488 (1951)(stating that under the substantial evidence standard the reviewer must examine the record as a whole and take into account whatever in the record fairly detracts from the weight of the decision below). First, the DON's testimony regarding how the drivers explained or showed her they had fastened the harnesses for Residents #1 and #3 was not clear or conclusive. At page 79 of the transcript, cited by SunBridge, the DON stated in connection with Resident #1, "Yeah, as far as I can remember" when asked whether the driver told or showed her that the harness was fastened behind the wheelchair (emphasis added). In subsequent testimony, also cited by SunBridge, the DON was shown a picture and asked to clarify what she meant by

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[13] A signed statement by the DON, dated June 14, 2006, addressing the firing of Driver #2, states that "[t]he driver did not follow [facility] policy *because she did not secure all four wheels,"* and that "[w]e had to err on the side of caution *because she did not secure all four wheels of the wheelchair."* Id. (emphasis in original). P. Ex. 21, at 1. While this statement concerns a feature of the van's safety equipment for wheelchair transport other than the safety harnesses, it does constitute an acknowledgment that at a minimum the driver did not follow facility policy related to safe transport of wheelchair-bound residents.

her "prior testimony." Tr. at 81. The DON responded, "I don't really understand exactly what you're saying. Basically, what I'm saying is, when the shoulder strap goes around the residents, it's a harness – it's a latch that sits on the floor . . . It's not here (indicating) it's right here, it hooks to the resident. . . . The resident looks like the picture – 1,2,3 – third picture. Now based on that picture – I really can't tell, it's really not a good picture – but based on the way this gentlemen is sitting, this appears to be what [the driver] explained to me."[14] Tr. at 81 (describing P. Ex. 25, at 3).

The DON's testimony, taken as a whole, was vague and confusing. Second, even assuming she had unambiguously identified a photograph where the harness was attached behind the wheelchair as the way SunBridge drivers explained to or showed her that it was done for Residents #1 and/or #3, it would not have been error for the ALJ to discount that testimony as evidence of the drivers' routine practice. Third, the DON's testimony was not based on her eyewitness observations of any resident being harnessed in the van and did not purport to address SunBridge's routine practices with regard to securing residents for transport in wheelchairs. Rather, her testimony was limited to the accidents involving Residents #1 and #3 and was based on her memory (which she essentially admitted was not perfect) of what the drivers involved in those accidents allegedly reported to her in the course of the investigations of those accidents. Finally, SunBridge cites nothing in the record that would corroborate the DON's assertion about how, she was told, the harnesses were fastened, and the SOD does not indicate that she made any such claim when interviewed by the surveyor. The incident reports completed by SunBridge after each incident say nothing about how or where the harnesses were anchored. See SunBridge Exs. 11, 18.

[14] On redirect, SunBridge's counsel asked the DON the following question about Resident #3: "Were you able to tell from the investigation whether the belt was secured the same way you testified Resident Number 1's belt was secured, that is, properly around her waist and hooked onto the floor behind her?" Tr. at 94. The DON answered "Yes," but we accord that answer little weight given the leading nature of the question and the fact that it is not an accurate description of her testimony, which was vague and inconclusive.

B. The risk to SunBridge residents posed by fastening the harnesses in front of the wheelchairs was foreseeable.

SunBridge argues that the ALJ erred in finding that it should have known after the first accident that "the safety belt system was inadequate in some way" because, SunBridge writes, "everyone knows that motor vehicle transportation carries some inherent risk of injury." P. Br. at 43. SunBridge also submits that the injuries sustained by Resident #3 in the second accident were not foreseeable because the way in which Resident #1 was seated in the first accident was different than the way in which Resident #3 was sitting in the second accident.

SunBridge mischaracterizes the ALJ Decision. The ALJ plainly stated that the issue was not whether the belts were adequate or worked as designed but, rather, "whether the staff was utilizing the equipment properly." ALJ Decision at 7. The ALJ concluded that staff were not using the harnesses properly, and we have concluded that substantial evidence supports that finding. Furthermore, contrary to what SunBridge asserts, the ALJ properly addressed foreseeability. As we indicated in Maine Veterans' Home, the question of foreseeability is not focused on whether the particular accidents could be foreseen, but rather whether the staff's routine misuse of the safety harnesses foreseeably increased the risk of serious harm to any resident riding in a wheelchair in SunBridge's van, not just in the event of an accident. DAB No. 1975, at 6-7. The ALJ found that it did.

> The risks to residents were inherent in Petitioner's staff's failure to comprehend how properly to use a necessary safety device that had been installed in the van by its manufacturer. Those risks created a high likelihood of eventual serious injury, harm, impairment, or death to a resident whether or not the improper fastening of the harnesses was the specific cause of the accidents sustained by the two residents.

ALJ Decision at 5. The ALJ also found the "hazard caused by improper fastening of the harnesses . . . entirely foreseeable because even a simple demonstration of their use established the consequences of fastening a harness to a floor anchor located in front of, as opposed to one located behind, a wheelchair." Id. We find no error in the ALJ's analysis. Indeed, it is consistent with our decisions and with the evidence of record.

Furthermore, under the analysis we articulated in Maine Veterans' Home, 42 C.F.R. § 483.25(h)(1) imposes on a long-term care facility a "continuum of responsibilities" to identify, remove,

and protect residents from hazards. DAB No. 1975, at 6-7. This "continuum of responsibilities" includes conducting adequate investigations into accidents to determine whether their underlying cause or causes can be addressed and do not pose ongoing, foreseeable hazards. Here, substantial evidence supports the ALJ's determination that SunBridge failed to conduct thorough investigations into the accidents. Had thorough investigations been done, they would have revealed that staff was incorrectly using the equipment.

As the ALJ noted, the accident report completed after the incident with Resident #1 on August 8, 2005, says that the resident did "slide out" of the wheelchair, yet contains no analysis of why the resident slid out of the wheelchair when the van made a sudden stop. ALJ Decision at 7 (citing P. Ex. 11). The report did not even mention the seat belts, even though Resident #1's wife, who was following the van at the time of the accident, informed the social worker that she observed her husband "goin[g] head first out of the wheelchair;" and that when she went to assist the driver, she observed "the wheelchair on top of her husband, who didn't have a seat belt on." CMS Ex. 13 at 23 (emphasis added); see also CMS Ex. 14, at 1 (Grievance/Complaint Report). The wife's allegations, as reported in the social progress notes, should have caused SunBridge staff not merely to inspect the safety belts to determine whether they were broken, but also to review thoroughly the manner in which the driver was securing the occupant restraints. Yet, as discussed, the accident reports provide no evidence of such a review.

We additionally reject as irrelevant SunBridge's argument that the positions in which Residents #1 and #3 were riding in the van were so different that it was not foreseeable that Resident #3 might sustain "an arguably similar injury several months [after the first accident]." P. Br. at 43. Foreseeability does not require being able to foresee that an accident will happen in the same way or result in similar injuries. Cf. Josephine Sunset Home, DAB No. 1908 (2004) (rejecting the proposition that an accident cannot be considered foreseeable unless it previously "occurred to the same person in the precise manner," and further stating that "[f]or a risk to be foreseeable, it need not have been made obvious by having already materialized"). Substantial evidence in the record indicates that SunBridge should have known that its drivers were not properly securing the harnesses and foreseen that failing to do so risked injuries to improperly-secured wheelchair-bound passengers, regardless of any differences in how the residents were positioned in their wheelchairs.

Furthermore, even if we accepted (which we do not) that SunBridge could not reasonably have foreseen the hazard posed by improperly fastening the safety belts based on the first accident, that hazard certainly was foreseeable after the second accident. Yet, at the time of the survey, approximately two months after Resident #3's accident, the drivers were still fastening the safety belts improperly.

Accordingly, we conclude that substantial evidence in the record as a whole supports the ALJ's conclusion that the risk posed to SunBridge residents by its staff's improper use of the van safety harnesses was foreseeable.

C. The ALJ did not exceed his authority or deny SunBridge a full and fair hearing.

SunBridge contends that the ALJ exceeded his authority by sustaining the CMPs on grounds other than those cited by the state agency and CMS. Specifically, SunBridge argues that the state agency and CMS based their deficiency determinations on findings that the safety belt systems in the van were inadequate and that the state agency required SunBridge to use wheelchair "waist restraints" not intended for vehicular transport to supplement the van's safety belts. P. Br. at 1-2. Rather than addressing the deficiencies as framed by the state agency and CMS, SunBridge submits, the ALJ determined that the cause of the noncompliance was SunBridge staff's failure to use the van's installed restraint systems correctly. The ALJ's "theory" was "never made before the hearing by the SSA or CMS," SunBridge contends. P. Br. at 3. Further, by "locking [SunBridge] into written direct testimony filed far in advance of the hearing," SunBridge submits it was denied a full and fair opportunity to address this "iteration of the deficiency first expressed in [the ALJ] Decision." Id. at 3-4, 38. Moreover, SunBridge argues, the ALJ misapplied the concept of de novo review to mean that he could "substitute a rationale for the agency's action that the agency itself did not express . . . without providing [SunBridge] a full and fair opportunity to offer evidence to address the issue." P. Br. at 38.

We have already indicated our agreement with the ALJ's conclusion that this argument is a "straw man." See pages 11-12, supra. We state more fully here the basis for our agreement. SunBridge's allegations mischaracterize the evidence, survey findings, CMS's determination, and the proceedings below. As reflected in the detailed SOD and in CMS's notification to SunBridge of its determination, the state agency and CMS concluded that SunBridge did not meet the participation requirement at 42 C.F.R.

§ 483.23(h)(1) because the manner in which SunBridge staff transported wheelchair-bound residents in the van was unsafe. CMS Exs. 2, 4. The determinations were not based on findings that the occupant restraint harnesses were inherently defective or broken, or that SunBridge failed to use supplemental lap belts, but on findings that *as SunBridge employees used and demonstrated the safety belts for the surveyor*, the residents were not safe and secure for transport. Accordingly, the state agency described the grounds for SunBridge's noncompliance with section 483.25(h)(1) of the regulations in the SOD as follows:

> . . . the facility *failed to provide safe transportation* for 2 of 2 residents that resulted in injuries for the residents . . . The facility will remain out of compliance . . . *until a method to use to safely secure residents for transport is implemented and facility drivers can be in-serviced regarding changes in the method to safely secure residents for transportation* . . . .

CMS Ex. 4 at 1, 20 (emphasis added). The SOD describes the basis of SunBridge's noncompliance with section 483.75 similarly, stating that "facility administration failed to ensure that 2 of 2 residents were secure during transport." Id. at 19.[15] Thus, as the ALJ observed, the state agency based the deficiency findings on the manner in which SunBridge was transporting wheelchair-bound residents in the van, not on grounds that SunBridge was required, but failed, to use equipment not intended for transportation safety to supplement the van's installed occupant restraints. CMS's determination was based, in turn, on the deficiency findings stated in the SOD. CMS Ex. 2.

Furthermore, the SOD documented that SunBridge did not have instructions showing how the safety belts were to be secured properly, and described the May 11 demonstration of the safety belt system in which a driver and the Maintenance Director showed conflicting understandings of where the safety belts were to be anchored to the floor and wherein the method demonstrated by the driver plainly failed to provide an adequate pelvic restraint. CMS Ex. 4, at 6-7. Therefore, the SOD provided SunBridge adequate notice that the manner in which employees secured the belts was at issue.

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[15] The SOD also states that the facility would remain out of compliance with the administration requirement "until drivers can be in-serviced on procedures to follow at the time of an emergency." CMS Ex. 4, at 20.

SunBridge's arguments to the contrary rest in part on the SOD's recounting of a second survey demonstration of the van safety belt system that occurred on May 12, 2006, a day after the first demonstration on which the ALJ relied. In the second demonstration, the DON sat in the wheelchair and after securing the van's safety harness, the Administrator and/or Maintenance Director "fastened the DON to the wheelchair" using a "portable lap (seat) belt." CMS Ex. 4, at 16. The surveyor wrote on the SOD her observation that the "DON was not able to slip forward when the shoulder harness and the lap belt were both in place." Id.

SunBridge also relies on the fact that its credible allegation of compliance, which was accepted on May 12, 2006 and resulted in the immediate jeopardy being lifted, included: "Residents identified, as using facility transportation on a weekly basis (dialysis) will have personal safety belts attached to the individual wheelchair[s]" and "[o]n 05/11/06, a gerichair and a wheelchair were identified for use with lap belts as well as the shoulder harnesses. . . ." CMS Ex. 4, at 1, 17-18, 21. Based on this evidence and the testimony of its own witnesses, SunBridge argues that the failure to use supplemental waist restraints not intended for use in motor vehicles was the basis of the deficiency findings.

In our view, SunBridge's reliance on this evidence for its theory that it was found out of compliance because of a failure to use supplemental restraints is misplaced. The significance, if any, of the surveyor's description of the May 12, 2006 demonstration on the SOD and in her notes is not clear on the face of that evidence, and we find nothing in the record that ties the demonstration to the state agency's or CMS's decision to lift the immediate jeopardy. We note that, despite the significance SunBridge now attributes to the surveyor's statements about this demonstration, SunBridge's counsel did not specifically question the surveyor about these statements when he cross-examined her at the hearing. He did attempt, unsuccessfully, through other lines of questioning, to elicit from the surveyor testimony that she required the facility to use supplemental restraints in order to correct the noncompliance. The surveyor testified instead that she did not tell SunBridge administrators and employees they had to use supplemental belts to correct the deficiencies. Tr. at 33.[16]

[16] SunBridge mischaracterizes the surveyor's testimony (continued...)

SunBridge's brief cites an excerpt from the surveyor's testimony that SunBridge says is "obviously referring to the May 12 demonstration ... ." P. Br. at 19, citing Tr. at 47. That cited statement is as follows: "When this [looking at SunBridge's pictures of its van safety harnesses] was attached to the DON in a later demonstration, and when she was secured with the belts behind her, she didn't move forward." Even assuming this testimony refers to the May 12 demonstration, the fact that the surveyor was testifying while looking at pictures of the van safety harnesses, not supplemental restraints, suggests she was focusing on where the harnesses were fastened (behind the DON), not on the fact that a supplemental belt was being used in addition to the harness. See Tr. at 47. It is also worth noting

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[16](...continued)
and survey notes as showing that the surveyor believed supplemental lap belts were necessary to keep passengers safe and that the survey agency required SunBridge to use them. P. Br. at 7-8 (citing Tr. at 28, 32-33), 10-11 (citing Tr. at 61); CMS Ex. 8, at 5. The evidence cited by SunBridge does not support these contentions. Pages 28 and 61 of the transcript contain the surveyor's statements to the effect that the van's safety belts failed to secure residents to their wheelchairs. However, in context, it is clear that the surveyor was talking about keeping residents secure in their wheelchairs by properly using the existing van restraint system – fastening the harness to the floor behind the wheelchair – not to attaching them to their wheelchairs by using supplemental restraints. The ALJ articulated this understanding on the record following his extended questioning of the witness to clarify the alleged basis for the noncompliance. See Tr. at 46-47, 50, 52. "The gist of her testimony . . . is that the facility learned . . . that fastening the belt in front of the resident enabled the resident to slide out of the wheelchair . . . ." Id. at 52. After that statement, SunBridge's counsel stated that "the judge has summarized what I understand your testimony so far to be pretty well." Id. CMS Exhibit 8, page 5, cited by SunBridge, is merely the surveyor's notes on what SunBridge's Administrator told her SunBridge had chosen as the elements of its credible allegation of compliance. Page 33 of the transcript contains a denial by the surveyor, consistent with her other testimony, that she told the facility that it must use supplemental belts in order to correct the noncompliance. On page 61 of the transcript, the surveyor stated, again consistent with her other testimony, that the method that SunBridge used to abate the immediate jeopardy was the facility's choice.

that the surveyor's statement gave SunBridge's counsel an opportunity to pursue this matter, but he did not do so.

With respect to the credible allegation of compliance, SunBridge chose to make the use of supplemental lap belts part of that allegation. Under the survey process the surveyor's "primary role" is "to assess the quality of care and services and to relate those findings to statutory and regulatory requirements for program participation." 42 C.F.R. § 488.110(m). While the surveyor is expected to explain the reason for a deficiency finding to the facility officials, the surveyor is not expected to try "to determine the root cause of any deficiency" if it is not obvious, nor is the surveyor to "recommend or prescribe an acceptable remedy." Id. Rather, it is the provider's responsibility to decide on and implement the actions necessary to achieve compliance. Id. Thus, as the ALJ noted, "[c]orrection of the deficiency was Petitioner's responsibility and the way in which it corrected the deficiency was Petitioner's choice." ALJ Decision at 10, n.5.

In addition, SunBridge's allegation of compliance sets out a number of different steps to correct the deficiencies, including contacting a "van products company" for "alternative methods for securing a resident in a wheelchair in the van." CMS Ex. 4, at 16-17, 20-21. The allegation further provided that, once SunBridge had heard from the company, "a decision [would] be made on the most effective measure to implement to secure residents." CMS Ex. 4, at 17, 21. The allegation of compliance also provided that "until a decision is made, other arrangements will be made to transport residents." Id. Thus, SunBridge provided CMS with a number of reasons for abating the immediate jeopardy that had nothing to do with supplemental restraints.[17]

Furthermore, even assuming (which we do not) that the SOD did not by itself provide clear notice to SunBridge as to CMS's basis for finding noncompliance, the ALJ did not err in developing and evaluating the evidence, nor did he deny SunBridge a full and fair opportunity to present its case. ALJ review is de novo. Thus, the issue before the ALJ is whether "the evidence as it is developed before the ALJ" supports the finding of noncompliance,

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[17] We also note that, while SunBridge's argument assumes that the term "lap belt" means the waist restraint device sometimes prescribed for residents needing postural support in wheelchairs, the surveyor plainly used the term "lap belt" in her testimony to refer to the part of a van wheelchair harness that provides pelvic restraint. Tr. at 40-46.

"not . . . how CMS evaluated the evidence as it stood at whatever point CMS made its assessment." Emerald Oaks, DAB No. 1800, at 13, 16 (2001). The ALJ hearing is not a "review of how or why CMS decided to impose remedies," nor is it "restricted to the facts or evidence that were available to CMS when it made its decision." Beechwood Sanitarium, DAB No. 1906, at 28-29 (2004), *motions granted in part and denied in part*, Beechwood v. Thompson, 494 F.Supp.2d 181 (W.D.N.Y. 2007). Rather, the hearing provides a fresh look by a neutral decision-maker at the legal and factual basis for the deficiency findings underlying the remedies. Id.

In this case, the ALJ properly admitted evidence into the record and heard testimony that enabled him to take a "fresh look" at the factual underpinnings of CMS's deficiency determinations. As the hearing proceeded, the ALJ "inquire[d] fully into all of the matters at issue, and received in evidence the testimony of witnesses and . . . documents that [were] relevant and material," as required by the regulations governing the conduct of hearings. 42 C.F.R. § 498.60(b). Based on the evidence and testimony presented, the ALJ concluded that the underlying deficiencies involved SunBridge staff's incorrect use of the van's safety belts. That the ALJ reached this conclusion did not, however, introduce an unrelated issue or aspect of the residents' care into the proceedings or change the fundamental basis of the deficiency citations – the failure of the facility to provide safe transportation for wheelchair-bound passengers in SunBridge's van, which posed a foreseeable accident hazard to SunBridge residents.

Moreover, the record shows that during the course of the proceedings below, SunBridge knew that the subject of how its employees should have secured the van's safety harnesses was at issue, and SunBridge had ample opportunity to respond to the testimony and evidence on which the ALJ relied to support his conclusion about the deficiencies. SunBridge did, in fact, respond to it. For example, during the hearing the surveyor answered a number of questions asked by the ALJ about the van safety belt demonstrations and where on the van floor staff anchored the safety belt systems. Tr. at 42-46. After that exchange, counsel for SunBridge cross-examined the surveyor at length, asking questions not only about the May 11 demonstration but also about whether the surveyor had actual knowledge of how and where the belts had been fastened during the accidents involving Residents #1 and #3. Tr. at 47 - 58. Also, as previously discussed, the DON testified, albeit unclearly, on that issue. Moreover, in its posthearing submission, SunBridge specifically addressed the "dispute at the hearing regarding how

these shoulder/lap belts were secured to the floor of the van." SunBridge Br. at 10-13.

Thus, SunBridge's arguments that it was denied fair opportunity to respond to the evidence supporting the ALJ's determination about the basis for a finding of noncompliance are contradicted by the evidence, hearing testimony and SunBridge's own posthearing submission.

D. The ALJ did not err in concluding that the term "resident environment" in section 483.25(h)(1) includes a motor vehicle owned and operated by the long-term care facility to transport residents.

SunBridge also submits that section 483.25(h)(1) does not give CMS "the legal authority to regulate the safety equipment on motor vehicles, or a nursing facility's operation of a motor vehicle." P. Br. at 38. SunBridge concedes that the Board rejected the same argument in Liberty – Mecklenberg but notes that the decision is currently on appeal to the Fourth Circuit Court of Appeals. SunBridge states that it wishes to preserve its right to pursue this issue should the Court of Appeals reverse the Board's interpretation of the regulation. SunBridge further argues that, while there are circumstances wherein a facility is required by section 483.25(h)(1) "to extend protective oversight . . . beyond the facility's walls," the Board's decision in Liberty is "overbroad and unrealistic." P. Br. at 40.

In Liberty – Mecklenberg, the petitioner argued that 42 C.F.R. § 483.25(h)(1) does not authorize CMS to impose remedies based on a facility's method of transporting wheelchair-bound residents in a motor vehicle because the term "resident environment" in the regulation does not include motor vehicles that take residents off-site for treatment or services. The ALJ rejected that argument and the Board agreed, concluding that "resident environment" for purposes of the regulation includes "all the spaces where the facility is responsible for the resident: whether it be in the buildings, on the grounds, in facility-operated vehicles, etc." DAB No. 2095, at 8 (citing ALJ Ruling at 1). The Board found the ALJ's reading of the term "resident environment" consistent with the language and context of the regulation, which emphasizes resident safety and protection and does not expressly limit the scope of the "resident environment." Id. at 8. "Clearly," the Board said, "the Secretary intended the term 'resident environment' to be construed as broadly as necessary to protect residents whose care facilities like Liberty have undertaken to provide." Id. Further, the Board concluded

that the ALJ's construction of the regulation was consistent with the quality of care principle underlying the specific participation requirements listed under section 483.25 of the regulations, that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being, in accordance with the comprehensive assessment and plan of care." 42 C.F.R. § 483.25. Id. The Board further affirmed the ALJ's rejection of Liberty's argument that by including a facility van transporting a resident within the scope of "resident environment" the federal government was undertaking to regulate vehicle safety, a responsibility normally consigned to states. Id. at 9. The Board agreed with the ALJ that "when a facility transports residents under its care in a van, the van is the resident environment, and the regulations apply, regardless of whether the van's equipment and operation is subject to regulation by another authority or not." Id. (citing ALJ Ruling at 2).

We conclude that the reasoning set forth in the Board's decision in Liberty – Mecklenberg is applicable here, and that the term "resident environment" in section 483.25(h)(1) includes the van that was owned and maintained by SunBridge, operated by staff trained and paid by SunBridge, and used to transport residents as part of the care SunBridge provided to them. By imposing CMPs against SunBridge for its violation of section 483.25 of the program regulations, CMS is properly enforcing federal participation requirements designed to ensure that the resident environment remains as free as possible of accident hazards, including hazards created by a facility's failure to properly use facility-owned and controlled safety equipment. This neither supplants nor interferes with state enforcement of motor vehicle laws.

E. The ALJ Decision does not conflict with the Board's decision in Liberty – Mecklenburg.

SunBridge argues that the "result" of the ALJ Decision is "that CMS's 'accident hazards' regulation [at 42 C.F.R. 483.25(h)(1)] *required* [SunBridge] to use some kind of waist restraints to supplement its van's safety belts. . . ." Id. at 1 (emphasis in original). This result, SunBridge argues, squarely contradicts the Board's decision in Liberty - Mecklenberg where, SunBridge asserts, the Board concluded that 42 C.F.R. 483.25(h)(1) *"prohibited* exactly that practice." Id. at 1 (emphasis in original); Id. at 2.

There is no merit to this argument. In the first place, we have already rejected SunBridge's assertion that the ALJ Decision here was based on failure to use supplemental restraints; we concluded, instead, that it was based on staff failure to properly use the existing van seat belt system. Thus, the use or non-use of supplemental restraints is simply not at issue. Furthermore, the cases are factually inapposite. In Liberty – Mecklenberg, the Board found the facility out of substantial compliance with the accident hazard regulation not because the facility was not properly using existing safety harnesses but, rather, because two of the four van safety harnesses for its wheelchair-bound residents were missing, and staff used soft waist belts (postural support waist restraints) instead when transporting more than two such residents at the same time. Furthermore, the evidence of record in Liberty – Mecklenberg showed that the "soft belts" were not intended to be used as vehicle restraint systems and, in fact, posed rather than prevented a risk of harm to the resident being transported.

2. The ALJ's finding of noncompliance with 42 C.F.R. § 483.75 beginning March 6, 2006 and ending June 19, 2006, is supported by substantial evidence and free of legal error.

Section 483.75 requires that "a facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain the highest practicable physical, mental, and psychosocial well-being of each resident." As the ALJ wrote, the regulation imposes a duty on facility management to assure that staff identify and address accident hazards. ALJ Decision at 10-11. The ALJ found that SunBridge did not meet this obligation because "management failed to comprehend" that staff were improperly using the van's safety harnesses. ALJ Decision at 11. According to the ALJ, SunBridge's administration should have recognized after the March 6, 2006 accident that there might be a serious problem relating to the staff's use of the van safety equipment. The ALJ also determined that SunBridge managers should have conducted more thorough investigations into the accidents, which would have revealed the hazard.

On appeal, SunBridge argues that a provider's noncompliance with another participation requirement – such as section 483.25(h)(1) here – does not, in itself, sufficiently establish the facility's noncompliance with the administration requirements. Rather, it argues, there must be a nexus, or connection, between the facility's noncompliance and the way in which the facility is administered to establish a deficiency under section 483.75. In this case, SunBridge submits, there is no such connection. SunBridge contends that CMS "offered no evidence" to show that

administrators "had any reason for unusual concern about use of its van." Further, SunBridge argues, management did "promptly and reasonably investigate Resident #1's accident, and simply drew different conclusions about the cause and consequences of that accident than did CMS." P. Br. at 53.

We find these arguments unpersuasive. As detailed above, substantial evidence supports the ALJ's conclusion that both accidents provided compelling reasons for managers to consider not only whether the van's safety equipment was not in working order, which is what the facility did, but also whether employees were *using* the equipment properly. CMS Exs. 4, 13, 14, 16. Management, however, failed to ascertain the latter or otherwise adequately analyze *why* the accidents occurred. We additionally note that SunBridge's own corporate policy directs managers and supervisors to "immediately investigate the accident to determine the [ro]ot cause of the accident. Once a cause is determined, steps must be taken to eliminate that cause in the future." P. Ex. 27, at 22.

The ALJ also sustained CMS's determination that SunBridge did not meet the participation requirement of section 483.75 because SunBridge's administration failed "to assure that the staff followed prescribed emergency procedures." ALJ Decision at 11-12. Specifically, the ALJ concluded that, in responding to the March 6, 2006 accident, management and staff did not follow the facility's emergency policy, set forth in the Sun Healthcare Group, Inc., Fleet Safety and Vehicle Operating Manual, that in the event of an accident, an injured person should not be moved if movement is likely to cause further injury. ALJ Decision at 11-12 (citing P. Ex. 27, at 22). The ALJ determined that SunBridge's management, contravening this policy, instructed the driver to drive the resident to the facility with the resident lying on the floor of the van.[18] ALJ Decision at 12.

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[18] The section of the vehicle operating manual cited by the ALJ also requires drivers to "[c]all the police, fire department and ambulance service," in the event of an accident. P. Ex. 27, at 22. The facility Administrator, however, testified that the driver at the time of Resident #3's accident was told to call the facility for directions. Tr. at 92-93. The ALJ Decision does not specifically address this apparent discrepancy between the operating manual and the directions given to the driver. Accordingly, neither the ALJ's decision nor ours relies on this aspect of the operating manual. However, we note that SunBridge's corrective action plan included instructing drivers

(continued...)

We conclude that substantial evidence supports the ALJ's determination. The evidence shows that the driver attempted to return the already injured resident to the wheelchair; when unsuccessful, the driver phoned the facility, whereupon the DON instructed the driver to position the resident flat on the floor of the van, cover her with a blanket, and return to the facility for assessment. P. Ex. 44, at 2; CMS Ex. 4, at 3, 7-8. These actions and instructions, the ALJ concluded, violated SunBridge's established corporate policy not to move injured persons if doing so would likely cause further injury, thereby putting the resident at risk of additional, preventable harm. P. Ex. 27, at 22. Notably, nowhere does SunBridge directly dispute that these actions and instructions violated established corporate policy.

SunBridge argues on appeal that CMS did not provide any notice before the hearing that the basis for the second deficiency citation included the employees' response to the second accident. P. Br. at 31-32. Further, SunBridge argues, the ALJ disregarded the evidence that SunBridge had other pertinent policies and procedures for drivers to follow in the event of an accident and that the driver appropriately followed those procedures. SunBridge also contends that the ALJ erroneously "substitute[d] his own opinion about a clinical issue for the clinical judgment of [SunBridge] staff, which actually was made in real time to address a real emergency." Id. This "subjective critique," SunBridge argues, ignored the reality of the options available to the van driver. Id.

These arguments are without merit. The summary in the SOD sets forth two bases for the administration deficiency. The first is premised on management's duties to assure that accident hazards are reasonably identified and corrected. The second relates to management's failure to assure that staff and management would respond appropriately to the emergency involving Resident #3 in the second accident. SOD, CMS Ex 4, at 19-20. The SOD explicitly states that SunBridge "was left out of compliance at a scope and severity level E until . . . drivers can be in-serviced on procedures to follow at the time of an emergency." Id. Further, SunBridge's allegation of compliance makes clear that SunBridge had notice at the time of the survey that the deficiency, in part, involved how employees had responded to the second accident.

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[18](...continued)
to call 911 in the event of an emergency.

> . . . [d]rivers will be in-serviced on procedures to take whenever maintenance problems or unexpected events occur with the vehicle. The driver will be instructed to get to a safe location, put on flashers, and notify emergency personnel if needed and then notify the administrator or DNS (director of nursing service) for further instructions. In the event of an emergency or accident, the drive[r] is to render all reasonable assistance to injured persons, contact police, fire department and/or ambulance service using 911.

CMS Ex. 4, at 21. Thus, we reject SunBridge's argument that it did not have notice that a basis for the deficiency involved its policies and procedures for responding to vehicular accidents.

We further reject SunBridge's arguments that the ALJ erroneously substituted his own opinion about a clinical issue for the clinical judgment of staff. In upholding the deficiency, the ALJ did not evaluate SunBridge employees' response to the second accident based on his own clinical judgment. Rather, the ALJ evaluated SunBridge employee and management actions based on SunBridge's own written corporate policies as set forth in the "Fleet Safety and Vehicle Operating Manual." ALJ Decision at 11-12 (citing P. Ex. 27). That manual specifically states that a supervisor is to train all drivers on "how to report an accident and what to do at the scene." Id. at 22. The manual also explicitly provides that drivers should not move injured persons if doing so is "likely to cause further injury."[19] Id. Nowhere in the manual does it state that there may be exceptions to these policies based on a facility's rural and remote location or the proximity of the vehicle to the facility at the time of the accident. In light of the evidence, the ALJ properly determined that SunBridge management failed to comply with and enforce the facility's own written policies.

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[19] The ALJ determined that, since the driver was not trained to assess the resident's injuries and accurately communicate the resident's condition at the time of the accident, management were in no position to make an informed judgement about whether it was safe to move "the unrestrained resident, lying on the van's floor, for even a short distance." ALJ Decision at 12.

3. The ALJ did not err in determining that SunBridge failed to prove that CMS's determination of immediate jeopardy was clearly erroneous.

We uphold the ALJ's determination that the deficiencies were properly cited at the immediate jeopardy level. The regulations define "immediate jeopardy" as 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. The evidence of record, much of it submitted by SunBridge and discussed in detail above, shows that on a routine basis SunBridge staff did not properly secure the van safety harnesses. Consequently, residents transported in the van were exposed to the "self-evident" dangers of traveling in a motor vehicle without the protection of properly used, necessary safety devices. ALJ Decision at 12. The inherent risks posed by SunBridge's noncompliance, the ALJ reasonably concluded, were likely to result in serious injury, harm or even death. ALJ Decision at 5, 12-13. As the ALJ further concluded, that likelihood of serious harm was all that was necessary to uphold the immediate jeopardy determination; CMS need not show that actual harm occurred.[20] Id. ("Even in the context of immediate jeopardy, CMS need only determine that serious harm was likely, not that it necessarily occurred." Briarwood Nursing Center, DAB No. 2115, at 12 (2007), citing Southridge Nursing and Rehabilitation Center, DAB No. 1778 (2001) (upholding immediate jeopardy determination despite the lack of serious actual harm and noting that it was merely "fortuitous" that such harm did not occur) and Daughters of Miriam Center, DAB No. 2067 (2007).)

SunBridge argues on appeal that even if CMS's deficiency determinations are upheld, these determinations do not, in themselves, show that SunBridge's noncompliance was "so dire as to make death or serious injury 'likely' for any of Petitioner's residents. . . ." P. Br. at 54. This argument ignores the law that once CMS has determined that the noncompliance was likely to cause serious injury or harm, it is the provider's burden to prove that determination "clearly erroneous." 42 C.F.R.

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[20] However, the ALJ further observed, and we agree, that the record shows that it was "highly likely that an improperly attached harness, in the case of Resident #3, caused that resident to slide out of her wheelchair." ALJ Decision at 5. The injury sustained by Resident #3, a fractured distal femur, would be serious actual harm for anyone and certainly for a frail elderly resident of a nursing home.

§ 498.60(c)(2). Our decisions make it clear that this is a heavy burden. E.g., Daughters of Miriam Center, DAB No. 2067, at 7 (2007); Liberty Commons Nursing & Rehab Center v. Johnston, DAB No. 2031 at 18-19 (2006), aff'd, Liberty Commons Nursing and Rehab Center – Johnston v. Leavitt, 241 Fed. Appx. 76 (4th Cir. 2007).

The ALJ found that SunBridge did not carry this burden of proof, and we agree. In addition to the evidence that we have addressed above, SunBridge relies on a National Highway Traffic Safety Administration (NHTSA) report to support its contention. P. Br. at 54 (citing P. Ex. 32). SunBridge states that the NHTSA report "indicates that serious injuries and death to wheelchair bound passengers riding in vans actually are extremely rare" and shows that during the 1991-1995 period, "only two wheelchair users (of all ages) were killed, and probably less than 100 elderly wheelchair users were seriously injured, in van accidents relating to 'improper or no securement.'" Id. SunBridge has not accurately described the 1997 NHTSA report. The report shows, among other things, estimated numbers of wheelchair users injured or killed by non-crash related activities from 1991-1995, the type of vehicles involved, the severity of the injuries, the causes of the injuries, and the estimated ages of the wheelchair users. P. Ex. 32. See also Liberty - Mecklenberg at 14-15 (discussing the NHTSA report). The report does not, however, address the probabilities of a wheelchair user sustaining harm, injury or death due to improper use of a van safety harness. P. Ex. 32. Thus, it is not probative of whether SunBridge's residents were likely to sustain harm, injury or death as a result of Petitioner's deficiency. Moreover, we note that the report states that the estimates contained in it may be "considered conservative" because the study did not capture all potentially relevant data. P. Ex. 32, at 1. Even using its conservative estimates, the report indicates that the number of wheelchair users injured or killed because of improper or no securement between 1991 and 1995 was 2,494, hardly a negligible amount, as SunBridge seems to imply. Finally, the table on which SunBridge relies for its assertion that "only two wheelchair users . . . were killed . . . in van accidents relating to 'improper or no securement'" during the 1991-1995 period (Table 5) does not use the same data on which the rest of the report relies. P. Br. at 54. Rather, Table 5 of the report, reflects "additional data" which were "anecdotal," totaled 12 deaths altogether, and could not be used to "extrapolate . . . to national estimates." Id. at 3. Thus, the 1997 NHTSA report falls far short of refuting CMS's determination that SunBridge's deficiency was likely to cause harm, injury or death to wheelchair-bound residents traveling in the van.

4. The ALJ's determination that SunBridge failed to prove that the duration of its noncompliance was for a shorter period than was determined by CMS is supported by substantial evidence and free of legal error.

The ALJ concluded that SunBridge did not prove that it abated the conditions creating the immediate jeopardy prior to May 12, 2006, or that it attained full compliance with the participation requirements any earlier than the date CMS determined the noncompliance had ended, June 19, 2006. Consequently, the ALJ upheld CMS's determination as to the duration of the noncompliance periods.

In appealing this finding, SunBridge essentially reiterates its arguments that the underlying deficiency determinations were erroneous and that it was "not noncompliant at all." P. Br. at 56. SunBridge also states that it did nothing to correct the alleged deficiencies other than "reinforce existing policies and procedures." Id. Nevertheless, SunBridge submits that if the Board finds a regulatory violation, "such noncompliance certainly did not persist for some nine months, at a cost of some $270,000." Id. We have already rejected SunBridge's argument that it was not noncompliant. Once a facility is found out of compliance it remains out of compliance until CMS finds that it has achieved substantial compliance "based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit; or . . . CMS or the State terminates the provider agreement." 42 C.F.R. § 488.454(a); see also 42 C.F.R. § 488.440 (providing that a per day CMP accrues until the facility achieves substantial compliance or the provider agreement is terminated). The skilled nursing facility has the burden of proving that it achieved substantial compliance on a date earlier than that determined by CMS. 42 C.F.R. § 488.454(e); Brier Oak Terrace Care Center, DAB No. 1798, at 8-9 (2001). SunBridge has submitted no evidence to substantiate its bare assertion.

Accordingly, we uphold the ALJ's conclusion that SunBridge failed to prove that the duration of its noncompliance was for a shorter period than was determined by CMS.

5. CMPs in the amount of $4,000 per day for the period beginning March 6, 2006 and ending May 11, 2006, and $50 per day for the period beginning May 12, 2006 and ending June 19, 2006, are reasonable.

The ALJ found the amount of the CMP imposed by CMS for the period of noncompliance at the immediate jeopardy level – $4,000 per day

– reasonable. He also sustained the penalty of $50 per day for the non-immediate jeopardy level of noncompliance as a matter of law, because it is the minimum CMP that may be imposed for non-immediate jeopardy level noncompliance.

On appeal, SunBridge argues that there was no basis for imposing any CMP, but we have already rejected that argument by upholding the ALJ's findings of noncompliance and immediate jeopardy. SunBridge also asserts that the ALJ failed to consider whether the CMPs had a "remedial" purpose and that "the Board has made clear that where such a 'remedial' purpose is absent, the CMP may take on the characteristics of an ultra vires, and therefore improper, penalty." P. Br. at 55, citing Emerald Oaks, DAB No. 1800 (2001); Careplex of Silver Spring, DAB No. 1683 (1999). SunBridge further argues that it was unclear what conduct CMS intended the CMPs to deter since it was never clear "what act or omission" supported the immediate jeopardy determination. P. Br. at 54-55. SunBridge also contends that the evidence does not support an enhanced CMP (an amount above the minimal amount) because CMS did not demonstrate that Sunbridge's conduct was particularly culpable or show an interrelationship of the deficiency findings.

With respect to SunBridge's argument that the ALJ was required to evaluate whether the CMPs served a remedial purpose, Petitioner mischaracterizes prior Board holdings. As we previously stated:

> [T]he Board has never held that a CMP may not be imposed as a remedy for noncompliance unless CMS demonstrates that it serves a remedial purpose. The applicable regulations state that "[t]he purpose of remedies is to ensure prompt compliance with program requirements." 42 C.F.R. § 488.402(a). By including CMPs among the remedies CMS may impose for noncompliance with federal requirements for skilled nursing facilities, the Department has already determined that CMPs serve a remedial purpose, and the Board is bound by that determination. If an ALJ or the Board finds that the amount of a CMP is not reasonable under the factors, they can change the amount. However, they cannot eliminate the CMP remedy or reduce the amount to zero. 42 C.F.R. § 488.438(e)(1); see also CarePlex at 16-17. In Emerald Oaks, the Board merely found that the ALJ had committed no error when she concluded that "the amount [of a CMP] imposed was within the reasonable range of amounts appropriate to achieving the remedial purposes of such sanctions." Emerald Oaks at 13 (emphasis added).

Liberty Commons Nursing and Rehab - Almance, DAB No. 2070, at 17-18 (2007), appeal docketed, Liberty Commons Nursing and Rehab - Almance v. CMS, No. 07-1329 (4th Cir. Dec. 14, 2007); see also CarePlex, DAB No. 1683 at 7-8 (indicating that the Secretary's promulgation of 42 C.F.R. § 488.438(f) setting out the factors to be considered when determining a CMP amount implements the remedial purpose of the alternative sanctions [including CMPs] provided for in the governing statute). Furthermore, as discussed in CarePlex and numerous subsequent cases, the regulations specifically prohibit ALJs from considering any factors other than those in 42 C.F.R. § 488.438(f) when reviewing the amount of a CMP. 42 C.F.R. § 488.438(e).

Finally, we reject SunBridge's argument that the evidence does not support a per day CMP of more than the $3,050 minimum the regulations provide for periods of immediate jeopardy. We note at the outset, as did the ALJ, that the $4,000 per day imposed here is close to that minimum. Furthermore, the ALJ determined the reasonableness of this amount by considering the factors in 42 C.F.R. §488.438(f) as he was required to do under the regulations and our cases. As set forth in the ALJ Decision, those factors include: the facility's history of noncompliance, its financial condition, the seriousness of the noncompliance; and the facility's culpability. 42 C.F.R. §§ 488.438(f)(1) - (4). Culpability includes, without limitation, "neglect, indifference, or disregard for resident care, comfort or safety."[21] 42 C.F.R. § 488.438(f)(4).

After noting that neither party had submitted evidence relating to the facility's history or financial condition, the ALJ proceeded to consider the remaining applicable factors for evaluating the reasonableness of the CMPs. The ALJ did this in detail, setting forth his rationale for upholding the $4,000 per day amount based on the seriousness of the deficiencies and the relative culpability of SunBridge. ALJ Decision at 14. The ALJ described the seriousness of the deficiencies in light of the evidence in the record showing the likelihood of harm to SunBridge's residents resulting from SunBridge's consistent failure to use the van's safety equipment as designed. Id. The dangers, he noted, were magnified by the compromised physical and mental conditions of SunBridge residents, such as Resident #3, who sustained a fractured femur merely by sliding out of her wheelchair during transit in the van. Id. Contrary to SunBridge's assertions, the ALJ also took into account evidence

[21] However, the absence of culpability is not a mitigating circumstance in reducing the amount of a CMP. Id.

relating to SunBridge's culpability, noting, in particular, SunBridge management's failure to investigate adequately the cause of the accident involving Resident #3. In sum, the ALJ properly reviewed the evidence as developed in the record and set forth detailed explanations to support his de novo determination that the CMP amount for the immediate jeopardy period was reasonable.

Finding no error in the ALJ's evaluation of the CMP amounts, we uphold his determination that the CMP imposed for the immediate jeopardy period was reasonable in amount and that the CMP for the subsequent period was reasonable as a matter of law.

Conclusion

Based on the above analysis, we uphold the ALJ Decision and affirm and adopt all of the ALJ's FFCLs.

/s/
Judith A. Ballard

/s/
Leslie A. Sussan

/s/
Sheila Ann Hegy
Presiding Board Member