Department of Health and Human Service

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	Date: May 22, 2009
Carver Living Center (CCN: 34-5434),	)	
	)	
Petitioner,	)	Docket Nos. C-07-316
	)	Decision No. CR1954
v.	)	
	)	
Centers for Medicare & Medicaid Services.	)	

DECISION

Petitioner violated 42 C.F.R. § 483.25(h)(1)[1] on November 14, 2006, and did not return to substantial compliance with program participation requirements until January 26, 2007. The civil money penalty (CMP) proposed by the Centers for Medicare & Medicaid Services (CMS) is not reasonable. A CMP of $3050 per day from November 14, 2006 through December 7, 2006, and a CMP of $50 per day from December 8, 2006 through January 24, 2007, a total CMP of $75,600, is reasonable.

I. Background

Petitioner, located in Durham, North Carolina, is authorized to participate in Medicare as a skilled nursing facility (SNF) and in the North Carolina Medicaid program as a nursing facility (NF). Petitioner was subject to surveys by the North Carolina Department of Health and Human Services, Division of Facility Services (the state agency), that were completed on October 12, 2006, November 29, 2006, December 21, 2006 and January 25, 2007.

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[1] All references are to the Code of Federal Regulations (C.F.R.) in effect at the time of the survey unless otherwise indicated.

The state agency notified Petitioner by letter dated October 18, 2006, that CMS would be required to deny payment for new admissions to Petitioner effective January 12, 2007, based upon the findings of deficiency from the survey ended on October 12, 2006, if Petitioner did not return to substantial compliance before that date. The Centers for Medicare & Medicaid Services (CMS) notified Petitioner by letter dated January 16, 2007, based upon the findings of the survey completed on December 21, 2006, that it was imposing a CMP of $3050 per day from November 14, 2006 through December 20, 2006, and a CMP of $100 per day from December 21, 2006, until the date on which Petitioner returned to substantial compliance; a denial of payment for new admissions (DPNA) effective January 12, 2007, if Petitioner did not return to substantial compliance prior to that date; and termination of Petitioner's provider agreement effective April 12, 2007, if Petitioner did not return to substantial compliance before that date. CMS also advised Petitioner that its authority to conduct a Nurse Aide Training and Competency Evaluation Program (NATCEP) had to be withdrawn for a period of two years.[2]

Petitioner requested a hearing by pleading dated March 15, 2007. The request for hearing was docketed and assigned to me for hearing and decision on March 20, 2007, and a Notice of Case Assignment and Prehearing Case Development Order (Prehearing Order) was issued at my direction.

A hearing was convened on November 5, 2007, in Raleigh, North Carolina. A 207-page transcript of the hearing was prepared. CMS offered, and I admitted, CMS exhibits (CMS Exs.) 1, 5-7, 13-21, and 24. Tr. 29, 57, 86. Petitioner offered, and I admitted, Petitioner's exhibits (P. Exs.) 1, 4-6, 9, 11-14, and 17-25. Tr. 34. Testifying for CMS was Kathleen Dunn, R.N., a state agency surveyor. Testifying for Petitioner were Jamie Royster and Tonya Mitchell, facility employees who both drove Petitioner's van. CMS and Petitioner filed post-hearing briefs and post-hearing reply briefs (CMS Br. and P. Br. and CMS Reply and P. Reply, respectively).

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[2] Petitioner did not have a NATCEP. Transcript (Tr.) at 12.

II. Discussion

A. Issues

The issues in this case are:

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

Whether the remedy imposed is reasonable.

B. Applicable Law

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

The Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility that is not complying substantially with federal participation requirements. "*Substantial compliance* means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R.

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

§ 488.301 (emphasis in original). A deficiency is a violation of a participation requirement established by sections 1819(b), (c), and (d) of the Act or the Secretary's regulations at 42 C.F.R. Part 483, Subpart B. Facilities that participate in Medicare may be surveyed on behalf of CMS by state survey agencies in order to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-488.28, 488.300-488.335. The regulations specify the enforcement remedies that CMS may impose if a facility is not in substantial compliance with Medicare requirements. 42 C.F.R. § 488.406.

The regulations specify that a CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP, $3050 per day to $10,000 per day, is reserved for deficiencies that pose immediate jeopardy to a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i), (d)(2). Pursuant to 42 C.F.R. § 488.301, "*(i)mmediate jeopardy* means a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." (Emphasis in original.) The lower range of CMP, $50 per day to $3000 per day, is reserved for deficiencies that do not constitute immediate jeopardy but either cause actual harm to residents, or cause no actual harm but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii).

The Act and regulations make a hearing before an administrative law judge (ALJ) available to a long-term care facility against which CMS has determined to impose an enforcement remedy. Act § 1128A(c)(2); 1866(h); 42 C.F.R. §§ 488.408(g); 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *Anesthesiologists Affiliated, et al*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Cal Turner Extended Care Pavilion*, DAB No. 2030 (2006)*; The Residence at Salem Woods*, DAB No. 2052 (2006). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); *see also* 42 C.F.R. §§ 488.330(e) and 498.3. However, the choice of remedies by CMS or the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance found by CMS if a successful challenge would affect the range of the CMP that could be imposed by CMS or impact the facility's authority to conduct a NATCEP. 42 C.F.R. §§ 498.3(b)(14) and (d)(10)(i). The CMS determination as to the level of noncompliance "must be upheld unless it is clearly erroneous" (42 C.F.R. § 498.60(c)(2)), including the finding of immediate jeopardy. *Woodstock Care Center*, DAB No. 1726, at 9, 39 (2000), *aff'd, Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and

severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g.*, *Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). Review of a CMP by an ALJ is subject to 42 C.F.R. § 488.438(e).

The standard of proof or quantum of evidence required is a preponderance of the evidence. CMS has the burden of coming forward with the evidence and making a prima facie showing of a basis for imposition of an enforcement remedy. Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense. *See Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd, Hillman Rehabilitation Ctr. v. United States Dep't of Health and Human Services, Health Care Fin. Admin.*, No. 98-3789 (GEB), slip op. at 25 (D.N.J. May 13, 1999); *Cross Creek Health Care Center*, DAB No. 1665 (1998); *Emerald Oaks*, DAB No. 1800; *Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 F. App'x. 181 (6th Cir. 2005); *Batavia Nursing and Convalescent Inn*, DAB No. 1911 (2004).

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

My conclusions of law are set forth in bold followed by my findings of fact and analysis.

The parties stipulated prior to hearing that the survey completed on November 29, 2006, alleged violations of 42 C.F.R. §§ 483.15(e)(1) (F Tag 246) and 483.25(a)(3) (F Tag 312). Joint Stipulation (Jt. Stip.) ¶ 5. The alleged violation of 42 C.F.R. § 483.25(h)(1) from the December 2006 survey resulted from a complaint to the state agency. Tr. 50-51, 53. Petitioner requested review of the deficiencies from the November and December surveys in its request for hearing but did not request review of the findings of deficiency from the surveys that ended October 12, 2006 or January 25, 2007. The parties stipulated at hearing that no remedy proposed by CMS was based upon the alleged deficiencies from the November survey and that those deficiencies are not at issue before me. Tr. 10-12; P. Br. at 1-2. The parties stipulated that a DPNA was in effect January 16 through 25, 2007 (Tr. 13), however the CMS notice indicates that the DPNA actually began on January 12, 2007 (CMS Ex. 5, at 3). The record reflects that the DPNA that began on January 12, 2007 was actually a mandatory or statutory DPNA that was required to be imposed three months after the findings of deficiency from the survey that ended on October 12, 2006, if Petitioner did not return to substantial compliance prior to the end of the three-month period. CMS Ex. 5; CMS Ex. 22 (not admitted); P. Ex. 6. The parties stipulated that the facility returned to substantial compliance with program participation requirements effective January 26, 2007, and the termination remedy was not effectuated. Tr. 11- 14; P. Ex. 25; Jt. Stip. ¶ 12.

The parties stipulated: that, based upon the alleged violation of 42 C.F.R. § 483.25(h)(1) from the survey completed on December 21, 2006, CMS imposed a CMP of $3050 per day from November 14, 2006 through December 20, 2006; that the state agency surveyors found that immediate jeopardy was abated as of December 21, 2006; and that the CMP was reduced to $100 per day from December 21, 2006 to January 24, 2007. The parties agreed that the alleged violation of 42 C.F.R. § 483.25(h)(1), and the CMPs from November 14, 2006 through January 24, 2007 based on that deficiency, are the only deficiency and remedies at issue before me. Jt. Stip. ¶¶ 9-13; Tr. 24-28; P. Br. at 1-2. Petitioner did not challenge the deficiency finding from a revisit survey completed on January 25, 2007 or the one-day, $150 CMP based on that deficiency. Tr. 26. Petitioner does not challenge or discuss the DPNA in either of its briefs. Although Petitioner alleges in its post-hearing brief that it corrected the alleged violation of 42 C.F.R. § 483.25(h)(1) by December 4, 2006, and that no CMP based upon that deficiency should have continued beyond that date (P. Br. at 12-15; Tr. 38), Petitioner does not dispute before me that it did not return to substantial compliance with program participation requirements prior to January 26, 2007, or that it was properly subject to the DPNA.

1. Petitioner violated 42 C.F.R. § 483.25(h)(1).

(a) Facts

Resident 4 was 76 years of age at the time of the accident that is the subject of the deficiency citation. Her diagnoses included diabetes mellitus, congestive heart failure, end stage renal failure with dialysis, peripheral vascular disease, and hypertension; she also had bilateral above the knee amputations, almost no lap, and was wheelchair bound. CMS Ex. 13, at 1; Tr. 184-85; CMS Ex. 17; P. Ex. 20. Resident 4 did not suffer from long or short-term memory loss and was independent in daily decision-making. CMS Ex. 13, at 2; Tr. 63.

Resident 4 was required to undergo dialysis treatments three times a week as a result of her diabetes and Petitioner was responsible for transporting Resident 4 to and from her dialysis appointments. During transport, Resident 4 was secured in a facility van while sitting in her own wheelchair. On November 14, 2006, Resident 4 and three other facility residents were being transported in the facility van after Resident 4 had been picked up at the dialysis center. The van was driven by certified nursing assistant (CNA) Jamie Royster. Transportation aide CNA Arnecia Langley accompanied Ms. Royster in the van. Ms. Royster placed the van wheelchair restraint system shoulder harness across Resident 4's torso after securing Resident 4's wheelchair to the facility van by locking four wheelchair belts and floor straps (two in front, two in back). The shoulder harness came across Resident 4's left shoulder, across her torso, through the space between the right wheelchair arm and the seat, and affixed to the floor. Ms. Royster did not place a lap belt across Resident 4's lower torso as a lap belt was not part of the van's restraint system. Resident 4 was not wearing a wheelchair lap belt and Ms. Royster was unaware

that she had such a belt in her wheelchair.[4] Ms. Royster was forced to stop suddenly in order to avoid hitting another vehicle that cut in front of the van and then abruptly stopped in order to turn left. After the sudden stop, Ms. Langley observed Resident 4 had slid from her wheelchair to the floor of the van. Ms. Langley told Ms. Royster to stop the van and Ms. Royster pulled the van to the side of the road, turned on the hazard lights, and went back to check on Resident 4. Resident 4 was sitting straight up on the floor. The shoulder harness was still secured after Resident 4 left her seat. Ms. Royster asked Resident 4 if she was o.k. and if she was getting her oxygen and Resident 4 indicted she was not injured, other than scraping her stump. Ms. Royster and Ms. Langley lifted Resident 4 to the edge of her chair and she "scooted" herself back into her chair. Ms. Royster strapped Resident 4 down and proceeded back to the facility. Resident 4 told Ms. Royster upon their return that her leg hurt, and Resident 4 was noted to have an abrasion on her right stump. Upon returning to the facility, Resident 4 complained of hip pain and was sent to the hospital. At the hospital, it was determined that Resident 4 had sustained a hip fracture. Given Resident 4's medical conditions, surgery to fix the hip was ruled out. Resident 4 sustained pain and depression as a result of her injury. Tr. 63, 146-49, 157-59, 171, 172, 174-75, 178; CMS Ex. 17, at 5-8, 12-15, 20-22, 38-43; P. Exs. 13, 14, 15, 16, 19, 20; P. Ex. 23, at 1; P. Br. at 5-6.

The unrebutted evidence is that the restraint system in the facility van had not been recalled, was not broken, was not otherwise damaged, and was reliable. Tr. 120, 189. After November 14, 2006, the facility van was sent out for maintenance and installation of a new restraint system. Tr. 146, 185-86; P. Exs. 21, 22. While the van was being serviced, an independent transportation company transported Petitioner's residents and Petitioner's drivers did not transport residents. Tr. 160, 185-87. On December 5, 2006, the facility's transportation staff received in-service training on the new restraint system, which consisted of an instructional video and quiz provided by the manufacturer regarding proper use of the seatbelt system and a hands-on demonstration session during which Petitioner's transportation staff had to demonstrate their ability to properly use the system to secure a wheelchair and resident. Tr. 160; P. Exs. 10, 11, 24. Jamie Royster and two transportation aides viewed the video and participated in the hands-on in-service training on December 5, 2006. Tr. 160. Tonya Mitchell, a back-up driver, attended the December 5, 2006 hands-on training with the other employees, but did not view the video until December 21, 2006. Tr. 180, 187, 192; P. Ex. 24. However, Ms. Mitchell had

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[4] In a statement dated January 31, 2007, Ms. Royster stated that she did secure Resident 4's wheelchair lap belt. P. Ex. 14, at 1, ¶¶ 8, 15. However, the credible evidence is that she was not aware the resident had a lap belt in her wheelchair. Tr. 148-49, 151-52, 154-57, 171-72, 177.

worked with a restraint system similar to the new restraint system with a prior employer. Tr. 186-88, 192. When Ms. Mitchell viewed the video on December 21, 2006, the only information from the video with which she was not familiar was the section on storage of the system. P. Exs. 11, 12. Petitioner does not remove and store the restraint system. P. Ex. 12. The facility van was returned to the facility on December 8, 2006, following installation of the new restraint system and repair of the mechanical lift. P. Ex. 22.

(b) Analysis

CMS urges that the facts establish a prima facie showing that Petitioner violated 42 C.F.R. § 483.25(h)(1) on November 14, 2006. I agree. CMS can point to no statutory or regulatory requirement, state or federal, which specifies the type of restraints to be used for transportation of people in wheelchairs. CMS Ex. 24, at 6. However, it is not necessary for CMS to cite a specific statutory or regulatory requirement for the safe transport of people in wheelchairs. Participating facilities, such as Petitioner, agree to provide each resident "the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being" (42 C.F.R. § 483.25) based upon a comprehensive assessment of the needs of the resident and the plan of care the care plan team develops as required by 42 C.F.R. § 483.20. The specific quality of care requirement at issue in this case requires a facility to ensure that "[t]he resident environment remains as free of accident hazards as is possible . . . ." 42 C.F.R. § 483.25(h)(1). The State Operations Manual (SOM), CMS's guidance to surveyors, instructs surveyors that the intent of section 483.25(h)(1), is that the facility prevents accidents by providing "an environment that is free from accident hazards over which the facility has control." SOM, Appendix (App.) PP, F Tag 323. The Board has provided some further interpretative guidance for adjudicating alleged violations of the section:

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

Maine Veterans' Home – Scarborough, DAB No. 1975, at 6-7 (2005); *see Liberty Nursing and Rehabilitation Center-Mecklenberg County*, DAB No. 2095 (2007); *Sunbridge Care and Rehabilitation for Pembroke*, DAB No. 2170 (2008).

In this case, Resident 4 required transportation to her dialysis appointments. Petitioner undertook to provide transportation for Resident 4 using its van. Petitioner's van was thus part of Resident 4's environment and Petitioner was obliged to ensure that environment was as free of accident hazards as possible. Petitioner argues that the incident with Resident 4 being ejected from her wheelchair was not foreseeable, i.e. it was not foreseeable that the van driver would have to stop abruptly to avoid hitting a car that cut her off and it was not foreseeable that Resident 4 would be ejected from her wheelchair when the van stopped abruptly. Petitioner's arguments are not persuasive. It is common knowledge and commonly accepted that accidents occur when one is driving or riding in a vehicle on the public streets and highways. Thus, it is readily foreseeable that one riding as a passenger may be involved in an accident involving the vehicle in which the person is riding. Based upon the fact that there was a foreseeable risk and an accident occurred, I conclude that there has been a prima facie showing of a violation. The burden of persuasion is thus upon Petitioner to show by a preponderance of the evidence that it was in substantial compliance or had an affirmative defense.

I conclude that Petitioner has failed to meet its burden. Given that Resident 4 was a bilateral amputee with almost no lap, it was incumbent upon Petitioner to plan for her safe transport when riding in the facility van. The evidence shows that Petitioner's van was equipped with a wheelchair harness system that included a shoulder belt but not a lap belt. While such a system may have been safe for an individual with legs, Petitioner has not adduced any evidence that it specifically planned for the safe transport of this bilateral amputee, instead asserting that the restraint system was not used inconsistently with manufacture's instructions, was in good repair, was used correctly, and Resident 4 had traveled safely in the van in the past, had good balance and coordination, and did not like to wear her wheelchair lap belt and did not wear it as a matter of personal dignity. P. Br. at 8. Petitioner's arguments do not establish that the facility appropriately assessed Resident 4's needs for safe transport, i.e. what measures needed to be observed and implemented to ensure she was not thrown about in the vehicle in the event of a crash or sudden stop. Petitioner's arguments also do not show that Petitioner actually planned for Resident 4's safe transport given her unique needs. Furthermore, Resident 4's wheelchair, which the evidence shows was securely fastened to the floor of the van and apparently moved little if at all during the accident, had a seat lap belt that was not fastened across the resident's lap. One may infer from the presence of the lap belt in the wheelchair that one intended function was to prevent the user from coming out of the seat of the chair. The lap belt was not used and Resident 4 was ejected from the wheelchair during a sudden stop. Use of the wheelchair lap belt was a reasonable step to mitigate the hazards associated with being transported, a step Petitioner failed to take.

Accordingly, I conclude that Petitioner has failed to show that it acted reasonably to ensure that Resident 4's environment was as free of accident hazards as possible, a violation of 42 C.F.R. § 483.25(h)(1).

2. Petitioner's violation of 42 C.F.R. § 483.25(h)(1) posed immediate jeopardy.

3. The finding of immediate jeopardy was not clearly erroneous.

4. Immediate jeopardy was abated on December 8, 2006.

Once CMS determines that a Petitioner's noncompliance poses immediate jeopardy, it is Petitioner's burden to prove that determination to be clearly erroneous. The Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy, and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1962, at 11 (2005), citing *Florence Park Care Center*, DAB No. 1931, at 27-28 (2004) (citing *Koester Pavilion*, DAB No. 1750 (2000)). In this case, Petitioner is permitted to challenge CMS's finding of immediate jeopardy because, if decided favorably to Petitioner, the decision could impact the range of CMP applicable. 42 C.F.R. § 498.3(b)(14).

Petitioner has not proved that CMS's finding of immediate jeopardy was clearly erroneous during the period November 14, 2006 through December 7, 2006. Resident 4 suffered a serious injury on November 14, 2006, due to Petitioner's failure to ensure that she was properly secured and safely transported in the facility van. Resident 4 suffered a hip fracture, a particularly serious injury in the elderly, and the fracture could not be corrected surgically given Resident 4's medical conditions. Resident 4, who was alert and oriented, suffered pain and depression, also significant injuries. Tr. 59-62; CMS Ex. 17, at 20-22, 41.

Petitioner did show that the jeopardy was removed or abated effective December 8, 2006, when the new restraint system with an integrated lap belt was installed in the facility's van and the van was returned to Petitioner. Staff had been trained on December 5, 2006 to use the new restraint system and had demonstrated their ability to use the new system. The evidence shows that back-up driver Tonya Mitchell did not view the video regarding the new system on December 5, 2006 with the other driver and aides. But the evidence that Ms. Mitchell had prior experience with a similar system and was able to demonstrate her competence to use it is sufficient for me to conclude that jeopardy was abated when the van was returned on December 8. The surveyors confirmed during the survey that Ms. Mitchell competently demonstrated use of the restraint system. CMS Ex. 13, at 9-10. The unrebutted evidence shows that the only additional information the video provided

Ms. Mitchell when she viewed it during the morning of December 21, 2006, was how to store the system, information that has nothing to do with the safe transport of residents, particularly as the evidence shows that the system was not removed and stored by Petitioner's staff. Tr. 187-88; P. Ex. 12. Thus, Petitioner has shown that the immediate jeopardy was abated as of December 8, 2006, and immediate jeopardy was clearly erroneous after that date.

Petitioner argues that immediate jeopardy was actually abated on December 4, 2006, when the facility van was sent out to have the new restraint system installed and Resident 4 was transported by a contractor. P. Br. at 3, 12. Surveyor Dunn seemed to agree with Petitioner that immediate jeopardy may have been abated for the period when Resident 4 was being transported by a contractor. Tr. 101. However, Petitioner has not presented evidence from which I can find that the contractor actually provided transportation of Resident 4 in a manner to minimize the risk of harm to residents due to accidental injury. There is no evidence as to the type of restraint system the contractor used for Resident 4's transport or that Petitioner assessed whether safe transport would be provided by the contractor for Resident 4. Accordingly, I cannot conclude that Petitioner took reasonable steps to mitigate the risk to Resident 4 of accidental injury during transportation away from the facility by the contractor or that immediate jeopardy was abated as a result.

5. There is a basis for the imposition of an enforcement remedy.

6. The proposed CMPs of $3050 per day for the period November 14, 2006 through December 20, 2006 and $100 per day for the period December 21, 2006 through January 24, 2007, are not reasonable.

7. CMPs of $3050 per day for the period November 14, 2006 through December 7, 2006, and $50 per day for the period December 8, 2006 through January 24, 2007, are reasonable.[5]

I have concluded that Petitioner violated 42 C.F.R. § 483.25(h)(1). Hence, there is a basis for the imposition of an enforcement remedy. The issues that still require resolution are the duration of the noncompliance with the regulatory provision and the reasonable amount for any CMPs imposed.

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[5] As already discussed, the parties stipulated the CMP was increased to $150 for January 25, 2007, based upon a different regulatory violation that caused Petitioner not to be in substantial compliance on that date.

If a facility is not in substantial compliance with program requirements, CMS has the authority to impose one or more of the enforcement remedies listed in 42 C.F.R. § 488.406, including a CMP. CMS may impose a CMP for the number of days that the facility is not in compliance or for each instance that a facility is not in substantial compliance. 42 C.F.R. § 488.430(a).[6] There are two ranges for per day CMPs. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP, from $3050 per day to $10,000 per day, is for deficiencies that constitute immediate jeopardy to a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i) & (d)(2). The lower range of CMP, from $50 per day to $3000 per day, is for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents or cause no actual harm but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii).

Petitioner was in violation of 42 C.F.R. § 483.25(h)(1) beginning on November 14, 2006. The violation posed immediate jeopardy through December 7, 2006, the day prior to the return of the facility van with the new restraint system installed, with staff having been adequately trained by December 5, 2006. Petitioner has failed to show that the immediate jeopardy determination was clearly erroneous. The $3050 per day CMP proposed by CMS is the smallest CMP that is authorized for a deficiency that poses immediate jeopardy. Accordingly, a CMP of $3050 per day for the period November 14, 2006 through December 7, 2006, is reasonable.

CMS proposed to impose a CMP of $100 per day for the period after immediate jeopardy was abated but before Petitioner was found to have corrected the violation of 42 C.F.R. § 483.25(h)(1) on January 24, 2006. Petitioner alleges that it corrected the violation of 42 C.F.R. § 483.25(h)(1) not later than December 21, 2006, and no remedy should be imposed for the violation after that date. P. Brief at 13. However, Petitioner's argument is not supported by the evidence. Petitioner's plan of correction included monitoring by its quality assurance (QA) committee. CMS Ex. 13, at 2. Surveyor Dunn testified that Petitioner's Administrator told her that monitoring by the QA committee would not occur until the committee's next meeting in January 2007. Tr. 99. Surveyor Dunn testified that Petitioner was not found to have remedied the violation until the revisit survey on

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[6] Petitioner argues that the $5000 per instance CMP recommended by the state agency would have been a more appropriate remedy. P. Br. at 14. However, Petitioner has no right to contest CMS's choice of remedies and I have no authority to review CMS's choice of remedies. 42 C.F.R. §§ 488.408(g)(2); 498.3(d)(11) and (14).

January 25, 2007, after monitoring for continued compliance had occurred by Petitioner's QA committee. Petitioner has not shown that it effected monitoring as part of its plan of correction prior to January 25, 2007. Thus, I conclude that Petitioner did not correct the violation of 42 C.F.R. § 483.25(h)(1) prior to January 24, 2006.

In determining whether the amount of a CMP is reasonable, the following factors specified at 42 C.F.R. § 488.438(f) must be considered: (1) the facility's history of non-compliance, including repeated deficiencies; (2) the facility's financial condition; (3) the seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404; and (4) the facility's degree of culpability. *Emerald Oaks*, DAB No. 1800, at 10 (2001); *CarePlex of Silver Spring*, DAB No. 1683, at 14–16 (1999); *Capitol Hill Community Rehabilitation and Specialty Care Center*, DAB No. 1629 (1997).

CMS proposed a CMP of $100 per day for the period after immediate jeopardy, which is at the low end of the $50 to $3000 range of penalties authorized for deficiencies that do not pose immediate jeopardy. 42 C.F.R. § 488.438(a)(ii). I have no information regarding the facility's history of non-compliance (other than in the survey cycle before me) and Petitioner has not provided me with information regarding the facility's financial condition. The deficiency at issue was a serious one that caused serious injury to Resident 4. However, by December 8, 2006, Petitioner had taken all necessary steps to remedy the regulatory violation except demonstrating that it was monitoring to ensure no recurrence. Considering the facility's efforts to remedy the violation, I conclude that the minimum authorized CMP of $50 per day is reasonable after immediate jeopardy was abated on December 8, 2006.[7]

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[7] I note Petitioner's argument that CMPs imposed in other cases have been calculated starting with the date of the survey and ending when the facility came into compliance, while here the CMP was assessed from the date of the "solitary instance of noncompliance," thus leading to the imposition of an excessive CMP in this case. P. Br. at 15. As noted by the Board, "[c]ase to case comparisons generally have little value given the unique circumstances of each case and the myriad factors that must be considered." *Western Care Management Corp., d/b/a Rehab Specialties Inn*, DAB No. 1921, at 94 (2004). In this case it was not unreasonable to begin the CMP with the date of the incident.

III. Conclusion

For the foregoing reasons, I uphold CMS's determination that Petitioner violated 42 C.F.R. § 483.25(h)(1) on November 14, 2006, and did not return to substantial compliance with program participation requirements until January 26, 2007. However, I find that immediate jeopardy existed only from November 14 through December 7, 2006, and that a CMP of $3050 is only reasonable through December 7, 2006. A CMP of $50 per day is reasonable from December 8, 2006 through January 24, 2007.

/s/
Keith W. Sickendick
Administrative Law Judge