Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
SunBridge Care and Rehabilitation for Pembroke, (CCN: 34-5409),	)	Date: August 13, 2007
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-06-593
	)	Decision No. CR1636
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose civil money penalties against Petitioner, Sunbridge Care and Rehabilitation for Pembroke, in amounts of $4,000 per day for each day of a period that began on March 6, 2006 and which ended on May 11, 2006, and $50 per day for each day of a period that began on May 12, 2006 and which ended on June 19, 2006.

I. Background

Petitioner is a skilled nursing facility doing business in Pembroke, North Carolina. It participates in the Medicare program. Its participation in Medicare is governed by sections 1819 and 1866 of the Social Security Act (Act) and by regulations at 42 C.F.R. Parts 483 and 488.

Petitioner was surveyed for compliance with Medicare participation requirements on May 12, 2006 (May survey). The surveyors found two distinct failures by Petitioner to comply substantially with these requirements and they found that, in both instances, Petitioner's

noncompliance was so egregious as to comprise immediate jeopardy for its residents.[1] CMS concurred with the surveyors' findings and determined to impose the civil money penalties that I describe in the opening paragraph of this decision.

Petitioner requested a hearing and the case was assigned to me for a hearing and a decision. I held an in-person hearing at Raleigh, North Carolina on June 5, 2007. I received into evidence exhibits from CMS which it identified as CMS Ex. 1 - CMS Ex. 19 and exhibits from Petitioner which it identified as P. Ex. 1 - P. Ex. 46. Additionally, I heard the cross-examination and redirect testimony of three witnesses whose sworn written direct testimony is in evidence as exhibits. Each party filed pre- and post-hearing briefs.

II. Issues, findings of fact and conclusions of law

A. Issues

The issues in this case are whether:

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

2. Petitioner proved to be clearly erroneous CMS's determination that Petitioner's noncompliance was at the immediate jeopardy level; and

3. CMS's remedy determinations are reasonable.

B. Findings of fact and conclusions of law

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

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[1] "Immediate jeopardy" is defined at 42 C.F.R. § 488.301 to mean noncompliance with one or more participation requirements that has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

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

The regulation that is at issue here requires a facility to ensure that its resident environment be as free of accident hazards as is possible. This regulation has been the subject of much litigation before the Departmental Appeals Board and its administrative law judges. It is settled that the regulation imposes on a facility the duty to anticipate possible accidents from all hazards that it knows or should know about and to take all reasonable measures in order to forestall the occurrence of preventable accidents.

The allegations of noncompliance in this case center on Petitioner's transportation of wheelchair-bound residents to appointments away from its premises. Petitioner maintains a van for such transportation, equipped to carry wheelchair bound residents, and its staff includes individuals who drive the van to and from appointments. CMS alleges that during the period that is at issue in this case Petitioner's staff failed to transport wheelchair-bound residents safely in its van.

Specifically, CMS contends that Petitioner's staff failed properly to secure residents in their wheelchairs while they were being transported. The consequence, according to CMS, was that residents could fall from their chairs during transportation with the likelihood of serious and even life-threatening injuries.

As part of its evidence, CMS cites accidents that occurred to two residents while they were being transported in Petitioner's van. The first of these accidents occurred on August 8, 2005 and involved a resident who is identified in the report of the May survey as Resident # 1. CMS Ex. 4, at 11 - 13. The second incident occurred on March 6, 2006 and involved a resident identified in the May survey report as Resident # 3. CMS Ex. 4, at 1 - 3. In the case of Resident # 3, it is undisputed that she slid out of her wheelchair while she was being transported and fell to the floor of the van, sustaining a fractured hip. In the case of Resident # 1, it is undisputed that there was an accident involving the resident while he was being transported that caused him to sustain abrasions and shoulder pain.[2]

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[2] The parties dispute whether Resident # 1 fell out of his wheelchair while being transported. CMS contends that the resident fell to the floor of the van. Petitioner argues that he was jostled while in the wheelchair and that he never actually fell. I find it unnecessary to resolve this fact dispute. I note, however, that Petitioner's own investigation of the accident involving the resident reports that the resident slid out of his wheelchair while in the van. P. Ex. 11, at 1.

Petitioner's noncompliance, according to CMS, lay in the manner in which it secured its wheelchair bound residents while they were being transported. Petitioner's van is designed to carry residents in their wheelchairs. The van is not equipped with seats except for the driver's seat and a passenger seat that is next to the driver's seat. P. Ex. 25, at 7. The remainder of the van is an empty shell into which residents and their wheelchairs may be placed. *Id.,* at 1. It is designed to hold more than one row of wheelchairs. *Id.* For each row, there are tie-downs located on the van's floor to which the wheels of a wheelchair may be secured. *Id.,* at 1, 3.

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 harnesses are intended to be anchored at three points: on the van's side panel; its ceiling; and, on the floor. P. Ex. 25, at 1, 2. Each harness is permanently fastened to the side panel and ceiling anchors. In order to restrain a passenger, a harness must also be attached to an anchor point on the floor of the van. A wheelchair bound resident will be securely held in his or her wheelchair if the chair is tied down securely to the van's floor *and* if he or she is harnessed correctly.

CMS offered persuasive evidence that harnessing a resident "correctly" means attaching the harness to an anchor point that is located *behind* the resident's wheelchair. When the harness is attached in this manner, it 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. Tr. at 42, 44, 45-46; P. Ex. 25, at 3 (images at top and lower right portion of page).

However, there is also an incorrect way of attaching the harness. If the harness is attached to an anchor point on the van's floor that is *in front* of the resident's wheelchair it fails to provide any pelvic restraint. Tr. at 40-42. In that circumstance, a wheelchair bound resident could slip out of the harness. *Id.*, at 31-32; *see* P.Ex. 25, at 3 (image at lower left portion of page).

The evidence offered by CMS supports the conclusion that Petitioner's staff did not understand the need to attach passenger harnesses to floor anchors that were located behind the wheelchairs of those residents who they were transporting. As a consequence, the staff failed to provide the residents with the protection that the harnesses were designed to provide. At the May 12 survey a surveyor asked Petitioner's staff to demonstrate how a wheelchair and its resident is secured while in the van. The demonstration was conducted by one of Petitioner's drivers with Petitioner's maintenance supervisor present. The driver fastened the harness to a floor anchor located *in front* of the chair, thus enabling the surveyor, who was seated in the chair, to slip out of the chair by leaning forward. CMS Ex. 4, at 6; Tr. at 41-42.

The evidence offered by CMS supports the additional conclusion that the staff routinely attached the harnesses to anchors located in front of the chairs thereby often putting residents at risk. The demonstration witnessed by the surveyor was not an isolated error, but established the staff's usual way of attaching the harnesses. And, it was an obvious error that was noticed immediately by Petitioner's maintenance supervisor. At the demonstration that I describe above, Petitioner's maintenance supervisor showed the driver how properly to fasten the harness to a floor anchor that was located behind the chair. However, the driver protested that she was unable to accomplish this when there were multiple wheelchairs present in the van. CMS Ex. 4, at 6 - 7; Tr. at 46. According to the surveyor the driver told her that:

> [I]n transporting four residents, as . . . [the driver] did some days of the week, . . . there was no way to secure those residents with the – with the harness going behind the chair, which would secure the resident, that she was not able to do that, that she could only secure the resident by the – by securing to the front of the van.

Tr. at 46; CMS Ex. 4, at 7.

The foregoing evidence, if not rebutted, 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. By routinely attaching the residents' harnesses incorrectly, Petitioner's staff made practically useless these essential safety devices. The hazard caused by improper fastening of the harnesses was 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.

In reaching this conclusion it is unnecessary for me to decide whether failure to attach the harnesses correctly was the cause of the accidents and injuries sustained by Residents #s 1 and 3, although it is highly likely that an improperly attached harness, in the case of Resident # 3, caused that resident to slide out of her wheelchair. 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. However, the fact that two residents sustained accidents while being transported should have, at the very least, put Petitioner and its staff on notice that something might be seriously wrong in the way that residents were being secured while they were transported.

The evidence offered by CMS thus proves that residents routinely were being transported in an unsafe manner and also that Petitioner's staff failed to heed obvious warnings that its manner of transporting these residents was unsafe.[3] At a minimum, and certainly after the accident involving Resident # 3 (the second of the two accidents), Petitioner's staff should have intensively reviewed the way in which residents were being transported. It is reasonable to conclude that, had it done so, the staff would have determined that harnesses were being attached incorrectly, thereby causing a likelihood of serious injury, harm, impairment, or death to residents.

Petitioner makes various arguments in response to CMS's case which I discuss below. But, it is important at the outset of my analysis of these arguments to identify what Petitioner does *not* challenge with affirmative evidence. Petitioner does not contest explicitly CMS's evidence showing that its staff routinely fastened the restraining harnesses in its vans to floor anchors located in front of the residents' wheelchairs. It has offered no affirmative proof showing that the harnesses were, in fact, routinely fastened behind the residents. Neither does it offer evidence to contest the evidence offered by CMS which proves that a resident would be capable of falling out of a wheelchair in the circumstance where the harness is fastened in front of, and not behind, the resident. Nor does Petitioner challenge CMS's assertion that fastening the harnesses in front of

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[3] There is another potential issue relating to Petitioner's transportation of residents in its van. At the hearing, I voiced a concern that Petitioner possibly had failed to assess its residents for suitability of van transportation. I premised my concern on the obviously frail and debilitated state of Resident # 3 and I wondered whether that resident should have been in Petitioner's van at all. I identified this as a new issue and I invited the parties to brief the evidence in terms of how it related to this issue. 42 C.F.R. § 498.56. CMS's counsel failed to address this issue in her post-hearing brief. Consequently, I decline to decide it here.

residents put them at risk of accidents.[4] And, finally, Petitioner does not deny that an intensive review of its procedures after the accident sustained by Resident # 3 would have made its staff's unsafe transportation practices apparent.

Petitioner asserts that its staff investigated the accident involving Resident # 3 thoroughly at the time and that Petitioner's maintenance director found no defect or problem with the van or its harnesses. Petitioner's post-hearing brief at 16. Petitioner concludes: "it appears that the van's safety equipment worked exactly as designed and intended to secure the Resident in place and to prevent serious injury." *Id.* This assertion dodges the issue. As I discuss in detail below, there is no dispute in this case that, had the harnesses in the van been attached properly, they would have restrained the residents who were being transported. Nor has CMS contended that the harnesses were defective or inherently unsafe. Therefore, the issue is not whether the van and its equipment worked as designed, as Petitioner asserts, but whether the staff was utilizing the equipment properly. The overwhelming and unrebutted evidence is that it was not.

Furthermore, the evidence offered by Petitioner does not satisfy me that it conducted the thorough and intensive investigation that it contends it conducted. It is apparent that, whatever investigation transpired, it failed to reveal the obviously erroneous way in which the van's drivers were attaching the harnesses to the van's floor. And, that error was so obvious that it was noticed immediately by a surveyor and by Petitioner's maintenance supervisor at a demonstration of the harnesses' use.

Petitioner's staff completed an event/incident report on August 8, 2005, after the accident involving Resident # 1. P. Ex. 11. The report contains a statement describing what happened to the resident, concluding a finding that the resident slid out of his wheelchair when the van made a sudden stop. *Id.*, at 1. But, the report contains no analysis of *why* the resident slid out of the wheelchair. In particular, it is devoid of any analysis of the functioning of the van's safety features. After the accident involving Resident # 3, on March 6, 2006, Petitioner's management collected statements from members of the staff.

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[4] Petitioner 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. However, among Petitioner's exhibits is a Department of Veterans Affairs publication entitled, "Preliminary evaluation of wheelchair occupant restraint system usage in motor vehicles." P. Ex. 40. The document contains a diagram (Figure 1) describing "zones of preferred and optional angles for pelvic restraints." *Id.*, at 3. The diagram clearly shows that the preferred and optional angles for such restraints depend on fastening the restraints *behind* an individual's wheelchair. *Id.* The document also contains a photograph (Figure 3) showing a harness's pelvic belt crossing over the armrest of a wheelchair and fastened to the floor behind the chair. *Id*., at 4.

P. Ex. 19. The statements include a statement from Petitioner's maintenance director in which he says:

> Upon looking at the safety equipment in the facility van, my inspection of all fasteners, belts and floor brake hookups I found nothing requiring repair and nothing defective due to improper use.

Id., at 5. It is evident from this statement that the maintenance supervisor examined the van's safety equipment, including the harnesses, to determine whether they were broken or had been rendered defective from improper use. But, it does not suggest that he queried the van's drivers to determine whether they were attaching the harnesses properly. It is reasonable to infer that the maintenance director did not ask the drivers to demonstrate how they attached the harnesses when he made his inspection after the March 6, 2006 incident because, when such a demonstration was performed for the surveyor on May 12, 2006, it was the maintenance supervisor who noticed that the harness would function properly if attached behind, and not in front of, a wheelchair. Tr. at 46.

Although Petitioner does not directly contest CMS's evidence concerning how harnesses were fastened, it asserts that there was a "dispute at the hearing" regarding how the harnesses were attached to the floor of the van. Petitioner's post-hearing brief at 10. It seems to contend that the survey report and/or testimony concerning how the harnesses were attached is vague and inconclusive. It also contends that the surveyor who conducted the May survey "suggested, but never actually directly said, that she was able slide under the belt for . . . [the reason that the belt was fastened in front of her] but had the belt been fastened behind the wheelchair, she would not have been able to slide out." *Id*. I disagree with these characterizations of the record. There was nothing vague about the survey report or the surveyor's testimony regarding the issue of how the harnesses were attached by Petitioner's staff. To the contrary, both the survey report and the surveyor's testimony identify the attachment of harnesses to floor anchors located in front of residents as an unsafe method of securing residents which caused a likelihood that residents would fall out of their chairs while being transported in the van.

In challenging CMS's noncompliance finding, Petitioner argues that CMS has no authority to regulate Petitioner's transportation of residents to off-premises sites. The logic of Petitioner's argument is that CMS's authority to regulate nursing facilities ends at a facility's doorstep. Thus, as Petitioner would have it, its staff's manner of transportation of residents – even if unsafe – is simply beyond the pale of what CMS is authorized by the Act and regulations to regulate. Petitioner argues also that motor vehicle safety regulation is uniquely within the purview of State regulations and is thus exempt from any authority that CMS might exercise.

I find Petitioner's argument to be without merit. The identical argument was addressed and rejected by an appellate panel of the Departmental Appeals Board in *Liberty Nursing and Rehabilitation Center - Mecklenburg County*, DAB No. 2095 (2007). CMS's authority to regulate the care given by a participating skilled nursing facility is not limited by the exterior walls of a facility's structure. There is literally nothing in either the Act or implementing regulations that suggests such limitations. Rather, the Act and regulations extend regulatory authority over the functions and operations of a nursing facility whether those functions and operations transpire within or outside of a facility's structure.

Moreover, there is nothing in the Act or regulations that suggests that CMS must or will defer to State or local authorities when it comes to regulating nursing facility care. There are many instances in which federal and State authority overlap. For example, CMS regulates the safety of facility structures through enforcement of the Life Safety Code. The fact that States may have their own laws or regulations (such as fire safety codes) which also regulate the safety of structures has never served as an impediment to CMS's authority.

Obviously, Petitioner operated its van as part of its facility and offered van transportation to residents as part of the care that it provided to them. The van in question is owned and maintained by Petitioner. It is driven by Petitioner's salaried staff. Petitioner trains its staff in safe operation of the van and ensures that the staff complies with facility policies and rules. I can discern no separation of the care provided to residents through their transportation by van from the care that Petitioner provides its residents within the walls of its facility.

Petitioner's reading of the Act and regulations would produce absurd results. For example, the regulation that is at issue here has long been held to require a facility to ensure that known or knowable risks of resident elopement are eliminated. A facility is responsible, under this analysis, for the safety of its residents inside the facility's structure. But, it is also responsible for its residents' safety in the event of their unauthorized departure (elopement). Petitioner's analysis would eliminate that responsibility.

Petitioner argues also that "the mere fact that a resident (or surveyor) could (or did) slip under an original-equipment vehicle safety belt does not necessarily mean that Petitioner's use of the safety equipment in the van was improper or unreasonable." Petitioner's post-hearing brief at 20. I find this argument to be unpersuasive. CMS's case is not premised on the "mere fact" of a resident slipping under a harness. The hazard in this case was not present in spite of Petitioner's proper use of safety equipment but it was caused by the staff's *improper fastening* of the van's harnesses. The surveyor was

able to slip out from under a harness during the staff's demonstration of its use because it was not fastened properly. She would not have been able to do so had it been fastened properly. Staff routinely fastened the harnesses improperly. Had the staff fastened the harnesses correctly then the hazard would have been eliminated.

Petitioner's central argument appears to be that CMS is unfairly contending Petitioner to be deficient "simply because Resident # 3 suffered a serious injury while being transported in Petitioner's van." Petitioner's post-hearing brief at 28. More specifically, Petitioner argues that CMS's position is that the harnesses in Petitioner's van were inadequate to protect Petitioner's residents – even when they were used exactly as is directed – and that Petitioner is liable for not having provided these residents with some additional protection such as supplementary lap belts. Petitioner reiterates this argument with slightly different phrasing, contending that: "the crux of this case is that CMS is attempting to impose liability against Petitioner because a safety device intended for one purpose – in this case, a vehicle safety belt system designed, used and intended to prevent catastrophic injury in a collision – failed to serve some other purpose – in this case, positioning or restraining a resident into a wheelchair." Petitioner's post-hearing brief at 32.

But, in fact, CMS does not assert that Petitioner was deficient notwithstanding its use of harnesses consistent with safety instructions. Nor does CMS contend that the harnesses were defective or were inadequate to protect residents in the van. Petitioner's argument is a straw man and does not in any sense reflect the true nature of Petitioner's noncompliance. Petitioner's assertion notwithstanding, the crux of this case is *improper use* of safety harnesses by Petitioner's staff. The improper use of these harnesses made residents vulnerable to precisely the type of accident that Petitioner contends that the harnesses were designed to protect against.[5]

2. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.75.

The regulation that is at issue here requires that a 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. The

[5] To support its argument Petitioner contends that the surveyor insisted that Petitioner could only correct its noncompliance by employing supplemental lap belts as addition to the van's harnesses. But, that is not what the surveyor required. The surveyor did not give the facility specific instructions as to how to correct its deficiency. Tr. at 57 - 58. Correction of the deficiency was Petitioner's responsibility and the way in which it corrected the deficiency was Petitioner's choice.

regulation's requirements include imposing a duty on a facility's management to assure that its staff identify and address accident hazards. It also requires a facility's management to assure that the staff follow established safety procedures and protocols.

CMS's allegations of Petitioner's noncompliance with this regulation derive in some measure from its contentions concerning Petitioner's failure to comply with the requirements of 42 C.F.R. § 483.25(h)(1). The logic behind CMS's argument is that Petitioner's failure to protect its residents against accident hazards embodied to a substantial extent a failure by its management to recognize and to address a serious accident risk resulting from the way Petitioner's staff transported its residents.

I find CMS's arguments to be persuasive and not rebutted by Petitioner. It is apparent that Petitioner's management failed to comprehend that Petitioner's staff was not properly fastening the van's safety harnesses and that this failure was an ongoing problem. The accident involving Resident # 3, which occurred on March 6, 2006, should have put Petitioner's management on notice that, potentially, there was a serious problem relating to the way its residents were being transported. But, Petitioner's management failed to investigate the manner of transportation adequately to reveal what turned out to be a glaring error by its staff, one that was being repeated each time the van was used to transport multiple wheelchair bound passengers (reported by one driver to occur on more than one day per week). Tr. at 46.

Petitioner argues that: "CMS offered no evidence that Petitioner's administration had any reason for unusual concern about use of its van . . . ." Petitioner's post-hearing brief at 45. I disagree. The two accidents that are at issue in this case – especially the accident involving Resident # 3 on March 6, 2006 – put Petitioner's management on notice that something might be seriously wrong with the way in which residents were being transported. And, had Petitioner's management looked closely at the way in which residents were being transported, it should have known immediately that the van drivers were routinely attaching safety harnesses incorrectly. The failure of management in this case was a failure properly to perform oversight and to identify and resolve an obvious safety hazard.

CMS also contends that Petitioner's management was deficient in failing to assure that the staff followed prescribed emergency procedures in dealing with consequences of the accident to Resident # 3. CMS Ex. 4, at 20. Petitioner's instructions to its van drivers for dealing with the consequences of an accident included an instruction that an injured person should not be moved if movement was likely to cause further injury. P. Ex. 27, at

22. CMS offered evidence to show, that in the immediate aftermath of the accident to Resident # 3, Petitioner's management instructed the driver to return the van to the facility with the resident lying on the floor of the van. That instruction clearly contradicted Petitioner's own policy and, potentially, put the resident at risk for exacerbation of her injury (a broken femur).

Petitioner argues that the instruction made sense in the context of the event. The accident occurred only a short distance from Petitioner's facility and, according to Petitioner, it was only logical, given the close proximity of the facility to the site of the accident, to return the van with its passenger to the facility so that facility staff could assess and provide care to the resident. That was particularly reasonable, according to Petitioner, because the nearest hospital is about a 30 minutes' drive from its facility.

I do not find this argument to be persuasive. The van driver was not a nurse and was not trained to assess the resident's condition. When Petitioner's management instructed the driver to return the van to the facility, its professional staff was unaware of the extent of the resident's injuries (grave, as it turned out) and were in no position to make an informed judgment about whether it was safe to drive the unrestrained resident, lying on the van's floor, for even a short distance.

3. Petitioner failed to prove that CMS's determination of immediate jeopardy was clearly erroneous.

Where CMS makes a determination that noncompliance is at the immediate jeopardy level, the burden falls on the facility to prove that determination to be clearly erroneous. In this case there is considerable evidence to support CMS's determination and I find that Petitioner failed to rebut it. Consequently, I find that Petitioner did not prove the immediate jeopardy determination to be clearly erroneous.

The risk to residents posed by improper attachment of harnesses is self-evident. As Petitioner acknowledges, these harnesses were designed to protect wheelchair bound residents being transported in Petitioner's van from the consequences of accidents to the same extent as shoulder and lap harnesses in any passenger vehicle are designed to protect the vehicle's occupants. Obviously, the devices must be attached correctly in order to perform their intended function. The evidence offered by CMS and not rebutted by Petitioner shows not only that the harnesses routinely were not being attached correctly but that the consequence of incorrect attachment was that they failed to give the protection that they were designed to provide. Residents being transported in Petitioner's van were thus highly vulnerable to serious injuries or death as a consequence of the staff's failure to attach harnesses correctly.

Petitioner has offered nothing to rebut this proof. Its assertion that the harnesses – if employed properly – would have protected its residents begs the question of whether its residents were at immediate jeopardy while being transported because, in this case, the overwhelming evidence is that the harnesses were not properly employed.

4. Petitioner failed to prove that the duration of its noncompliance was for a shorter period than was determined by CMS.

CMS found that Petitioner was deficient at the immediate jeopardy level beginning with the accident sustained by Resident # 3 on March 3, 2006.[6] It determined that immediate jeopardy persisted until May 12, 2006 and it found continued noncompliance, albeit at a non-immediate jeopardy level until June 19, 2006.

Where, as in this case, one or more deficiencies is established, the burden falls entirely on the facility to prove that it corrected the deficiency or deficiencies by a given date. In other words, assuming a deficiency or deficiencies to be present, there is a presumption of continued noncompliance until such time as the facility demonstrates that it has eliminated the deficiency or deficiencies. A facility must overcome the presumption of continued noncompliance with affirmative evidence if it alleges that it corrected its deficiency or deficiencies at an earlier date than that which CMS has determined to be the compliance date.

Petitioner did not meet that burden here. The evidence offered by CMS establishes that Petitioner's staff continued to attach improperly the van's harnesses during the period between March 6 and May 12, 2006. As I discuss above, the van's driver acknowledged on the date of the survey that she was routinely attaching the harnesses to floor anchors located in front of the residents' wheelchairs. This evidence shows that immediate jeopardy persisted during the entire period between March 6 and May 12. Petitioner offered nothing to rebut it.

Moreover, Petitioner has not offered any proof showing that it, in fact, attained full compliance with participation requirements at any date earlier than June 19, 2006. Petitioner's plan of correction addressing the deficiencies in this case cites June 2, 2006 as the date when all correction would be completed. P. Ex. 1. However, Petitioner did not argue that, in fact it had fully complied with participation requirements by that date.

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[6] In fact, it found that Petitioner's immediate jeopardy level noncompliance with 42 C.F.R. § 483.75 commenced in October 2005 with the accident involving Resident # 1. However, CMS imposed no remedy for the period between that accident and the accident involving Resident # 3 and, for that reason, it is unnecessary for me to address whether immediate jeopardy existed during the earlier period.

5. CMS's civil money penalty determinations are reasonable.

Regulations establish that civil money penalties for immediate jeopardy level deficiencies may be imposed in amounts of from $3,050 to $10,000 per day. For non-immediate jeopardy level deficiencies, the civil money penalty amount must fall within a range of from $50 to $3,000 per day. 42 C.F.R. § 488.438(a)(i), (ii). The regulations also establish criteria for deciding the reasonableness of a penalty falling within one of the two penalty ranges. Those criteria include: the seriousness of a facility's noncompliance; its compliance history; its culpability; and its financial condition. 42 C.F.R. §§ 488.438(f)(1) - (4); 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)).

My responsibility in deciding what penalty amounts are reasonable is to make a de novo analysis of the evidence as it relates to the regulatory criteria governing penalty amounts. In other words, I do not simply review CMS's determination for reasonableness but, rather, consider the record of the case de novo in deciding what is reasonable.

Neither party offered evidence or analysis concerning Petitioner's financial condition or its compliance history. Consequently, I must base my decision as to penalty amounts solely on the seriousness of the deficiencies and Petitioner's relative culpability for them.

I find that the penalties for immediate jeopardy level noncompliance – $4,000 per day – are reasonable based on my analysis of the evidence as it pertains to these two criteria. I note initially that $4,000 is a relatively low immediate jeopardy penalty amount because it is close to the minimum daily penalty amount of $3,050. The evidence shows that Petitioner's noncompliance was serious. The consistent failure by Petitioner's staff to attach the van's safety harnesses correctly rendered these devices inadequate for the purpose for which they were designed. Residents being transported in Petitioner's van were unprotected from the dangers associated with accidents. The dangers to the residents were magnified by their physical and mental conditions. Obviously, many of the residents who were being transported were elderly, frail, and demented individuals who were far less capable of withstanding the consequences of an accident than would have been younger and healthy individuals. This conclusion is more than demonstrated by the injury sustained by Resident # 3 – a fractured femur – caused merely by sliding out of her wheelchair while the van was in motion.

Petitioner had a very high duty of care when it came to transporting its residents. It was required to do everything within its ability to assure that the van's safety harnesses were attached properly, in order to protect these frail and ill individuals. It failed routinely to do that.

There is also an element of culpability which supports the $4,000 daily penalty. The drivers' failures to attach the harnesses correctly should have, and would have, been apparent to Petitioner's management had it closely investigated the cause of the accident to Resident # 3. It is obvious to me that management failed to discover this glaring and persistent error because it failed to ask the right questions or to look closely at the way in which its staff was transporting residents.

As for the $50 daily non-immediate jeopardy penalty amount, I sustain this because it is the minimum penalty amount for non-immediate jeopardy level deficiencies. Therefore, it is reasonable as a matter of law.

/s/
Steven T. Kessel
Administrative Law Judge