Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: June 19, 2007
Care Center of Opelika,	
Petitioner,	Civil Remedies CR1556 App. Div. Docket No. A-07-69
	Decision No. 2093
- v. -	
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Care Center of Opelika (Opelika) appealed the January 23, 2007, decision of Administrative Law Judge (ALJ) Carolyn Cozad Hughes. Care Center of Opelika, CR1556 (2007)(ALJ Decision). The ALJ sustained a determination by the Centers for Medicare & Medicaid Services (CMS), based on survey findings by the Alabama Department of Public Health (ADPH or state survey agency), that Opelika failed to comply substantially with three federal requirements governing the participation of long-term care facilities in the Medicare and Medicaid programs. CMS found, and the ALJ agreed, that from July 27 through October 5, 2005 (71 days), Opelika was not in substantial compliance with the requirement that a SNF's nurse's station be equipped to receive resident calls through a communication system from resident rooms and toilet and bathing facilities, 42 C.F.R. § 483.70(f)(Tag F463). CMS also determined that Opelika's noncompliance with the call system requirement during that time period constituted immediate jeopardy, and the ALJ upheld that determination as not clearly erroneous. CMS further found, and the ALJ agreed, that

from October 6, 2005 until it achieved substantial compliance,[1] Opelika was not in substantial compliance with the requirements that a resident has the right to receive services in the facility with "reasonable accommodation of individual needs and preferences" except when resident health or safety would be endangered, 42 C.F.R. § 483.15(e)(1)(Tag F246), and that a facility ensure that resident environments remain as free of accident hazards as possible, 42 C.F.R. § 483.25(h)(1)(Tag F323). The ALJ found the $3,050 per day CMP for the period of immediate jeopardy a reasonable amount as a matter of law, and she also found reasonable the $100 per day CMP imposed for the remaining period of noncompliance.

We affirm the ALJ's finding of fact and conclusion of law (FFCL) III.A. that Opelika failed to comply substantially with the resident call system requirement at 42 C.F.R. § 483.70(f) and that CMS's determination of immediate jeopardy with respect to this noncompliance was not clearly erroneous. As discussed below, the ALJ's finding of noncompliance is supported by substantial evidence and free of legal error, and Opelika has not shown that CMS's determination of immediate jeopardy was clearly erroneous. We summarily affirm the reasonableness of the CMP imposed for the immediate jeopardy period since, as the ALJ correctly concluded (ALJ Decision at 1, 12), $3,050 is the minimum per day CMP permitted by law. 42 C.F.R. § 488.438(a)(1)(i). We also summarily affirm FFCL III.B., in which the ALJ found that Opelika was not in substantial compliance with 42 C.F.R. § 483.15(e)(1)(F246) and 42 C.F.R. § 483.25(h)(1)(F323), since Opelika expressly declined to appeal that finding. RR 3, n.1. We summarily affirm, as well, FFCL III.C., in which the ALJ found that the $100 per day CMP imposed for the period of noncompliance at the non-immediate jeopardy

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[1] The ALJ declined to decide the date on which Opelika achieved substantial compliance with all federal requirements, finding the record confusing on this issue, ALJ Decision at 2, n.2. However, she stated that if the parties disagreed on this date, they could move to reopen pursuant to 42 C.F.R. § 498.100. In its request for review (RR) by the Board, Opelika stated that it had petitioned to reopen the ALJ Decision to resolve this issue. RR at 4, n.4. However, Opelika subsequently told the Board, during a May 24, 2007 telephone call, that it had withdrawn the petition since the parties have agreed that November 4, 2005, is the date the facility achieved substantial compliance. See P. Exhibit (Ex.) 8; RR at 4; CMS Br. at 2. During the phone call, Opelika also told the Board that it no longer requested oral argument.

level was reasonable, inasmuch as Opelika does not present on appeal any basis for overturning that FFCL.[2] In particular, Opelika makes no argument concerning any of the regulatory factors considered in determining the amount of the $100 per day CMP. Batavia Nursing & Convalescent Inn, DAB No. 1911, at 57 (2004), aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson, No. 04-3687 (6th Cir. Aug. 3, 2005), 2005 WL 1869515; citing Wisteria Care Center, DAB No. 1892, at 10 (2003)("The Board may decline to consider an issue that is 'unaccompanied by argument, record citation or statements that articulate the factual or legal basis for the party's objection to the ALJ's finding.'").[3]

Applicable Legal Provisions

Long-term care facilities participating in the Medicare and Medicaid programs are subject to the survey and enforcement procedures set out in 42 C.F.R. Part 488, subpart E, to determine if they are in substantial compliance with applicable program requirements which appear at 42 C.F.R. Part 483, subpart B. "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," in turn, is defined as "any deficiency that causes a facility to not be in substantial compliance." Id.

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[2] Opelika merely asks the Board "to reduce the [total] CMP to $5,000, which is based on a $50 per day CMP for the period beginning July 27, 2005 and ending November 3, 2005." RR at 23. As indicated above, we may not, as a matter of law, reduce the CMP to $50 per day for the immediate jeopardy period (July 27 through October 5, 2005). For the remaining period of noncompliance (October 6 through November 3, 2005), Opelika presents no argument to support its assertion that the CMP should be reduced to $50 per day. Moreover, the ALJ addressed the factors she was required to consider under 42 C.F.R. 488.438(f) to determine whether the $100 per day CMP was reasonable. See ALJ Decision at 11-12.

[3] Wisteria Care Center cited the Guidelines - Appellate Review of Decisions of Administrative Law Judges Affecting A Provider's Participation In the Medicare and Medicaid Programs of the Departmental Appeals Board (Guidelines), which can be found at www.hhs.gov/dab/guidelines/prov.html ("The Board will not consider issues not raised in the request for review, nor issues which could have been presented to the ALJ but were not.")

A long-term care facility found not to be in substantial compliance is subject to various enforcement remedies, including per day CMPs. 42 C.F.R. §§ 488.402(c), 488.408. CMS may impose 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). 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).

"Immediate jeopardy" is defined 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. CMS's determination that a deficiency constitutes immediate jeopardy "must be upheld unless it is clearly erroneous." Woodstock Care Center, DAB No. 1726, at 9 (2000), citing 42 C.F.R. 498.60(c)(2), aff'd, Woodstock Care Center v. Thompson, 363 F.3d 583 (6th Cir. 2003). The Board has held that a facility that challenges an immediate jeopardy determination bears a heavy burden to show that CMS's determination is clearly erroneous. See, e.g., Daughters of Miriam Center, DAB No. 2067, at 7 (2007); Liberty Commons Nursing Center - Johnston, DAB No. 2031 at 18 (2006); Barbourville Nursing Home, DAB No. 1962, at 11 (2005), aff'd, Barbourville Nursing Home v. Leavitt, 2006 WL 908631 (6th Cir. Apr. 6, 2006)(Immediate jeopardy upheld when "CMS present[s] evidence from which '[o]ne could reasonably conclude' that immediate jeopardy exists.")

The regulation at issue here, 42 C.F.R. § 483.70(f), provides as follows:

> Resident call system. The nurse's station must be equipped to receive resident calls through a communication system from –
>
> (1) Resident rooms; and
> (2) Toilet and bathing facilities.

CMS's interpretive guidelines for surveyors state that the intent of the regulation "is that residents, when in their rooms and toilet and bathing areas, have a means of directly contacting staff at the nurse's station" and that "this communication may be through audible or visual signals and may include "wireless systems." CMS State Operations Manual (Pub. 100-07)(SOM), Appendix PP - Guidance to Surveyors for Long Term Care Facilities, at 296 (discussing § 483.70(f), Tag F463, Resident

Call System). The guidelines further state that this requirement is satisfied "only if all portions of the system are functioning (e.g., system is not turned off at the nurses' station, the volume too low to be heard, the light above a room or rooms is not working)." Id. Surveyors are instructed to consider whether the facility has "a functioning communication system from rooms, toilets, and bathing facilities." Id.

Standard of Review

Our standard of review on a disputed conclusion of law is whether ths ALJ decision is erroneous. Our standard of review on a disputed finding of fact is whether the ALJ decision is supported by substantial evidence on the record as a whole. Guidelines; Batavia, at 7; Hillman Rehabilitation Center, DAB No. 1611, at 6 (1997), aff'd, Hillman Rehabilitation Ctr. v. U.S. Dep't of Health and Human Servs., No. 98-3789 (GEB) at 21-38 (D.N.J. May 13, 1999).

Case Background[4]

The state survey agency completed a complaint investigation at Opelika on July 7, 2005, and a revisit certification survey on October 6, 2005. ALJ Decision at 2. On October 28, 2005, CMS notified Opelika that based on the revisit survey, it had determined that Opelika was not in substantial compliance with 42 C.F.R. § 483.70(f) for the period July 27 through October 5, 2005 because it did not have a functioning call system, and that the absence of the same posed immediate jeopardy to resident health and safety. Id., citing CMS Ex. 1, at 9-12; CMS Ex. 2.[5] After a

[4] 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.

[5] Opelika notes that ADPH cited the call light deficiency as having a scope and severity of less than immediate jeopardy but that CMS changed the scope and severity to immediate jeopardy. RR at 10, 22. However, Opelika does not deny CMS's authority to make the change, and the law clearly provides such authority. See 42 U.S.C. § 1819(f)(providing that a State makes recommended findings regarding SNF noncompliance and recommends actions to remedy the noncompliance but the Secretary makes the ultimate findings of noncompliance and decides what remedial

(continued...)

follow-up visit on December 8, 2005, CMS determined that Opelika had achieved substantial compliance with program requirements as of November 4, 2005, and so notified the facility. Id., n.2; RR at 4, n.2, citing P. Ex. 8. Opelika sought ALJ hearings on both surveys, and ALJ Hughes consolidated both cases under docket number C-06-138. ALJ Decision at 2, n.1. The parties agreed to have the case decided on the written record. ALJ Decision at 3.

Opelika is a 225-bed facility physically organized into four sections. ALJ Decision at 4, citing CMS Exs. 6, 7; P. Ex. 9. The call light system at issue was installed in 1975 and served Section One, which contained 47 rooms (73 beds). Id., citing CMS Ex. 3, at 3; P. Ex. 36, at 1. The ALJ recounted the following system malfunctions and facility responses, beginning in 2002:

- March 2002 -"main panel" at nurse's desk replaced
- 2003 -"main control unit" replaced
- 2005 -"main control unit" replaced
- March 24, 2005 - entire system "went down" for one week
- June 22, 2005 - control panel malfunction for 3 rooms
- July 27, 2005 - "system broke down," partial functioning thereafter
- September 6, 2005 - requisition for new system
- September 19, 2005 - installation begins
- October 6, 2005 - installation completed

ALJ Decision at 4-5, citing P. Exs. 23, 32-37, 42, 44; CMS Exs. 3, 4.

The ALJ concluded that the "uncontroverted evidence" showed that Opelika "had no reliable call light system" from July 27 through October 5, 2005. ALJ Decision at 5. She recognized that "extraordinary and unforeseeable circumstances" could preclude a deficiency finding, but concluded that "[t]he circumstances surrounding the July 2005 failure of the call light system were neither extraordinary nor unforeseeable." Id. She specifically

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[5](...continued)
actions to take); Lake Mary Health Care, DAB No. 2081, at 5-7 (May 14, 2007)(rejecting as inconsistent with the governing statutes and regulations the provider's arguments that CMS should not have found noncompliance under a federal requirement additional to the one cited by the State and that CMS should not have determined that immediate jeopardy existed when the State had cited the noncompliance at a scope and severity level less than immediate jeopardy).

rejected Opelika's argument that it had taken all reasonable steps to maintain the system in working order. Id.

The ALJ took into consideration the "significant efforts" of facility maintenance staff to keep the system operational, but noted that maintenance documents demonstrated that Opelika "knew it had an old, unreliable system - broken down more often than it was operational." ALJ Decision at 5-6, citing P. Ex. 42 at 2 (Cook Declaration (Decl.) ¶8); P. Exs. 22-35. The ALJ stated that after the week-long failure in March, Opelika "should have known the system was on its way out and that it needed to start planning for a replacement system." ALJ Decision at 6. She also noted that in June, 2005, maintenance staff could not repair the system due to age and bad wiring. Id., citing P. Ex. 23, at 5. She also noted that after the system broke down in July, the technician "told the facility's maintenance director that he needed to replace all of the rooms' old call stations with a new series." Id., citing P. Ex. 23, at 8. The ALJ stated that Opelika should have known the process for getting a new system in place was lengthy and should have begun that process "probably in March" but not later than June, upon learning from maintenance staff that the system could not be repaired. Id., citing P. Ex. 43 at 1 (Williams Decl. ¶5); P. Ex. 44, at 2 (Hornsby Decl. ¶¶ 5, 6. "Yet, the facility did not even contact vendors to discuss the system's replacement until September . . . ." ALJ Decision at 6. She thus disagreed that the facility had taken "'all reasonable steps' to maintain an effective call light system." Id.

The ALJ also found that the facility's distribution of hand bells to residents as a back-up system "was not an effective substitute for an electronic call light system . . . ." ALJ Decision at 7. She first noted that Opelika distributed hand bells "to some, but not all, of the Section One residents." Id. at 6. The facility added "bell monitors" on August 24 (a month after the call light system had broken down) to walk the halls and listen for bells, but only for 12 hours a day (7:00 p.m. through 7:00 a.m.). Id., citing P. Ex. 12, at 1, 7, 9, 23; P. Ex. 44 at 3 (Hornsby Decl. ¶12). She noted that from July 27 until the bell monitors were added on August 24, Opelika made no special efforts to assist regular nursing staff to hear and respond to hand bells. Id., n.6. She also noted that bell monitors were occasionally not assigned or were "pulled" to cover staffing shortages. Id., citing P. Ex. 12, a 1, 7, 9, 23.

The ALJ also found that –

- Not all residents were capable of using hand bells.

- Hand bells were not available in all rooms for residents capable of using them.
- Hand bells "provided no coverage for toilets and bathing areas."
- Bell monitors did not hear ringing bells or heard them, but did not respond in a timely manner or at all.
- Room checks by bell monitors left large periods of time when residents were "effectively out of contact with facility staff."

Id. at 7-8, citing CMS Ex. 21 (DuBose Decl. ¶¶17, 18); CMS Ex. 23; CMS Ex. 22, at 3. The ALJ cited the surveyor's statement that he saw no bells in a number of rooms housing residents capable of using bells. ALJ Decision at 7, citing CMS Ex. 21, at 10 (DuBose Decl. ¶17). The ALJ credited the administrator's claim that staff subsequently located bells in all but three of these rooms but also noted that the administrator provided no details about where the bells were found. Id., citing P. Ex. 44 at 4 (Hornsby Decl. ¶16). The ALJ then concluded, "[t]he uncontroverted evidence thus establishes that three capable residents had no bells in their rooms at the time of the survey, and fifteen other capable residents did not have bells readily available to them."[6] ALJ Decision at 7.

Based on this record regarding the malfunctioning call light system and the ineffectiveness of the substitute system, the ALJ found "that, from July 27 through October 5, 2005, the facility had no effective call light system, and was thus not in

[6] The surveyor stated in his declaration, "I identified many residents without manual call bells who were capable of using them" and then listed the 12 rooms in which those residents resided. This is the same list contained in the ALJ Decision. However, six of the rooms contained two residents (e.g. 111A-B). Thus, a total of 18 residents resided in the listed rooms. That explains how the ALJ arrived at her conclusion that three capable residents had no bells and 15 capable residents had no bells readily available. In her declaration, Opelika's administrator stated with respect to the bells found by staff in the rooms of the 15 residents, "These bells were placed within reach of these residents." P. Ex. 44 at 4, ¶ 16. (emphasis added) Since the administrator did not state that the bells were found within reach of the residents and gave no details about where they were found, the ALJ apparently inferred that the bells were not within reach of the residents when found but were subsequently put within their reach. We find this a reasonable inference.

substantial compliance" with the regulatory requirement for call systems.[7] Id. at 8.

On appeal, Opelika challenges FFCL III.A., in which the ALJ found that Opelika was not in substantial compliance with 42 C.F.R. § 483.70(f)(resident call system) and that said noncompliance constituted immediate jeopardy from July 27 through October 5, 2005, and FFCL III.C., in which the ALJ found that the $100 CMP for the non-immediate jeopardy period was reasonable. RR at 5.

Discussion

I. The ALJ's finding of noncompliance with 42 C.F.R. § 483.70(f) is supported by substantial evidence and free of legal error.

Opelika does not dispute the material facts on which the ALJ relied for this finding and even admits that its "electronic call light system malfunctioned during the period from July 27, 2005, through October 5, 2005." RR at 13. However, Opelika argues that the ALJ erred in concluding that it failed to comply with the regulatory requirement by having an "essentially inoperable" electronic call light system. RR at 11. Opelika asserts that the regulation does not require an electronic call light system but, rather, only requires that a facility's nurse's stations be equipped to receive calls "through a *communication system* from resident rooms and toilet and bathing facilities." Id. (italics in original). Opelika also asserts that a facility may maintain substantial compliance notwithstanding an inoperable or malfunctioning call light system "so long as the alternate communication system is reliable and effective." RR at 11, citing Lake Shore Inn Nursing Home, Inc. v. CMS, DAB CR1361 (October 14, 2005), (Lake Shore).

Opelika misreads the ALJ's finding here and the Lake Shore decision. As we noted earlier, the ALJ did not find that only an electronic call system would comply with the regulation. While she began by discussing the extended malfunctioning of the

[7] Although the phrase "call light system," on its face might suggest the finding relates only to an electronic system, the ALJ's discussion underlying that finding clearly shows that her use of the phrase encompasses not only the malfunctioning electronic call system but also the ineffective substitute, non-electronic call system. Accordingly, it is clear, in context, that the ALJ found that the facility had no effective "call system" within the meaning of 42 C.F.R. § 483.70(f), and we see no need to modify her finding.

electronic call system, she then proceeded to consider, based on the facts of record, whether the hand bell system used as a substitute was an effective communication system. She concluded that it was not. ALJ Decision at 7. She found the substitute system ineffective, in part, because not all residents had access to the hand bells or were capable of using them; the bells could not always be heard, even by monitors walking through the halls; and, the hand bell system provided no coverage at all for the toilets or bathing facilities. The regulation expressly requires a communication system "from ... [t]oilet and bathing facilities." 42 C.F.R. § 483.70(f). Thus, in our view, the absence of any substitute call system in these rooms, without more, justifies the finding of noncompliance here. As Rosemary Wilder, R.N., indicated in testimony cited by the ALJ, "bathrooms can be very dangerous for nursing home residents. It is not uncommon for elderly people to be seriously injured in bathrooms. Therefore, it is imperative that the residents have some means to communicate with the nursing staff while in the bathroom." CMS Ex. 22, at 3 (Wilder Decl. ¶6), cited in ALJ Decision at 7. The ALJ's finding also is supported by the declaration testimony of surveyor DuBose, who personally tested the hand bell system by ringing bells on two occasions and received no response, even after waiting as long as an hour. CMS Ex. 21, at 10, ¶18. The ALJ noted that the surveyor's personal experience was supported by statements from some of the facility's bell monitors, that hand bells wrung "on the far end" of the unit could not be heard, and residents would stop ringing before the monitors could answer them. ALJ Decision at 7, citing P. Ex. 38, at 1. The evidence discussed provides more than substantial support for the ALJ's finding of noncompliance with the call system requirement.

The Lake Shore decision, by ALJ Smith, is not binding on other ALJs or on the Board,[8] but, in any event, provides no basis for disturbing the ALJ's findings in this case. In Lake Shore, CMS cited a deficiency under survey tag F463 at the immediate jeopardy level for a malfunctioning call light system. Lake Shore at 5. ALJ Smith interpreted 42 C.F.R. § 483.70(f) as requiring that a "communication system, whatever system that is, be effective and reliable. To be effective and reliable, the system *must work*" in order to protect resident health and safety. Id. at 6 (italics in original). He concluded that "Petitioner had a system in effect where residents were dependably able to convey messages and that the amount of time that the system was down was adequately addressed by staff." Id. at 9. Because he

[8] The decision was not appealed to the Board.

found the facility in substantial compliance, he found no basis for the finding of immediate jeopardy. Id.

ALJ Hughes' legal analysis is entirely consistent with the analysis in Lake Shore. Both decisions focus on whether there was an effective communication system in place while the electronic systems were malfunctioning. ALJ Smith's reasoning that any communication system, "whatever system that is ... must be effective and reliable [and] ... must work," id. at 6, is consistent with ALJ Hughes' finding that "[w]ith or without bell monitors, the hand bell system was not an effective substitute for an electronic call light system . . . ." ALJ Decision at 7. The different conclusion reached by ALJ Smith with respect to the effectiveness of the substitute system can be explained by the facts of that case, which are clearly distinguishable from those here. The call light malfunction in Lake Shore occurred only when five or more residents on the affected wing pressed their call lights simultaneously, which the ALJ found happened "rarely." Lake Shore at 7. The facility staff was aware when the system went down and knew how to and did reset it within 5-10 minutes of a malfunction. Id. Until the system was back in operation, nurses physically went into every room to check whether the light was depressed. Id. Furthermore, although the call system in Lake Shore dated back to 1968, id. at 8, the facility experienced no problems with it until November 2003 and replaced it by March 2004, id. at 4-5.

By contrast, Opelika's system outages affected the call lights in an entire unit containing 47 rooms and 73 beds, and the malfunctions had started more than three and a half years earlier. ALJ Decision at 4. Opelika's system shut down for a week in March 2005, experienced partial outages in June and went down completely on July 27. Id. at 4-5. Subsequently, the system functioned partially with repairs but kept shorting out until it was replaced in early October 2005. Id. at 5. These facts are established by the facility's own maintenance records and capital requisition form. See P. Exs. 22, 23, 32. They are also supported by the declarations of the maintenance director and administrator. See P. Exs. 42, 44.

In Lake Shore, the ALJ also found that the backup measures taken by the facility assured that an effective communication system was in place during the call light failures. Lake Shore at 7, 9. In addition to distributing hand bells to residents able to use them, Lake Shore equipped impaired residents with personal alarms; instructed staff to be on the alert for any sign the electrical system was down and to test the system when no lights were on; had staff on the evening and night shifts make more

frequent rounds; and, placed notices of the possibility that the call system would fail on bulletin boards. Id. at 5. Opelika distributed hand bells to residents capable of using them (although not all such residents, the surveyor found) and asserts that it checked more frequently on residents whose doors were closed or were known to be sick. RR at 14, 15. However, Opelika does not assert that it equipped residents who could not use bells with any devices they could use to communicate with nursing staff. Furthermore, although Opelika began using monitors to listen for ringing bells, it did not do so until a month after the July 27 outage, and neither the bells nor the monitoring system were effective for the reasons addressed by ALJ Hughes. See ALJ Decision at 7. In sum, Lake Shore is factually inapposite, in addition to not being legally binding or analytically inconsistent with the ALJ decision being reviewed here.

Opelika challenges the ALJ's finding that it should have begun planning for a replacement call light system earlier than it did, arguing that "it is entirely unreasonable and contrary to the law to conclude that Opelika "should have replaced its call system at the first sign of trouble." RR at 19. Opelika mischaracterizes the ALJ's finding. She did not find that the facility should have replaced the system at the "first sign of trouble," which could have been as early as 2002, when the main panel had to be replaced, or 2003, when the main control unit was replaced for the first time. The ALJ did find that Opelika should have begun planning for a replacement system no later than June of 2005 based on the existing system's well-documented maintenance history and, beginning with the March breakdown, the repeated system outages, the difficulty in finding parts and making repairs and the short-lived effectiveness of those repairs, when they worked at all. The ALJ recognized that maintenance staff made "significant efforts" to keep the system functioning, but she also noted that facility documents showed the system broken down more than operational. Id. at 6. She also cited a June 22, 2005 work order for repair of outages that had occurred in certain rooms. ALJ Decision at 6, citing P. Ex. 23 at 5. That order contains hand-written notes showing that the outages never were corrected for the reason "system old – Bad wiring." Id. Opelika itself does not state an alternative date with respect to when it should have begun planning for a replacement system, and the ALJ's finding that it should have begun this planning by June, 2005 can reasonably be inferred from the facility's own

records.[9] Yet, Opelika waited until September to begin soliciting bids for a new system. Based on the record as a whole, the ALJ reasonably rejected Opelika's assertion that it had taken "'all reasonable steps' to maintain an effective call light system." Id. Substantial evidence supports the ALJ's finding of noncompliance with 42 C.F.R. § 483.70(f), and she made no legal error.

II. We affirm the ALJ's finding that CMS's determination of immediate jeopardy is not clearly erroneous.

Opelika asserts, "The fact that no resident was harmed during the 71-day period that the electronic call system was malfunctioning is not merely 'fortuitous' as suggested by ALJ Cozad Hughes." RR at 21. We note at the outset that this is another admission by Opelika that its call light system was not working from July 27 through October 5, 2007. These admissions totally undercut Opelika's later argument that the ALJ's finding that "the alleged immediate jeopardy period lasted from July 27, 2005 through October 5, 2005 is not supported by substantial evidence [and] ignore[s] evidence that facility staff continued to repair the system as late as August 19, 2005, and that the system did not irreparably shut down until August 22, 2005." RR at 22. As long as the system was malfunctioning, Opelika was required to have an effective back-up system in place, and it did not. Moreover, as the ALJ correctly concluded, whether any resident was actually harmed as a result of this malfunctioning (or the absence of an effective substitute system) is irrelevant since actual harm is not required to support a determination of immediate jeopardy; the likelihood of serious harm is sufficient. ALJ Decision at 8.

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[9] Opelika states later in its brief that "the system did not irreparably shut down until August 22, 2005." RR at 22. However, this is not the same as an assertion that until that date Opelika continued to think the system could be successfully repaired rather than replaced. Furthermore, such an assertion would be contradicted by evidence of record, for example, the work order indicating that call lights in certain rooms were not and could not be repaired after ceasing to function in June and the technician's report in July that all of the call lights would have to be replaced. Ultimately, the issue of when the facility should have begun planning for a new call system is irrelevant, because given the undisputed continual malfunctioning of the existing system, the material question is whether Opelika had an effective substitute call system in place during the period beginning July 27, 2005, when it clearly did not have a functioning call light system.

Indeed, Opelika acknowledges as much when it quotes the definition of "immediate jeopardy" in 42 C.F.R. § 488.301. RR at 20-21.

As the ALJ noted, the party seeking to overturn an immediate jeopardy determination must show that it is clearly erroneous. 42 C.F.R. § 488.301. The Board has stated in a number of cases, e.g., Daughters of Miriam Center, supra, that this is a very heavy burden, and that an immediate jeopardy determination is not clearly erroneous so long as CMS has presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists," Barbourville Nursing Home, supra. The evidence of record, discussed elsewhere in this decision, more than supports a reasonable conclusion that the absence of an effective call system for more than two months presented a likelihood of harm to the facility's residents. As the ALJ discussed, citing the testimony of Rosemary Wilder, R.N.,

> Nursing home residents include a highly vulnerable population, who often need immediate assistance. Nurse Wilder correctly points out that residents use call systems for mundane matters, but also to remind nursing staff to bring them medication or to request assistance in going to the bathroom. The system is also a critical part of the facility's emergency system since it immediately alerts staff of a resident's acute symptoms or accident, and allows staff to summon additional help in an emergency.

ALJ Decision at 9, citing CMS Ex. 22, at 2 (Wilder Decl. ¶ 3).

We find no basis for overturning the ALJ's conclusion that CMS's determination that the absence of an effective call system (whether electronic or some effective substitute system) posed immediate jeopardy to the health and safety of residents, because it deprived residents (and staff attending residents) of the ability "to communicate expeditiously with the nurse's station from the resident rooms as well as from toilet and bathing facilities." ALJ Decision at 9. Opelika argues that there was no risk of serious harm because "frequent monitoring of residents [was] conducted by facility staff members." RR at 21. The only evidence of record about monitoring is the evidence regarding the bell monitors. However, as discussed earlier, the bell monitors did not start until late August, more than a month after the electronic system went down, and only worked in this capacity 12 hours a day. Furthermore, as the statements of the bell monitors

themselves show, this monitoring was insufficient to assure that all bells were heard and answered in timely fashion, especially for residents at the far ends of the unit or with their doors closed. See P. Ex. 38.

For the reasons discussed, we affirm the ALJ's finding that CMS's determination of immediate jeopardy for the period July 27 through October 5, 2005 was not clearly erroneous.

Conclusion

Based on the above analysis, we uphold the ALJ Decision in its entirety.

/s/
Judith A. Ballard

/s/
Leslie A. Sussan

/s/
Sheila Ann Hegy
Presiding Board Member