Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: March 28, 2008
Oxford Manor,	
Petitioner,	Civil Remedies CR1686 App. Div. Docket No. A-08-38
- v. -	Decision No. 2167
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Oxford Manor, a nursing facility located in Oxford, North Carolina, requested review of the decision by Administrative Law Judge (ALJ) Steve Kessel in Oxford Manor, DAB CR1686 (2007)(ALJ Decision). The ALJ Decision upheld the determination by the Centers for Medicare & Medicaid Services (CMS) to impose on Oxford Manor a civil money penalty (CMP) of $3,050 per day for the period April 26 through June 21, 2006 and a CMP of $50 per day for the period June 22 through July 22, 2006.

Oxford Manor's lengthy appeal brief contains numerous misstatements about what the ALJ did and found and what the record shows. Since the ALJ Decision is clear and thorough, we do not here identify every respect in which Oxford Manor's brief is simply incorrect. The ALJ Decision also sets out the legal context in which the issues arise and the undisputed facts regarding the history of the case and the residents' characteristics, so we do not repeat them here. Instead, we address below Oxford Manor's legal arguments on appeal, explaining how they are based on erroneous premises or on a

misreading of past Board decisions. We then explain why we reject Oxford Manor's assertions about the lack of any evidentiary basis for the ALJ's findings, as well as its complaints about the fairness of the hearing process. We conclude that the ALJ Decision is free of legal and procedural error and based on substantial evidence in the record as a whole.

Accordingly, we uphold the ALJ Decision and affirm and adopt each of his findings of fact and conclusions of law.

1. Oxford Manor's legal arguments are based on erroneous premises.

A. Oxford Manor's arguments about the role of a statement of deficiencies and the burden on CMS have no merit.

Oxford Manor presents arguments about the role of a statement of deficiencies (SOD) resulting from a survey of a long-term care facility. Oxford Manor argues that the general rule is that allegations in a charging document are not evidence. Oxford Manor says the Board has never addressed "whether a sanction may be premised *solely* on uncorroborated allegations set forth in a Statement of Deficiencies where a petitioner denies or rebuts such allegations." Appeal Brief (App. Br.) at 11, n. 3.

Contrary to what Oxford Manor suggests, however, this Board has addressed the role of an SOD, indicating that an SOD may function both as a notice document and as evidence of the facts asserted therein. See, e.g., Pacific Regency Arvin, DAB No. 1823 (2002). The Board has also discussed the regulatory requirements for who is qualified to conduct surveys of long term care facilities and for how the results of those surveys must be documented, as relevant to evaluating the surveyors' findings and opinions. See, e.g., Omni Manor Nursing Home, DAB No. 1920, at 11 (2004), citing 42 C.F.R. §§ 488.314(a)(1), (2), and (3); 488.26(c)(3) and (d).

The Board has also said that if a finding in an SOD is not disputed, CMS need not present evidence in support of the finding. Batavia Nursing and Convalescent Center, DAB No. 1904 (2004), aff'd, Batavia Nursing and Convalescent Center v. Thompson, 129 Fed. Appx. 181 (6th Cir. 2005). If a finding in an SOD is disputed, the issue once both parties have presented their evidence, as they did here, is whether the petitioner showed substantial compliance by a preponderance of the evidence. Id. Mere denial by a petitioner is not enough. If the petitioner

presents no evidence to rebut CMS's evidence of noncompliance or if the evidence on which the petitioner relies is irrelevant or unreliable or outweighed by evidence to the contrary, the petitioner has not met its burden.

Here, moreover, Oxford Manor's suggestion that the ALJ was relying only on the SOD and improperly had shifted the burden to Oxford Manor to prove it was in substantial compliance has no merit. First, most of the key facts on which the ALJ relied were undisputed by Oxford Manor. Second, CMS presented testimony from the surveyors corroborating their findings documented in the SOD, as well as their contemporaneous notes made during the survey, and both parties provided documentation from the facility's records.

To the extent Oxford Manor is suggesting that the ALJ wrongly placed the ultimate burden of persuasion on Oxford Manor, that suggestion also has no merit. First, placing that burden on Oxford Manor is appropriate based on the applicable statute and regulations, which we fully analyzed in Batavia. Second, even if CMS had the ultimate burden to show lack of substantial compliance by a preponderance of the evidence, we would conclude that CMS met that burden here. Allocation of ultimate burden of proof is material only where the evidence is in equipoise. Fairfax Nursing Home, Inc. v. U.S. Dep't of Health and Human Services, 300 F.3d 835, 840, n.4 (7th Cir. 2002), on appeal from Fairfax Nursing Home, Inc., DAB No. 1794 (2001), cert. denied 537 U.S. 1111 (2003). The evidence was not in equipoise in this case.

B. Oxford Manor's arguments based on the foreseeability of particular incidents have no merit.

Oxford Manor based much of its argument on the misconception that it was found to have violated long term care facility participation requirements based solely on "incidents" that were not foreseeable. Even a cursory reading of the SOD, the surveyors' testimony, and the ALJ Decision, however, indicates that the noncompliance was evidenced not by the incidents themselves but by what the circumstances surrounding the incidents (and the surveyors' queries about the incidents, observations while at the facility, and review of the records) revealed about whether the facility had been following its own policies and plans of care for its residents and about the facility's lack of adequate response to the residents' behavior and needs.

The basis for concluding that the facility was not ensuring that

the resident environment was free of accident hazards was not merely the "incident" in which a Certified Nurse Assistant (CNA) found Resident #10's Wanderguard electronic bracelet under Resident #10's bed with marks the CNA identified as burn marks. Instead, the basis included findings such as the following (which Oxford Manor did not dispute): staff indicated to the surveyor that they knew that Resident #10 had been keeping a lighter in his room; this was contrary to facility smoking policy; the facility records showed no steps to take the lighter away or to investigate the incident with the bracelet even after it was reported to the facility's Business Manager; and Resident #10 had not been assessed for competency to smoke between the time of his admission in November 2005 and the survey in June 2006. Indeed, it is undisputed that, when Oxford Manor assessed Resident #10 during the survey, it found him not competent to smoke unsupervised, even outdoors. There is no evidence that the facility took any steps to remove his lighter from his room, even after the CNA reported he had burned off his Wanderguard bracelet. The risks of danger to himself and others if Resident #10 continued to have the means to burn off his Wanderguard bracelet were not merely "hypothetical," as Oxford Manor asserts. Given the documented (and undisputed) facts that he had anxiety about being in the facility and wanted to go home, and, among other relevant problems, had impaired judgment and an unsteady gait (although he could walk), foreseeable risks included that he would burn himself, start a fire in the facility, or elope (thus placing himself in unsupervised situations where he might fall or otherwise risk injury).

Similarly, with respect to an incident in which Resident #5 eloped from the facility, the noncompliance was found not merely because Resident #5 eloped. The facility had attached her Wanderguard bracelet to her wheelchair, rather than to her person. Since she was ambulatory, she thus was able to walk out of the facility without setting off the door alarm. These facts are undisputed, as are facts such as that she had mental deficits, impaired judgment, and an unsteady gait. Yet, after the elopement, Oxford Manor had done nothing to change the practice of attaching the bracelet only to her wheelchair, and the interventions it planned would not prevent her from eloping undetected in the same way she had.[1]

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[1] The ALJ did, as Oxford Manor points out, reject its evidence that it could not have foreseen the elopement. Substantial evidence in the record supports the ALJ's finding that her elopement was foreseeable, since she was ambulatory.

(continued...)

Thus, as the ALJ clearly explained, the issues in this case focused not on whether the cited incidents were foreseeable but on whether the facility's response was adequate to meet the regulatory standards. Tr. at 61-64. Oxford Manor claims that the SOD was unclear about what the surveyors thought the facility did wrong, but the obvious concern was about what it did not do.

C. The ALJ did not err in relying on the facility's own smoking policy.

Oxford Manor's brief generally tries to divert attention from the key (and largely undisputed) findings that staff knew Resident #10 had a cigarette lighter in his room, contrary to its own policy, and that Oxford Manor had not followed its policy to reassess competency of the resident to smoke every six months, even after the incident with the Wanderguard bracelet. Oxford Manor argues that holding the facility to its own policy interferes with the judgment of staff who know a resident and his/her needs.

This argument has no merit. A facility policy such as the smoking policy here may play various roles in evaluating compliance with federal requirements. Spring Meadows Health Care Center, DAB No. 1966, at 16-20 (2005); Century Care of Crystal Coast, DAB No. 2076 (2007). Here, Oxford Manor's policy functioned as evidence that the facility understood the dangers if residents are allowed to keep lighters in their rooms and to smoke unsupervised in other than designated areas. The policy also shows that Oxford Manor understood the need to periodically reassess whether a resident is competent to smoke unsupervised, even in designated areas. The policy is also evidence of the standard of care the facility expected its staff to provide.

While the existence of such a policy may not necessarily rule out an exception for a particular resident, it is fair to expect that if facility staff exercise professional judgment in deciding not to follow facility policy with respect to a particular resident, they document that judgment and give a reason why not. In the absence of such contemporaneous documentation, it is certainly reasonable to infer, when staff do not follow the policy, either that they are not aware of it or that they are simply

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[1](...continued)
See, e.g., CMS Ex. 34, at 41; CMS Ex. 16. But the point here is that Oxford Manor's premise that the noncompliance finding was based only on an unforeseeable incident misrepresents the basis for that finding.

disregarding it.

Oxford Manor argues that facility staff had decided not to strictly enforce the facility's smoking policy with respect to Resident #10, but provided no documentation that any such professional judgment was made by the team responsible for planning Resident #10's care, either before or after staff knew about the incident with the bracelet. Moreover, the only testimony Oxford Manor presented with respect to Resident #10's smoking was that of its current Director of Nursing (DON). P. Ex. 33, at 4. That testimony does not support Oxford Manor's general assertion about the staff's alleged exercise of professional judgment, much less address why Resident #10 was allowed to continue to have a lighter in his room contrary to facility policy after the Wanderguard bracelet was found.

Thus, we conclude that, in relying on the facility's own policy, the ALJ was not improperly substituting his own judgment for that of professionals who knew the resident.

2. Substantial evidence in the record supports the ALJ's findings regarding Oxford Manor's failure to ensure the environment was free from accident hazards, as required by 42 C.F.R. § 483.25(h)(1).

A. Substantial evidence supports the ALJ's findings regarding the incident with Resident #10's Wanderguard bracelet.

Oxford Manor argues that it was never confirmed that Resident #10 burned his Wanderguard bracelet off. Oxford Manor acknowledges, however, that the "bracelet contained what appeared to be burn marks, which suggested that the Resident had burned it off." App. Br. at 15. Moreover, the CNA who found the bracelet under Resident #10's bed also reported that, at the time, Resident #10 was keeping a lighter in his room. P. Ex. 1, at 8. This CNA clearly thought the bracelet had been burned off, since he told the surveyor he had reported that it had been burned. Id. at 6. The Business Manager to whom the CNA gave the bracelet told the surveyor that the CNA "brought me the alarm that had been burned off" and that the "strap was burned," and the description of the surveyor (who examined the bracelet) is consistent with burning. Id. at 8. An investigation might possibly have found otherwise, but Oxford Manor does not deny it conducted no investigation. The point, in any event, is that, even though the appearance of the bracelet was consistent with burning and staff knew Resident #10 had been keeping a lighter in his room and wanted to go home,

there is no probative evidence anything was timely done to take the lighter from him.

Oxford Manor argues that there is no evidence that the Resident "had burned his arm, that he had burned off the bracelet inside the building, etc." App. Br. at 15. Given that the incident was reported, the bracelet was replaced, and the Resident was counseled about it, Oxford Manor says, it "frankly is not sure why ALJ Kessel elevated this incident to major importance." Id. Oxford Manor contends that--

> the staff of any nursing facility deals with resident noncompliance and similar operational issues and anomalies every day and a facility would be in pandemonium if every CNA or nurse treated every unusual incident as the proverbial 'federal case.' . . . Residents try to remove alarm bracelets all the time . . . no one at Petitioner's facility considered this particular incident significant enough to initiate an investigation, write an incident report, or to bring the matter to the Administrator's personal attention. That judgment arguably may be debatable, but it is also undisputed that the Resident was not injured, which is the typical trigger for such an investigation or report. . . . [T]he CNA who dealt with the matter plainly was satisfied that verbal counseling of the Resident was an appropriate and sufficient response. In fact, that intervention worked just fine. Again, ALJ Kessel offers no reference to any expert testimony, standard of care, etc., to support his personal opinion about what the CNA should have done. Indeed, the ALJ never says what else the regulation would require.

Id. at 15-16. On its face, however, section 483.25(h)(1) requires a facility to ensure that the resident environment is free of accident hazards. The facility's policy is evidence that it knew lighters in residents' rooms where they could use them unsupervised were accident hazards and also is evidence of the nursing standard of care. P. Ex. 13, at 1, quoted in ALJ Decision at 5. Oxford Manor conceded, moreover, that "[i]f the Resident actually did burn the bracelet off . . . that obviously could be a potentially hazardous situation . . . ." P. Post-hearing Br. at 12-13.

The ALJ reasonably concluded there are obvious and foreseeable hazards in the situation. Resident #10 might burn or attempt to burn his Wanderguard bracelet off again and either burn himself or be able to elope from the facility undetected (and thereby

place himself in an unsupervised situation) or might inadvertently start a fire that would endanger others. Indeed, Oxford Manor's assertion that residents "try to remove alarm bracelets all the time" supports a conclusion that Resident #10 was likely to try it again. The ALJ reasonably found troubling the fact that, despite facility policy and the obvious danger, Oxford Manor did nothing to ensure that Resident #10 did not continue to have a lighter available in his room where he could use it unsupervised and might remove the bracelet again or even to investigate how the bracelet had been removed.[2]

There is also no merit to Oxford Manor's assertions that the CNA had made a "professional judgment" that all Resident #10 needed was counseling and that the counseling must have been sufficient since the resident had not tried to again burn off the Wanderguard bracelet in the period between the incident (described as occurring about two months before the survey) and the survey. First, as the ALJ pointed out, it does not make sense to think that counseling would be sufficient, given Resident #10's undisputed mental deficits. Second, Oxford Manor does not explain how, even if it was the CNA's judgment that it was acceptable to leave a lighter in Resident #10's room, that judgment could take precedence over facility policy prohibiting lighters in residents' rooms. Third, Oxford Manor presented no evidence this CNA did, in fact, think at the time that the counseling she gave the Resident would suffice. Since the CNA stated that she went to the office to report that the bracelet was burned off and told the Business Manager, who was there, she obviously expected facility management to become involved. P. Ex. 1, at 5-6. Indeed, the then DON told the surveyor that, if she had known about the incident, she "would have made sure he didn't have a lighter." P. Ex. 1, at 8. Finally, we are not willing to assume, as Oxford Manor's assertions do, that the CNA's counseling was effective and that Resident #10 made no other attempt to burn off the bracelet. No other attempt was documented or admitted, but this does not necessarily mean there was none. And, as we discuss below, there is evidence that on May 29, 2006, he did not have his bracelet on when he left the building.

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[2] Oxford Manor's Exhibit 13, at 2, is a plan to address Resident #10's propensity to have and hide a lighter. But this document is undated, and Oxford Manor's posthearing brief (at 9, n.2) describes this document as "apparently created during the survey."

B. The ALJ reasonably relied on statements made by Oxford Manor staff to the surveyor.

Oxford Manor criticized the ALJ for relying on what Oxford Manor calls "second or third hand allegations by CNA's." App. Br. at 12-13. As this Board has consistently held, statements such as those made by the CNAs to the surveyor may be admitted in an administrative proceeding and may constitute substantial evidence, for purposes of review. See, e.g., Omni Manor, *supra*; Pacific Regency Arvin, *supra*; Richardson v. Perales, 402 U.S. 389, 410 (1971). The relevant issue is whether there are indicia that the statements are reliable.

Here, the ALJ could reasonably rely on the statements made to the surveyor by staff. Oxford Manor did not deny that its staff made the statements to the surveyor (who testified they did, based on her contemporaneous notes from the survey). Oxford Manor had an opportunity to present the declarants as witnesses but chose not to do so. Moreover, the staff's statements were consistent with each other, with the statement by Resident #10's wife that he smoked in the bathroom, and with other evidence in the record.

Oxford Manor misrepresents the evidence when it argues that "not a single one of the referenced statements that the ALJ relied upon for his 'inference' of a significant violation actually says that the Resident was smoking indoors, or in an unsafe manner, much less that Petitioner's staff was indifferent to the matter." App. Br. at 12. Oxford Manor contends that "Surveyor Edwards never testified that she saw or heard of any evidence that the Resident smoked indoors, much less that she found any evidence that the Petitioner staff was indifferent." Id. It is true that Surveyor Edwards did not testify that she saw smoke in the room or that she saw Resident #10 smoke in his room, but she said she smelled smoke in the room on June 22. Tr. at 14.[3] And, even if the statements she said she heard from the staff only implied that Resident #10 smoked indoors, Surveyor Edwards was also relying on the statement by his wife that he smoked in the bathroom (and the housekeeper had complained about it) and on her review of Resident #10's record. Tr. at 7-8; CMS Ex. 38, at 3; P. Ex. 1, at 8-9. Resident #10's record contains statements

[3] That she did not see him smoke inside on June 21 or 22 is not significant since by that time the facility had been alerted about the problem and taken steps to address it. Also, the surveyor was told that, since Resident #10's lighter had stopped working about two weeks before the survey, he had been getting lights from other residents' lit cigarettes. P. Ex. 1, at 8.

directly indicating that he was smoking in the halls, with no indication that he was redirected to designated smoking areas. For example, nurses' notes state: "pt. walking halls smoking cigarettes" and "pt walking in halls smoking." P. Ex. 11, at 12 (5/29/06 note) and at 13 (6/5/06 note). Surveyor Edward's testimony also referred to the findings in the SOD (supported by her survey notes). CMS Ex. 38, at 3. Those findings included other evidence of the facility's indifference, such as statements to the surveyor by the Business Manager and the then DON indicating that either the Business Manager never told the DON about the report of the burned Wanderguard bracelet or that the DON never acted on it after being told, even though she said she would take care of it. P. Ex. 1, at 6-8. Oxford Manor does not deny that these statements were made, and presented no testimony from either individual.

Oxford Manor also seeks to dismiss the staff's statements about Resident #10 as relating to the first few months after he was admitted to the facility and still adjusting to the facility's smoking policy. The ALJ properly rejected this argument, based on the statements by staff and Resident #10's wife indicating that the presence of a lighter in Resident #10's room was observed well after he was admitted to the facility and at least up to a couple of weeks before the survey (when apparently it stopped working). ALJ Decision at 9. Also, as the ALJ noted, the surveyor observed that the room smelled of smoke and smoking materials were present. Tr. at 14.

Oxford Manor argues that the ALJ too readily dismissed its arguments about the presence of cigarette butts in Resident #10's room. Oxford Manor asserts that the SOD -

> specifically recites that a staff person told the surveyor that the Resident hoarded cigarette butts, and "goes out [the back door] 20 times a shift (8 hours) and smokes a small amount of a cigarette each time. He smokes the same cigarette several times."

App. Br. at 14, citing P. Ex. 1, at 6. The term "hoarded" does not appear in the SOD. Even if the resident would smoke only a small amount of a cigarette each time he went outside and then "hoard" the butts, however, it is still reasonable to infer from the evidence as a whole that his smoking was not limited to the outside designated areas.

Oxford Manor also argues that the presence of the butts is irrelevant because its smoking policy permitted residents to keep cigarettes. The policy, however, only permitted residents "who

are determined by assessment to be competent" to "retain cigarettes" and does not specifically mention cigarette butts. P. Ex. 13. As discussed below, Resident #10 had not been periodically assessed for competency to smoke, as required. Also, interpreting the policy to permit any resident to "hoard" cigarette butts seems unreasonable, given that one of the tests for safe smoking on the only assessment document Oxford Manor submitted is whether the resident "disposes of ashes and butts." P. Ex. 5, at 3.

Ample probative and reliable evidence in the record as a whole indicates the staff were well aware Resident #10 was given lighters and cigarettes by his family, kept a lighter and cigarette butts in his room, and smoked inside the facility as well as in the designated areas, contrary to facility smoking policy. Yet, there is no evidence showing that the facility took steps to remove the hazard prior to the survey, even after receiving information that Resident #10's Wanderguard bracelet was found under his bed, apparently burned off.

C. Oxford Manor ignores the significance of its failure to reassess Resident #10's competency to smoke every six months, as required.

Another problem that Oxford Manor ignores is the undisputed fact that Oxford Manor performed no quarterly assessments of Resident #10's competency to smoke, as its policy required. Oxford Manor asserts that CMS "premised its citation on the allegation that Petitioner's staff *never* assessed Resident #10's competency to smoke," but that, in fact, Oxford Manor had assessed the resident to be a "safe smoker." App. Br. at 10, citing P. Exs. 5 and 33 (italics in original). Under the smoking policy, a "resident assessed as competent" is permitted to smoke unsupervised in designated areas (outside of the facility), using a lighter kept at the nurses station. P. Ex. 13, at 1.

First, contrary to what Oxford Manor suggests, the ALJ did not find (nor did he need to find) that Oxford Manor <u>never</u> assessed Resident #10. He stated instead that "staff did not perform an assessment between his admission on November 30, 2005 and the June survey of the need to supervise Resident #10 while he smoked." ALJ Decision at 5. This finding was undisputed by Oxford Manor.

Oxford Manor seeks to downplay the significance of its failure to assess Resident #10's competency quarterly, as required by facility policy, but does not deny that, when Resident #10 was assessed during the survey in June 2006, he was found

incompetent. While arguing that Resident #10 was stable, Oxford Manor provided no evidence showing the assessment that he was incompetent to smoke unsupervised at the time of the survey was based on characteristics or behaviors that could not have been identified before the survey if he had been assessed quarterly. The record shows that Resident #10 had been exhibiting increased signs of anxiety and confusion as early as March 2006, was increasingly stating he wanted to go home in April 2006 (when he apparently burned off the bracelet), and then was attempting to leave the facility more often in May 2006. P. Exs. 11 and 10. On May 21, after he had left the facility several times and been redirected inside, the staff applied a new Wanderguard to his leg and he "stated he was going to cut it off." P. Ex. 11, at 10. As discussed below, he also attempted to elope on May 29. Oxford Manor points out that the Resident's physician had taken steps to address his anxiety. But Oxford Manor does not explain why, if these steps were sufficient, the interdisciplinary team assessed him on June 22 as not competent to smoke without supervision.

Second, to the extent Oxford Manor is suggesting that the ALJ should have discussed the evidence regarding the November 30, 2005 assessment since CMS's position was premised on a finding that Resident #10 was never assessed, we disagree. The key issue was whether Oxford Manor's staff was following its own smoking policy. There is ample evidence that it was not. Moreover, Oxford Manor's evidence regarding the November 2005 assessment does not reliably establish even one assessment consistent with the smoking policy. That policy requires an assessment by the "IDT (Interdisciplinary Team)." P. Ex. 13, at 1. Although the assessment form which Oxford Manor submitted for Resident #10 is called an "Interdisciplinary Assessment," it is signed by only one nurse, in contrast to the Basic Assessment Tracking Form (using what is called the Minimum Data Set to comprehensively assess the Resident), which is signed by four individuals. *Compare* P. Ex. 5 *with* P. Ex. 4. Surveyor Edwards testified that, although she saw the document on which Oxford Manor relies (which she referred to as the "24-hour" physical assessment), Oxford Manor did not during the survey produce any assessment on its "smoking assessment form," instead producing only a blank document, when she requested to see smoking assessments for Resident #10. Tr. at 25-29. The "24-hour" document, moreover, has checks under both the "Yes" and the "No" columns in response to the question "Is the resident a smoker?" P. Ex. 5, at 3. Although someone crossed out the check in the "No" column and initialed the change, there is no notation or other convincing

evidence about when this change was made.[4] The DON testified that Resident #10 had been assessed as a "safe smoker" shortly after his admission. P. Ex. 33, at 4. She signed neither of the assessment documents done at the time, however, and she does not state that the assessment was performed by an IDT, as required.

In sum, it is undisputed that Oxford Manor did not perform any assessment after November 30, 2005, although its policy required quarterly assessments, and this failure is itself significant. Moreover, Oxford Manor's evidence about the November 2005 assessment is flawed and does not undercut either the ALJ's conclusions or the reliability of the survey findings.

D. The ALJ did not improperly disregard testimony of Oxford Manor's Director of Nursing.

Oxford Manor argues that the ALJ improperly disregarded the testimony of its DON, which Oxford Manor says established that Resident #10 was supervised adequately, and indicated that staff had removed prohibited items from him in the face of knowledge he possessed them. According to Oxford Manor, the ALJ "premised his dismissal of Director of Nursing Foster's testimony on the bizarre conclusion" that she did not "testify that she personally supervised Resident #10 and she does not detail the supervision that allegedly was provided to the resident.'" App. Br. at 11, n. 2, citing ALJ Decision at 7. Oxford Manor points to her testimony that "I also know Resident #10 well," and says that "she went on to offer detailed testimony regarding his condition, smoking habits, etc." Id., citing P. Ex. 33, at 3-4. Oxford Manor also says that, under the ALJ's rules, the DON was not allowed to testify orally at the hearing and that the ALJ should have questioned her "instead of opining that her written statement is untrue, incompetent, or both." Id. According to Oxford Manor, "While decisions about witness credibility generally are reserved to fact-finders, the notion that an ALJ can draw this sort of conclusion from a witness he never even permits to speak is far-fetched, and mocks due process." Id.

This argument has no merit. Evaluating whether a statement by a witness has an adequate foundation is a basic part of a judge's role going to the weight to give such evidence. Indeed, in federal court, evidence may not be admitted if it "lacks

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[4] We also note that, although someone checked "Yes" in the line for "[i]nitiate smoking care plan for residents identified as smokers," Oxford Manor did not show it in fact did this for Resident #10 prior to the survey. P. Ex. 5, at 3.

foundation." Rule 602, Fed. R. Evidence. That the DON may have personal knowledge of the resident does not establish that she has personal knowledge of the supervision provided to that resident on a day-to-day basis.[5] Moreover, if she had such knowledge either directly or through others, Oxford Manor certainly had the opportunity to have her include that in her written direct testimony to show the foundation for her statement about the supervision the resident received, but did not do so.

Contrary to what Oxford Manor seems to be arguing, the DON's testimony that she was not aware of Resident #10 ever smoking unsafely does not establish conclusively that he never did so. The ALJ could reasonably give greater weight to the statements made to the surveyor by the individuals who actually provided care to Resident #10 and by his wife.[6] Statements explaining why the ALJ did not find her testimony convincing do not necessarily reflect an evaluation by the ALJ that the DON was lying or incompetent, as Oxford Manor suggests, but instead explain why the ALJ gave greater weight to conflicting evidence. Evaluating conflicting evidence is perfectly proper and consistent with due process, even if the testimony being evaluated is only in writing.

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[5] We note that the DON who testified was the Assistant DON at the time of the survey. See, e.g., Ex. 33, at 1. The ALJ apparently mistakenly thought she was the same DON to whom the Business Manager said he had given Resident #10's bracelet after it was found under his bed and who later denied having received the bracelet. ALJ Decision at 7. This was not, however, the key reason why the ALJ found the testimony of the current DON unconvincing.

[6] Oxford Manor argues that the CNA who said Resident #10 "always" had a lighter and cigarettes in his room acknowledged that she had not worked with the Resident for a couple of weeks and that this qualifier should have affected the weight given to her statement. App. Br. at 12, n. 4. This argument might have merit if the issue were whether Resident #10 "always" had the lighter in his room. The issue here, however, was whether staff had knowingly allowed Resident #10 to keep a lighter in his room, even after his Wanderguard bracelet had been found under his bed. Since this CNA had directly provided care to Resident #10 until a couple of weeks before the survey, the ALJ could reasonably give more weight to her statement on this issue than to the DON's statements.

Finally, as discussed below, Oxford Manor's argument misrepresents the process the ALJ used to receive testimony.

3. Substantial evidence in the record supports the ALJ's findings with respect to the requirement to ensure adequate supervision and assistance devices to prevent accidents, as required by 42 C.F.R. § 483.25(h)(2).

A. Substantial evidence supports the ALJ's finding that Resident #10 was not adequately supervised.

Regarding supervision of Resident #10, Oxford Manor argues that the ALJ should have addressed the survey finding that Resident #10 had eloped from the facility in May 2006. Otherwise, Oxford Manor argues, there is no evidence of systemic violation of the requirement that the facility provide adequate supervision and assistance devices to prevent accidents. App. Br. at 17-18. In finding noncompliance, however, the ALJ relied on the evidence regarding lack of supervision of Resident #10's smoking activities, not only on the evidence regarding Resident #5. ALJ Decision at 11.

Oxford Manor admits that "[i]f, in fact, the Resident did smoke unattended and unsupervised inside Petitioner's Center, that would be a significant problem." App. Br. at 31. Oxford Manor points to the DON's testimony suggesting that Resident #10 was noncompliant with the facility's smoking policy only for a short period after his admission, and asserts that "[t]here is simply no record evidence at all to support ALJ Kessel's repeated assertions that the Resident did, as a matter of fact, continue to possess lighters, smoke indoors, etc., thereby endangering himself and others." Id. The evidence discussed above, however, shows that Oxford Manor's claim is simply not true.

Moreover, even if staff sometimes redirected Resident #10 when he was found smoking in the halls (as the DON testified), that is not sufficient to show the supervision was adequate, given the evidence that staff said they were aware he kept a lighter in his room and had noted he was smoking in the halls, but did not say or note that they had done anything about it.

Based on the evidence as a whole regarding the lack of adequate supervision for Resident #10's smoking and use of a lighter, the ALJ reasonably concluded that he did not need to address the dispute over whether Resident #10 had eloped in May 2006.

Contrary to what Oxford Manor contends, however, there is

persuasive evidence that Resident #10 eloped from the facility on May 29, 2006, without triggering the door alarm (which may have been because he again removed his bracelet), so addressing this issue would not help Oxford Manor. Oxford Manor relies on the investigation report that states Resident #10 was "followed" out of the building as showing he was being supervised at all times. Appeal Br. at 19, citing CMS Ex. 37. The person who wrote the investigation report apparently thought this was so and that the alarm had gone off. CMS Ex. 37, at 26. But the evidence as a whole shows that the transportation aide who went out after him did not do so because she was supervising him or because she heard the alarm go off, but because of her transport duties, and that it was only fortuitous that she went out shortly after he did. P. Ex. 1, at 29-30; P. Ex. 15; Tr. at 19-22. Oxford Manor suggests that Resident #10 would have gone only as far as the gazebo that was on facility property, but contemporaneous notes say he was "going toward the street, stating he was going home." P. Ex. 11, at 12; see also, CMS Ex. 37, at 26.

Moreover, a social worker documented that she had been told Resident #10 had left the building without a Wanderguard. P. Ex. 12, at 1. She was apparently mistaken about the date of the elopement, but this does not necessarily mean she did not accurately record what she was told about the circumstances, as Oxford Manor's Administrator opined based on later statements about what occurred. P. Ex. 34. One CNA told the surveyor he had observed the bracelet on in the early morning, and another told her he observed it on 30 minutes after the incident, but that does not establish that the bracelet was on when Resident #10 went outside at 1 p.m. P. Ex. 1, at 29-30; P. Ex. 11, at 12. Also, notes from an "IDT Meeting related to Residents with Wanderguards" dated June 20, 2006, states that Resident #10 "has removed Wanderguard x 2 since admission." CMS Ex. 29, at 2.

Oxford Manor asserts that it documented that staff checked for application of the bracelet each shift, but the cited document shows checks only for the period February 11-28, 2006, and, during that period, the checks were not documented for at least 13 out of 54 shifts. P. Ex. 9, at 1; see also Tr. at 35 (surveyor was told documentation of checks per facility Wanderguard policy was at nurses' station, but it could not be located); CMS Ex. 10 (Wanderguard Policy). This evidence, if anything, raises even more questions about whether Oxford Manor was adequately addressing the risk that Resident #10 would elope.

B. Substantial evidence in the record supports the ALJ's findings regarding Resident #5.

With respect to the findings related to Resident #5, Oxford Manor argues that the ALJ disregarded Board decisions. These arguments have no merit because they are based on Oxford Manor's misconception that it was found out of compliance based solely on the Resident's elopement on April 26, 2006. Instead, as discussed above, the finding of noncompliance was based primarily on the lack of adequacy of the response.

Oxford Manor says the ALJ failed to consider the multiple interventions it planned to prevent Resident #5 from wandering, including some added on April 26, 2006, presumably in response to the elopement. The ALJ did, however, consider those interventions, pointing out the glaring defect in the plan – it does not address the flaw in the facility's surveillance of Resident #5 that enabled her to elope. ALJ Decision at 14. The ALJ said that this defect should have been apparent to anyone who knew the circumstances, and we agree. After she had been observed in bed (with her clothes on) at 8:00 p.m., she had wheeled herself to near the front door, stood up, and was able to walk out undetected because her Wanderguard was attached to her wheelchair, not to her body, and there was no other device or adequate means by which Oxford Manor would be alerted that she had done so. Oxford Manor does not identify any intervention addressing the problem of her ability to circumvent the alarm system when the Wanderguard bracelet was not placed on her body.

Oxford Manor asserts that it treated her for anxiety after the elopement and within a few days she was no longer exhibiting the same level of anxiety that presumably caused her to leave, but was back to her "baseline" status. Oxford Manor asserts that the ALJ failed to take into account its evidence that the Resident's routine included sitting outside in her wheelchair in front of the facility, that she had never tried to elope from there in 13 years, and that she did not try it again after the incident on April 26. Her record shows that she did, in fact, try to elope again on April 27, after the care plan was modified. P. Ex. 26, at 6-7; P. Ex. 30, at 3; P. Ex. 31, at 1 ("got out of w/c & headed toward the street").

The ALJ reasonably concluded, in any event, that Oxford Manor did not show that treating her for anxiety after the elopement was an adequate response. First, Oxford Manor itself presented evidence that she showed no signs of anxiety on the night of April 26. P. Ex. 35. If she eloped on a night when she was not in fact particularly anxious, Oxford Manor could not reasonably think

that she would attempt elopement only when anxious. Second, the record shows and Oxford Manor admits that Resident #5 did periodically get anxious about her children. While the record shows that the staff intervention of calling a family member sometimes worked, it did not always work. Tr. at 45-46; P. Ex. 33, at 1-2 (she "typically will calm down after she speaks to her daughter"). Thus, even if Oxford Manor did attribute the April 26 incident to her anxiety, Oxford Manor should have been able to foresee that she might become anxious again at night when unobserved and try to elope in the same way she had before.

The ALJ also reasonably concluded that the facility could not reasonably rely on her prior history of safely sitting outside during the day once the facility had new information about the risk of her deliberately circumventing the alarm. Also, she had eloped between 8 and 9 p.m., rather than during the day when there would be more people around who might observe her leaving.

The ALJ faulted Oxford Manor for not considering alternatives to leaving the Wanderguard on her wheelchair. ALJ Decision at 13, n.9; 15, n.10. Oxford Manor points out that she was typically in her wheelchair. Even if Oxford Manor could reasonably still attach a Wanderguard to her wheelchair as one means to detect an elopement attempt, however, the problem is that Oxford Manor developed no intervention or plan for supervision adequate to address her ability to circumvent this means, as she had on April 26. Oxford Manor protests that CMS did not specify what more the facility could have done, but the ALJ mentioned that the facility could have placed a pressure cushion on her wheelchair that would alert staff if she stood up (which is a step the facility took during the survey). Also, while Oxford Manor provided testimony that Resident #5 had refused to wear the Wanderguard bracelet on her person, the only contemporaneous documentation of such a refusal is right after she was returned to the facility on April 26, when she was agitated. P. Ex. 26, at 6. On the other hand, there is documentation that she acquiesced in placement of the Wanderguard bracelet on her ankle during the survey. P. Ex. 28, at 2; CMS Ex. 34, at 11-12.

Oxford Manor argues that the ALJ improperly disregarded the DON's testimony that staff had decided years ago to place the bracelet on her wheelchair in the face of repeated refusals to wear the bracelet on her person. As noted, though, her medical record contains only one documented refusal. Moreover, there is no contemporaneous evidence that a decision was made by her care team to place the bracelet on her wheelchair. The plan of care for her wandering says: "Apply wander guard and check for placement [each] shift." P. Ex. 21, at 2. This plan is dated

April 26, 2006, but there is no indication in the plan that the care planners determined it was acceptable to place the Wanderguard on her wheelchair, even with awareness that this placement had enabled her to defeat the purpose of the alarm by simply leaving the chair and walking out. Id. The facility's Wanderguard policy, moreover, says staff will place the Wanderguard "on the resident." P. Ex. 1, at 15. In light of this policy and the April 26, 2006 incident, one would have expected placement on the wheelchair to have been specified in her care plan, if she did in fact always refuse to have it placed on her person and if her care team had made a conscious decision to continue to place the bracelet on the wheelchair instead of on her person.

In any event, the ALJ reasonably concluded that the facility was not providing adequate supervision and assistance devices to prevent accidents if it continued to rely on attaching a Wanderguard bracelet to her wheelchair as the only means to alert staff if she left the facility at night, even though they knew she was capable of defeating that means. Oxford Manor presents no evidence that her care team, in fact, decided after the elopement that she was not likely to try to elope in the same way again. The DON testified that she "did not, and do not, believe that there was anything inappropriate" about the facility's practice of letting the resident sit outdoors "without close supervision" even after her elopement. P. Ex. 33, at 2. This statement, however, presumes some level of supervision other than "close supervision" during the time Resident #5 liked to sit outside, which was during the day. The DON did not, however, express any opinion about whether it was appropriate for the facility to continue to rely on a Wanderguard placed on the wheelchair to prevent elopement at night, despite the fact that the DON concedes that "[i]t seems obvious to me that the Resident planned her escape fairly carefully, and knew that the Wanderguard would alert the staff had she gone through the door in her wheelchair." Id. at 3.[7]

[7] As noted above, the care plan dated April 26 does not indicate the care team was aware of any issue about where staff were placing the bracelet. The incident report for the April 26 elopement contains no information in the part of the report form related to safety devices. P. Ex. 3, at 1. This undercuts Oxford Manor's position that the care team was aware of how Resident #5 had eloped but exercised their professional judgment and decided that continuing to place the bracelet on the wheelchair instead of on Resident #5 was acceptable.

Thus, we reject Oxford Manor's assertion that the ALJ improperly substituted his own personal opinion for the professional judgment of facility staff.

4. The ALJ did not err in concluding that CMS's determination that immediate jeopardy existed was not clearly erroneous.

Oxford Manor argues that the ALJ erred in concluding that CMS's determination that immediate jeopardy existed from June 22 through July 22, 2006 was not "clearly erroneous" (the standard that applies under the regulations). Oxford Manor cites to this Board's statement in Spring Meadows, *supra*, that the regulations indicate there must be a causal connection between a facility's noncompliance and the existence of serious injury or a threat of injury. Oxford Manor says it is--

> hard to see how this standard can be met on the present record. It certainly is true that *some* resident who was a smoker might smoke unsafely and thereby endanger himself or others - but that potentially is true of every smoker, and clearly does not describe a causal relationship between some asserted noncompliance by Petitioner in this case, and some risk of serious harm, even in theory, much less in this case.

App. Br. at 35-36. This argument, however, is based on Oxford Manor's premise that--

> there is no evidence in this record that Petitioner tolerated an unsafe situation, or even that Resident #10 ever actually smoked unsafely. And CMS certainly offered no evidence that could support a finding how, even in theory, any act or omission by Petitioner had any causal relationship to any such risk.

App. Br. at 36. This premise is simply mistaken, however. As discussed in section 2.B. above, there is ample evidence to show that Oxford Manor's staff was aware, among other things, that Resident #10 kept a lighter in his room; that his Wanderguard was found under his bed and appeared to have been burned off; that Resident #10 smoked in the bathroom; and that he was wandering the halls smoking. Yet, Oxford Manor did not take his lighter away, even after the bracelet was found, and the counseling a CNA gave him was clearly inadequate to address the foreseeable risks. Moreover, the evidence discussed in section 2.C. shows that he was not competent to smoke unsupervised even in designated areas, but had not been timely assessed for competency per facility policy. Oxford Manor's omissions and failures to follow its own

smoking policy placed not only Resident #10 at risk, but other residents as well.

With respect to Resident #5, Oxford Manor says CMS focuses on the decision to let the Resident wear her bracelet on her wheelchair, rather than her wrist, but "CMS never offered evidence, or even argument, why this practice was unreasonable under the circumstances, much less how it exposed *this* resident to 'likely' serious harm or death, even after her elopement." App. Br. at 36 (italics in original). Oxford Manor does not dispute that "resident elopements are dangerous and undesirable." Id. Oxford Manor characterizes itself, however, as balancing the "remote possibility that the Resident might try to elope again by walking away, against the reality that the Resident continued to refuse to wear the bracelet." App. Br. at 36. This argument misses the point that, if Resident #5 always refused to wear the bracelet (which was not properly documented), Oxford Manor needed to address with some other means the risk that she would elope again as she did on April 26. Oxford Manor's reasons for viewing the risk as minimal are not persuasive.

Even if staff reasonably thought the risk that this particular resident would elope again in the same way was remote, moreover, it was not clearly erroneous for CMS to determine that there was the likelihood of serious harm, given Oxford Manor's failure to adequately address elopement and other accident risks of which it was aware and to follow its own policies intended to address those risks. CMS does not have to determine that it is likely that any particular resident will suffer serious harm from a facility's noncompliance. Here, CMS's determination that Oxford Manor's failure to address such risks was likely to cause serious harm to some resident was not clearly erroneous.

5. The ALJ did not err in concluding that the noncompliance continued until July 22, 2006.

The regulations governing the duration of a CMP are found in 42 C.F.R. §§ 488.454 and 488.440. Section 488.454(a) provides that "alternative remedies," such as a per day CMP, continue to accrue until "[t]he facility has achieved substantial compliance, as determined by CMS or the State based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit." Section 488.454(e) states that an alternative remedy may terminate on a date prior to a revisit survey if the facility "can supply documentation acceptable to CMS or the State survey agency that it was in substantial compliance" on that earlier date and was capable of remaining in

substantial compliance. The language of section 488.440(h)(1) expresses the same concept, with specific reference to a CMP:

> If an on-site revisit is necessary to confirm substantial compliance and the provider can supply documentation acceptable to CMS or the State agency that substantial compliance was achieved on a date preceding the revisit, penalties are imposed on a per day basis until the date of correction for which CMS or the State receives and accepts written credible evidence.

Section 488.440(b) states that a per day CMP is "computed and collectible . . . for the number of days of noncompliance until the facility achieves substantial compliance."

Here, it is undisputed that the surveyors found on a revisit that Oxford Manor did not achieve substantial compliance until July 22. While there is evidence in the record that Oxford Manor took some corrective actions during the survey (which CMS accepted as removing the immediate jeopardy), CMS also reasonably determined it needed to verify through a site visit that the corrective actions continued to be implemented and actually corrected the problems. Oxford Manor cites to no credible and verifiable evidence that it in fact was in substantial compliance prior to July 22.

In Guardian Health Care Center, DAB No. 1943, at 27-29 (2004), this Board concluded that, under the regulations, to establish when it came back into substantial compliance a facility has to have a survey finding to that effect or to have submitted "credible evidence" establishing substantial compliance that is verifiable without a survey. Oxford Manor cites Guardian and some ALJ decisions to support its position that CMS cannot reasonably presume continued noncompliance here. App. Br. at 36-38.[8]

This case is clearly distinguishable from Guardian, however. In that case, the Board determined that summary judgment in CMS's favor was not appropriate based solely on a finding of noncompliance with section 483.25(h)(2) because the facility had shown there was a genuine dispute of material fact regarding the duration of the noncompliance. Guardian's administrator asserted in her declaration that it would be inappropriate to leave a per day CMP in effect after November 14, 2002 because the survey

[8] To the extent any one of the cited ALJ decisions suggests a different standard, it is inconsistent with the regulations.

agency found, during the December 5, 2002 revisit, that the facility's noncompliance with section 483.25(h)(2) had been corrected as of November 14, 2002. Since CMS had abandoned its reliance on other deficiency findings in moving for summary judgment, the Board held that CMS could not reasonably rely on its finding that those other deficiencies were not corrected until December 5 as establishing that the noncompliance continued past November 14. Here, unlike Guardian, CMS is relying on what the revisit survey found regarding when the facility achieved substantial compliance after taking action to correct the deficiencies at issue.

Thus, the ALJ did not err in concluding that the noncompliance continued until July 22, 2006.

6. Oxford Manor's complaints about the ALJ and the procedures he used have no merit.

Oxford Manor criticizes the ALJ because the ALJ Decision used language that Oxford Manor says "mockingly disparaged" or "sarcastically" dismissed its evidence. App. Br. at 9, 14. We do not agree with that description. Some of the cited language is wording that is common in legal opinions (for example, the ALJ used the term "straw man" to describe one of Oxford Manor's arguments). Other language is a metaphor used in common speech (the ALJ said Oxford Manor was trying to make "a silk purse out of a sow's ear"). We do not, moreover, find these descriptions to be inaccurate.

Nor do we agree with Oxford Manor's assertion that the ALJ "embroidered" considerably on the allegations in the SOD. App. Br. at 8. These and other similar assertions in the brief seem to arise because of a basic misconception about what constitutes evidence in an administrative proceeding and what the role of an ALJ is. Such assertions not only do a disservice to the ALJ but to those who are not familiar with the law and the administrative hearing process and therefore might give credence to such unfounded assertions.

Oxford Manor also complains about the ALJ's procedure of having the parties submit their witnesses' direct testimony in writing and permitting them to cross-examine the witnesses at the hearing. The ALJ's prehearing order, however, says that generally he will accept written direct testimony in lieu of in-person testimony. Prehearing order at 3. This does not rule out presenting direct testimony in person. Here, Oxford Manor does not argue that it asked for an exception for any of its witnesses prior to the hearing, and there is no evidence in the record that

it did. Moreover, the transcript of the hearing shows that Oxford Manor did not seek to present any oral testimony from its witnesses, even after CMS declined to cross-examine them.

Oxford Manor suggests that the procedure violated due process because cross-examination is the means our legal system uses to test credibility. This Board has held, based on case law, that the use of written direct testimony is not itself prejudicial, as long as the right to effective cross-examination is preserved. Pacific Regency Arvin, at 8. Here, CMS declined to cross-examine Oxford Manor's witnesses, but may have done so even if Oxford Manor had presented its witnesses' testimony orally. The ALJ's failure to question the DON himself does not make his evaluation of her testimony somehow less valid, as Oxford Manor suggests. As this Board said in Beechwood Sanitarium, DAB No. 1906, at 62 (2004):

> Even where witnesses' testimony is submitted in written form, so that the ALJ does not directly observe demeanor, the ALJ may reasonably make judgments about what testimony to believe and what weight to assign. The fact-finder must resolve conflicting testimony in some way, where it cannot be understood in a manner that removes the inconsistencies. This may be done by assessing plausibility, evaluating the overall coherence of a witness's account, considering what interests or bias a witness may have, looking at other corroborating or conflicting evidence in the record, and so on.

As we discussed above, the ALJ reasonably determined that the DON's testimony was not reliable, in light of the conflicting evidence in the record and other relevant factors, such as the fact that she did not claim to have personally supervised Resident #10 and provided no detail about what supervision was allegedly given the Resident.

Conclusion

For the reasons stated above, we affirm the ALJ Decision and affirm and adopt each of his findings of fact and conclusions of law.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Judith A. Ballard
Presiding Board Member