Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: June 27, 2007
Liberty Nursing and Rehabilitation Center – Mecklenberg County,	
Petitioner,	Civil Remedies CR1559 App. Div. Docket No. A-07-67
- v. -	Decision No. 2095
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Liberty Nursing and Rehabilitation Center – Mecklenberg County (Liberty) appeals the January 23, 2007, decision of Administrative Law Judge (ALJ) Jose A. Anglada. Liberty Nursing and Rehabilitation Center – Mecklenberg County, CR1559 (2007)(ALJ Decision). The ALJ sustained a determination by the Centers for Medicare & Medicaid Services (CMS), based on survey findings by the North Carolina State Survey Agency (NCSSA), that Liberty failed to comply substantially with federal requirements governing the participation of a long-term care facility (facility) in the Medicare and Medicaid programs from November 30, 2004 through February 9, 2005. The noncompliance involved the following requirements and time periods: that the resident environment remain as free of accident hazards as possible, 42 C.F.R. § 483.25(h)(1)(Tag F323) (November 30, 2004 through January 4, 2005) and that the facility develop and implement written policies and procedures prohibiting neglect, 42 C.F.R. § 483.13(c)(1)(i)(Tag F224), and ensure that each resident receives adequate supervision and assistance devices to prevent accidents, 42 C.F.R. § 483.25(h)(2)(Tag F324)(January 5 through February 9, 2005). CMS determined that the noncompliance from November 30, 2004 through January 12, 2005 posed immediate

jeopardy and imposed a civil money penalty (CMP) of $3,050 per day. The ALJ upheld the immediate jeopardy determination as not clearly erroneous and also found that the CMP amount was reasonable as a matter of law. CMS found that noncompliance continued at less than the immediate jeopardy level from January 13 through February 9, 2005 and imposed a CMP of $100 per day for that period of time. The ALJ upheld the finding of noncompliance for that period and determined that the amount of the CMP was reasonable.

We conclude that the ALJ did not err in denying Liberty's motion for partial summary judgment. We affirm the ALJ's findings of fact and conclusions of law (FFCLs) that Liberty was not in substantial compliance with 42 C.F.R. §§ 483.25(h)(1) from November 30, 2004 through January 4, 2005 and with 483.139(c)(1)(i) and 483.25(h)(2) from January 5 through January 12, 2005 and that Liberty's noncompliance from November 30, 2004 through January 12, 2005 constituted immediate jeopardy. We summarily affirm the ALJ's conclusion regarding the amount of the CMPs imposed for those time periods since, by law, $3,050 per day is the lowest per day amount that may be imposed for immediate jeopardy. 42 C.F.R. § 488.438(a)(1)(i). We also summarily affirm the ALJ's findings of fact and conclusions of law that Liberty continued to be out of substantial compliance at less than the immediate jeopardy level from January 13 through February 9, 2005 and that the amount of the CMP imposed for that period of continuing noncompliance ($100 per day) is reasonable.

Liberty expressly states that it does not dispute that it was not in substantial compliance with 42 C.F.R. §§ 483.13(c)(1)(i) and 483.25(h)(2) beginning January 5, 2005 or that its noncompliance with those requirements constituted immediate jeopardy; it disputes only how long its noncompliance with those requirements lasted. Specifically, Liberty asserts that no noncompliance persisted after January 6, 2005, and that CMS had no basis for imposing any remedy after that date. P. Br. at 42. To support that assertion, however, Liberty presents only its argument that it abated the immediate jeopardy that began on January 5, 2005 within 48 hours thereafter, an argument that the ALJ rejected and the Board also rejects for the reasons discussed in this decision. Liberty makes no independent argument disputing the ALJ's finding that Liberty continued in noncompliance at less than the immediate jeopardy level from January 13 through February 9, 2005 or his finding that the $100 per day CMP for that period is reasonable. Accordingly, we summarily affirm those findings. See 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.'").[1]

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.

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 is a determination of the level of noncompliance which "must be upheld unless it is clearly erroneous." 42 C.F.R. 498.60(c)(2); Woodstock Care Center, DAB No. 1726, at 9 (2000),

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[1] 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.")

aff'd, Woodstock Care Center v. Thompson, 363 F.3d 583 (6th Cir. 2003).

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

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

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[2]

NCSSA completed complaint investigation surveys at Liberty on January 4, 2005 and January 14, 2005. ALJ Decision at 1. NCSSA sent Liberty a statement of deficiencies (SOD) for each survey. CMS Exs. 1, 2, 3. On February 22, 2005, CMS sent a letter[3] informing Liberty of CMS's determination, based on the complaint surveys, that Liberty was not in substantial compliance with federal requirements; that its noncompliance constituted immediate jeopardy from November 30, 2004 through January 12, 2005; that Liberty had continuing noncompliance at a non-immediate jeopardy level from January 13, 2005 until such time as it achieved substantial compliance; and, that CMS was imposing a CMP of $3,050 per day for the period of immediate jeopardy and

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[2] 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.

[3] This notice letter amended a notice letter sent on February 4, 2005, which, in turn amended a notice letter sent on February 1, 2005.

$100 per day for the continuing noncompliance.[4] CMS Ex. 1; ALJ Decision at 1-2. Liberty appealed and, after having its motion for partial summary judgment denied, received a hearing by ALJ Anglada on April 25, 2006. ALJ Decision at 2.

On November 30, 2004, a resident (identified for privacy reasons as Resident No. 3) complained to Liberty's administrator, Sharon Stiles, that wheelchair bound residents were being transported to off-site treatments in vans without being properly secured. Id. at 5. Ms. Stiles wrote up the complaint on a grievance form which also indicated that she then instructed the van driver (Durk Campbell) to use a belt around the residents to secure them in the van and ordered a new van. Id., citing P. Ex. 7. Ms. Stiles completed an affidavit, dated January 10, 2005, in which she indicated that Mr. Campbell was one of two van drivers until he quit his job unexpectedly on December 21, 2004, and that he drove the older van, the one at issue here. Id., citing P. Ex. 6 at 1. The other driver, Robert Powe, drove a leased van until it was returned to the rental agency on December 30, 2004, after which he started driving the old van previously driven by Mr. Campbell. Id. The vans were used to transport dialysis patients to treatment. Id. After she learned that NCSSA surveyors were talking to Resident No. 3, Ms. Stiles checked the old van and determined that only two of the seat belts for residents being transported in wheelchairs were operable. P. Ex. 6, at 1. Ms. Stiles said she reviewed transportation logs and "saw that there were several days in which Durk [Mr. Campbell] took three patients at the same time." Id.; ALJ Decision at 6. When she questioned Mr. Campbell as to how he was securing the third resident since there were only two van seat belts, he responded that "he was using a wheelchair seat belt/soft belt."[5] Id.

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[4] On a February 10, 2005 revisit survey, CMS determined that Liberty had corrected the non-immediate jeopardy noncompliance found on the January 14, 2005 complaint survey as of February 9, 2005 but was not in substantial compliance with other federal requirements. CMS increased the $500 per day CMP for the continuing noncompliance effective February 10, 2005, but Liberty chose not to appeal the findings of noncompliance from the February 10, 2005 revisit. ALJ Decision at 13; P. Br. at 4.

[5] In the record, and this decision, the soft belts are variously referred to as "soft belts," "lap belts," "soft lap belts," "wheelchair belts" or "soft waist restraints". The soft belt is a cotton and polyester device, like a sash with wide straps, used to keep a resident in a wheelchair from falling out

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Ms. Stiles also stated in her affidavit that when she asked Mr. Powe how he and Mr. Campbell had been transporting the residents, he responded that he also was using a soft belt. Id. Ms. Stiles admitted that she had told Mr. Powe to use the soft belts but she also stated, "but that was not to take the place of the seat belts." Id.

During the survey, Mr. Powe told the surveyor that during his orientation, he told Mr. Campbell that the old van did not have enough safety belts for all the wheelchairs and that he (Mr. Powe) noticed this again when he began driving this van himself at the end of December. CMS Ex. 3, at 4-5; Tr. at 23 (testimony of NCSSA surveyor Joyce Valmassoi). Mr. Powe also told the surveyor that "maybe twice" he transported three wheelchair residents with only enough seat belts for two of them. Id. at 5; 24. Mr. Powe also told the surveyor that, as instructed by the administrator, he had used a soft waist restraint as a substitute for the missing belts for "maybe" two residents. Id. at 5; 24-25. Liberty did not order replacement seat belts until January 4, 2005, the day of the survey. Tr. at 28. At the hearing, Mr. Powe denied transporting residents in wheelchairs who were not properly secured by seat belts. Tr. at 94. In his testimony, Mr. Powe also denied using soft restraint belts as substitutes for seat belts,[6] and when asked whether he had ever been taught that it was okay to use these soft belts in a vehicle responded that that was "ridiculous." Tr. at 95.

The surveyor testified that using soft belts in place of van seat belts constitutes a safety hazard, and exposes residents to the risk of injury. ALJ Decision at 7, citing Tr. at 27. The company that makes the soft belts, the Posey Company, warns: "Never use a Posey product as a seat belt in a moving vehicle.

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[5](...continued)
of the wheelchair; it goes around the resident's waist and ties to the back of the wheelchair. Tr. at 27-28; CMS Ex. 14 at 3, 4.

[6] As the ALJ explained, Mr. Powe described the seat belts used in a van to secure residents in wheelchairs as follows: "'[i]f you're transporting a wheelchair, they're supposed to be strapped to the chair with what you call a four-point restraint, which has two straps in the front, one on each wheel, two straps in the back, one on each wheel. And it holds the wheelchair in place. And they're supposed to have a full harness seatbelt, as you would in a regular car.'" ALJ Decision at 7, citing Tr. at 93.

Posey products are not designed to withstand the force of a crash." CMS Ex. 14 at 3, cited in ALJ Decision at 7.

Discussion

A. The ALJ's finding of noncompliance with 42 C.F.R. § 483.25(h)(1) from November 30, 2004 through February 4, 2005 is supported by substantial evidence and free of legal error.

1. The ALJ did not err in denying Liberty's motion for partial summary judgment.

Liberty moved below for partial summary judgment in its favor on the issue of its noncompliance with 42 C.F.R. § 483.25(h)(1). Liberty argued that federal requirements governing the participation of long-term care facilities in the Medicare and Medicaid programs do not authorize CMS to impose remedies based on a long-term care facility's unsafe operation of a motor vehicle, even if that vehicle is operated by the facility. ALJ Anglada denied the motion. On appeal, Liberty argues that the ALJ's denial of its motion for partial summary judgment is legal error. P. Br. at 32. We find no error, and, indeed, find the ALJ's analysis persuasive. CMS cited its findings regarding Liberty's failure to properly secure residents riding in wheelchairs in the van under 42 C.F.R. § 483.25(h)(1). That regulation provides, "The facility must ensure that the resident environment remains as free of accident hazards as is possible." Liberty argued below, and reiterates here, its theory that "resident environment" means the environment inside the nursing home and does not extend to the operation of motor vehicles taking residents off-site for treatment or services.[7] The ALJ rejected that argument, finding that the "resident environment is

[7] Liberty relies, in part, on the fact that the examples of "accident hazards" listed in CMS's State Operations Manual (SOM), which provides guidance to surveyors, does not include automobiles. However, the SOM specifically indicates that the list is not exclusive. Furthermore, as CMS points out, the list does include "[e]quipment or devices that are defective, poorly maintained, or not used in accordance with manufacturer's specifications (e.g., wheelchairs or geri-chairs with nonworking brakes, and loose nuts and bolts on walkers[.]" SOM (Pub. 100-07)(SOM), Appendix PP - Guidance to Surveyors for Long Term Care Facilities, at 192 (discussing Tag F323). While these examples do not include motor vehicles, they do relate broadly to the safety of equipment used for resident transport or mobility.

wherever there is a confluence of resident and a facility's responsibility for the resident." Ruling at 1. He explained,

> Logically, the facility is responsible for keeping the resident environment as free of accident hazards as possible in all the spaces where the facility is responsible for the resident: whether it be in the buildings, on the grounds, in facility-operated vehicles, etc.

Id. We agree with the ALJ's conclusion. His finding as to what constitutes the "resident environment" is consistent with the language of the regulation, which focuses on safety in the resident's environment without specifying any limitations as to the scope of that environment. Clearly the Secretary intended the term "resident environment" to be construed as broadly as necessary to protect residents whose care facilities like Liberty have undertaken to provide.

Finding that the resident environment encompasses facility vehicles transporting residents also is consistent with the overall quality of care requirement of which section 483.25(h)(1) is a part. The multiple specific requirements listed under the quality of care requirement share the same regulatory objective, that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." 42 C.F.R. § 483.25. The Board has held that "while the regulations do not make facilities unconditional guarantors of favorable outcomes, the quality of care provisions do impose an affirmative duty to provide services ... designed to achieve those outcomes to the highest practicable degree." Estes Nursing Facility Civic Center, DAB No. 2000, at 6, citing Woodstock Care Center v. CMS, DAB No. 1726, at 25, aff'd, Woodstock Care Ctr. v. Thompson, 363 F.3d 583 (6th Cir. 2003). The Sixth Circuit described the federal standard as "a higher standard than the common law," 363 F.3d at 590, and as requiring the facility to take "all reasonable precautions against residents' accidents," 363 F.3d at 589 (emphasis in original). Finding that residents travel at their own risk when a facility that has undertaken their care and treatment transports them to treatment or services rendered off-site (such as the dialysis treatments to which Liberty's vans transported its residents) would not be consistent with this high standard of care.

We also agree with the ALJ that there is no merit to Liberty's argument that by including a facility van transporting a resident to treatment or services within the scope of "resident environment" the federal government, in effect, is undertaking the regulation of vehicle safety, a duty normally consigned to states. As the ALJ aptly concluded, "The two schemes, vehicle safety regulation and nursing facility regulation, have nothing to do one with the other. But, when a facility transports residents under its care in a van, the van is the resident environment, and the regulations apply, regardless of whether the van's equipment and operation is subject to regulation by another authority or not." Ruling at 2.

The ALJ did not err when he denied Liberty's motion for partial summary judgment.

2. The ALJ's finding of noncompliance with 42 C.F.R. § 483.25(h)(1) is supported by substantial evidence and free of legal error.

Liberty argues that the record does not support the ALJ's finding that it was not in substantial compliance with 42 C.F.R. § 483.25(h)(1). Liberty expressly states that it does not dispute that its older van, which was used to transport residents to treatments off-site, had space for four residents riding in wheelchairs but had seat belts for only two of these spaces. P. Br. at 8-9. However, Liberty asserts that the record contains no evidence to support the ALJ's finding that its van drivers, Mr. Campbell and Mr. Powe, sometimes transported more than two residents at a time in wheelchairs in this van using soft belts as substitutes for the missing van seat belts, an unsafe practice. Contrary to Liberty's assertion, there is substantial evidence in the record to support the ALJ's findings.

Liberty makes a number of arguments raising doubts about the reliability of Resident No. 3's statements to the administrator (as recorded in the grievance) and to the surveyor (when interviewed) to the effect that she saw residents in wheelchairs being transported in the van without being safely secured. See P. Br. at 9-17, 23-24. Like the ALJ, we do not find those arguments relevant since the ALJ's analysis does not rely on Resident No. 3's statements.[8] See ALJ Decision at 7. Instead,

[8] However, the ALJ did infer from actions taken by the administrator pursuant to Resident No. 3's grievance (ordering a new van and instructing Mr. Campbell to use a belt around the

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the ALJ relies, in principal part, on a sworn affidavit by Liberty's administrator, Sharon Stiles, that Liberty itself put into evidence, and on statements van driver Robert Powe made to the NCSSA surveyor during an interview. ALJ Decision at 6-7, citing, e.g., P. Ex. 6, at 1; Tr. at 25, 27, 44. As the ALJ found, Ms. Stiles' affidavit provides evidence that on at least two occasions, Mr. Campbell transported three residents in wheelchairs, when the van had only two operable seat belts for wheelchairs. Ms. Stiles said she reviewed Liberty's transportation logs and "saw that there were several days in which Durk [Campbell] took three [wheelchair] patients at the same time." Id.; ALJ Decision at 6. Liberty points out that the bracketed word "wheelchair" does not appear in Ms. Stiles' statement but was added by the ALJ. That is correct. However, in context, it is clear that Ms. Stiles, as the ALJ indicated in the bracket, was referring to patients riding in wheelchairs in the van. She reviewed the van transportation records for the purpose of responding to a direction from her corporate employers "to check the van for seat belts" because NCSSA surveyors were talking to Resident No. 3, and because she had already determined that "only two seat belts in the van was [sic] operable." P. Ex. 6 at 1. (There is no dispute that the reference to "only two seat belts" is to the van seat belts for wheelchairs, not the seat belts for passengers seated on the van seats.) Furthermore, Ms. Stiles' statement that Mr. Campbell drove "three patients at the same time" is followed by her statement that she asked Mr. Campbell how he was securing the third resident "since there was only two van seat belts," and that Mr. Campbell responded that "he was using a wheelchair seat belt/soft belt." Id. Liberty objects to reading the term "wheelchair seat belt/soft belt as necessarily referring to use of a soft belt rather than a van seat belt for wheelchairs. However, throughout her affidavit Ms. Stiles used the term "van seat belts," when she intended to refer to the safety restraints used to secure wheelchair passengers in the van. Since she did not use that term in the sentence in question, it is clear that she was not referring to those restraints but to the soft belts used in nursing homes to keep residents from falling out of wheelchairs and which the

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[8](...continued)
residents to secure them in the van) that "there was substance to the concern." ALJ Decision at 5, citing P. Ex. 7. We need not decide whether this was a reasonable inference since the ALJ did not rely on the resident's complaints. However, the inference is reasonable since the administrator presumably would not have taken these steps if she thought the complaints had no merit.

manufacturer warned should not be used as seat belts in moving vehicles.

Liberty also argues that Ms. Stiles was confused as to which driver used soft belts. The ALJ found no confusion, stating, "It is clear from her affidavit that both drivers used the soft belt to secure wheel chair residents in the facility van." ALJ Decision at 7. We agree. As discussed above, Mr. Campbell told Ms. Stiles he "was using a wheelchair seat belt/soft belt" for the third wheelchair resident he transported in the van containing "only two van seat belts." P. Ex. 6, at 1. Similarly, the affidavit states that when Ms. Stiles questioned "Robert [Mr. Powe] as to how he and Durk [Mr. Campbell] was [sic] transporting patients[,] Robert stated that he was using a lap belt in [sic] which I did tell him to use ... ."[9] P. Ex. 6, at 1. If Liberty thought that Ms. Stiles' affidavit needed clarification, it could have called her to testify at the hearing, but Liberty did not do so.

The ALJ also relied on statements made by van driver Robert Powe to the NCSSA surveyor that he had "maybe twice" transported three wheelchair residents when there were van seat belts for only two of them and had used soft lap restraints as seat belts for two residents. Decision at 7, citing Tr. at 25, 44; CMS Ex. 3, at 5;

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[9] Ms. Stiles claimed that she thought the van drivers were using both the soft belts and the van seat belts and that she did not know until the survey that they were not using the latter. P. Ex. 6, at 1. However, these assertions are inconsistent with her statement elsewhere in the affidavit that she told them to use the soft belts "because I did not want any patient injured in the van." Id. She gives no reason why she would need to be concerned about an injury in the van if the residents were properly restrained with the van seat belts, and none is apparent. Furthermore, as the manufacturer's instructions indicate, and administrator Stiles should have known, the soft belts are not designed to prevent injury in moving vehicles and should not be used for that purpose. CMS Ex. 14, at 3. Ms. Stiles also stated that she did not find out that only two van seat belts for wheelchairs were operable until January 3, 2005, when her corporate employer called to ask her to check the van for seat belts. However, this statement is inconsistent with her statement to the surveyor that she told Mr. Campbell, who left Liberty on December 21, 2004, to order new seat belts for the van and assumed that he had done so. CMS Ex. 3, at 3.

Tr. at 24. Liberty argues here that the ALJ should not have relied on those statements but should, instead, have relied on Mr. Powe's testimony during the hearing that he never transported residents without a van seat belt or used a soft belt as a substitute. Tr. at 94-95. However, the ALJ found that testimony not credible, explaining,

> Such testimony given for litigation purposes, more than a year after the incident, does not have the probative value nor candor of the statement by the Administrator that is more contemporaneous with the events here under consideration. Additionally, at a time closer to those events, he [Powe] admitted to the surveyor that he used the soft belt on residents being transported in the van on a couple of occasions.

ALJ Decision at 7, citing Tr. at 25, 44. The Board generally defers to an ALJ's credibility determinations and does not disturb them unless they are clearly erroneous. The Board explained this standard as follows:

> Among the tasks normally undertaken by the ALJ is evaluating the credibility and persuasiveness of witness testimony. Absent clear error, we defer to the findings of the ALJ on weight and credibility of testimony. Koester Pavilion, DAB No. 1750, at 15 (2000). In making credibility evaluations of testimony, the ALJ may reasonably consider many factors, including "witness qualifications and experience, as well as self-interest." Community Skilled Nursing Centre, DAB No. 1987 (2005), aff'd sub nom., Community Skilled Nursing Ctr. v. Leavitt, No. 05-4193 (6th Cir. Feb. 23, 2006).

Madison Health Care, Inc., DAB No. 2049, at 7-8 (2006). Liberty asserts that in considering Mr. Powe's veracity, the ALJ should have considered his demeanor at the hearing and his law enforcement and military background, which, Liberty argues, "presumably require seriousness of purpose." P. Br. at 20, n. 15. The ALJ heard Mr. Powe's testimony about his credentials and was in a position to observe his demeanor. There is no evidence that he failed to take these factors into consideration or that he did not give them appropriate weight when rejecting Mr. Powe's testimony. We find no error at all, much less clear error, in the ALJ's credibility determination.

As discussed above, substantial evidence supports the ALJ's determination that Liberty was not in substantial compliance with 42 C.F.R. § 483.25(h)(1). Liberty makes no argument about the period of this noncompliance. Accordingly, we summarily affirm the ALJ's finding that Liberty was out of compliance with 42 C.F.R. § 483.25(h)(1) from November 30, 2004 through January 4, 2005.

B. CMS's determination that Liberty's noncompliance with 42 C.F.R. § 483.25(h)(1) posed immediate jeopardy is not clearly erroneous.

The ALJ upheld CMS's determination that Liberty's noncompliance with 42 C.F.R. § 483.25(h)(1) posed immediate jeopardy for Liberty's residents, finding that determination not clearly erroneous. ALJ Decision at 12, citing 42 C.F.R. § 498.60(c)(2). The ALJ applied the correct legal standard, and we find no basis for reversing his decision to uphold CMS's determination.

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. Liberty argues that the ALJ's finding of noncompliance "does not compel a subsidiary finding that the alleged noncompliance was so dire as to make death or serious injury 'likely' for any of Petitioner's residents – and certainly not for the entire period November 30, 2004 through January 4, 2005 ... ." However, whether such a finding is compelled is not the issue. As the ALJ correctly noted, it is Liberty's burden to show that the finding that serious harm was likely to result from the facility's failure to use van seat belts to secure residents being transported in vans is clearly erroneous. 42 C.F.R. § 488.301. The Board has stated in a number of cases that this is a very heavy burden. E.g., Daughters of Miriam Center, DAB No. 2067, at 7 (2007); Liberty Commons Nursing and Rehab Center – Johnston, DAB No. 2031 at 18-19 (2006). CMS's determination of immediate jeopardy 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, DAB No. 1962, at 11 (2005), aff'd, Barbourville Nursing Home v. Leavitt, 2006 WL 908631 (6th Cir. Apr. 6, 2006); Liberty has not carried that burden.

The surveyor testified that the noncompliance was cited as immediate jeopardy because "[in] any kind of accident or sudden stop or sharp turn, the residents could come out of their

wheelchairs and get hurt, hit their head, break a bone." Tr. at 29. She further stated that they could suffer concussions or even die as a result of not being properly secured. Id. The surveyor also testified that in addition to not providing adequate restraint in the event of an accident, the soft belts used by the van drivers as substitutes for the missing van seat belts could actually cause injury. Tr. at 27. She noted that there had been situations "where the residents actually fell out of [the soft restraint], got choked by it, because it was so loose or not located in the right place." Id. Petitioner dismisses the surveyor's testimony on the likelihood of harm issue as "anecdotal" or "speculative" but did not offer any contrary testimony at the hearing; neither did Liberty dispute the surveyor's qualifications to testify about these matters. It is reasonable to conclude from the surveyor's testimony, as the ALJ did, that there is a likelihood that serious harm will befall residents seated in wheelchairs while being transported in vans unsecured by van seat belts.

Liberty put into evidence a 1997 statistical report by the National Highway Traffic Safety Administration (NHTSA) regarding "Wheelchair Users Injuries and Deaths Associated with Motor Vehicle Related Incidents." P. Ex. 8. Liberty cites that report for the statistic that "in the most recent five-year period studied for the report, only two wheelchair users of all ages were killed, and probably less than 100 elderly wheelchair users were seriously injured, in van accidents relating to 'improper or no securement.'" P. Br. at 39. Assuming Liberty is correct about these statistics,[10] they do not help Liberty rebut the finding of immediate jeopardy. The ALJ found that the report "cannot serve as a basis for ignoring the facility's duty to transport its wheelchair residents in its passenger van in a safe

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[10] It is not clear how Liberty arrived at the conclusion that "probably less than 100 elderly wheelchair users were seriously injured." However, even assuming that is true, the report also shows that "[v]ans were involved in almost half (48%) of the injuries to wheelchair users related to motor vehicles during the five year study period" and that "[o]f the 2,494 wheelchair users whose injuries were related to improper securement, 65% ... involved vans ... , P. Ex. 8, at 2, and, that "[t]he majority (5,233 or 73%) of the wheelchair users injured or killed in motor vehicle incidents [due to all injury producing activities listed in the report] were at least 60 years old ...," P. Ex. 8, at 3. If anything, these statistics underscore the risk to elderly residents sitting in wheelchairs while riding in vans.

manner, regardless of whether the number of those who have lost their lives being so transported is few." ALJ Decision at 12.

We agree that the report cannot absolve Liberty of its duty to protect its residents. However, we also find the report unhelpful to Liberty on the immediate jeopardy issue because the report merely gives information about the causes and severity of injuries resulting from accidents that actually occurred involving persons riding in wheelchairs in vans and other motor vehicles during the time period covered by the report. The report does not purport to provide, nor does it provide, any information about the likelihood of such accidents or injuries occurring (attributable to any cause) or, indeed, tell us anything about the frequency of such accidents or injuries. Thus, it cannot refute either CMS's determination that Liberty's transportation of wheelchair residents in a van without securing them with van seat belts was likely to cause serious injury or death or the ALJ's conclusion that "[p]etitioner should have foreseen that transporting residents in wheelchairs in an unsafe manner in its passenger van was likely to cause serious injury, harm, impairment, or death." Id.

We affirm the ALJ's FFCL sustaining CMS's determination of immediate jeopardy as not clearly erroneous.[11]

C. Liberty's noncompliance with the requirements at 42 C.F.R. §§ 483.13(c)(1)(i)(F224) and 483.25(h)(2)(F324) existed at the immediate jeopardy level from January 5 through January 12, 2005 and continued from January 13 through February 9, 2005.

As previously stated, Liberty concedes that it was not in substantial compliance with 42 C.F.R. §§ 483.139(c)(1)(i)(F224) and 483.25(h)(2)(F324) and that this noncompliance constituted immediate jeopardy. However, Liberty contends that it abated the immediate jeopardy and achieved substantial compliance by January 6, 2005, whereas the ALJ found that Liberty did not abate the immediate jeopardy until January 13, 2005 and continued to be in noncompliance, at less than the immediate jeopardy level, from January 13 through February 9, 2005. P. Br. at 42. We find that

[11] Although Liberty asserts that the immediate jeopardy, if correctly cited at all, should not have been found to exist for the entire period November 30, 2004 through January 4, 2005, it cites no evidence that it abated the jeopardy earlier. The evidence of record supports the opposite conclusion because, as Liberty does not dispute, staff did not even order seat belts to replace the two missing seat belts until January 4, 2005.

substantial evidence on the record as a whole supports the ALJ's determination that the immediate jeopardy was not abated until January 13, 2005, and that Liberty's noncompliance continued from January 13, 2005 through February 9, 2005.

The noncompliance with sections 483.13(c)(1)(i) and 483.25(h)(2) for the period January 5 through February 9, 2005 involved the elopement of Resident No. 4 on January 5, 2005. The material facts are undisputed. The resident had Alzheimer's disease and was assessed as an elopement risk. CMS Ex. 2 at 1-2. Because of this risk, she wore a wanderguard on her wrist, a device designed to set off door alarms if she tried to exit the facility. Id. at 2. At 5:00 p.m. on January 5, Resident No. 4's family arrived for a visit but discovered that she was not in her room on the 3rd floor. Id. The police returned the resident to Liberty at 8:30 p.m. Id. at 3. She apparently had gone from the 3rd floor to the main floor by elevator, despite the fact that the elevator was alarmed and required someone to punch in a code before it would move. Id. at 7; P. Br. at 45. The resident then exited through three sets of automatic glass doors in the front lobby, near the receptionist's desk. Id. at 5. Only the outside doors were alarmed at the time of the elopement, and none of the doors locked automatically when approached by a resident wearing a wanderguard. Id. at 5, 7-8. Although an alarm went off when Resident No. 4 left, the receptionist said there were people coming in and out and she was not sure who or what set off the alarm. Id. The receptionist was not familiar with Resident No. 4 at that time. Id. at 6. The receptionist did not see a staff member she could consult and did nothing more. Id. Facility staff called her at home at 7:00 p.m. that night, and then she realized it must have been Resident No. 4 who had set off the alarm. Id. Although Liberty had a book with pictures of residents known to be elopement risks at the receptionist desk, Resident No. 4's picture was not in the book before she eloped. Id.

The ALJ found that the jeopardy had not been abated before January 13, 2005 because, as a plan of correction (POC) signed by Liberty on January 14, 2005 shows, the lobby door alarm system was not fully operable even as of January 14, 2005, which was the date of the complaint survey, and the 24-hour staff monitoring of the doors that the facility said it started after the elopement was not adequate. ALJ Decision at 10, citing CMS Ex. 25. On appeal, Liberty does not deny that its alarm system was not fully operable as of January 14, 2005. Furthermore, it acknowledges that the vendor was still "fine tuning" an automatic door locking system for the lobby doors "through the survey." P. Br. at 46. The POC on the Statement of Deficiencies for the January 14, 2005

survey, which Liberty's administrator signed on February 2, 2005, gives "1/24/05" as the facility's anticipated completion date for making the alarm and automatic door locking mechanisms on the lobby doors fully operable and installing a "mag lock" on the side door. CMS Ex. 2, at 1. Liberty argues, however, that "the morning after the elopement ... [i]t posted a 24-hour watch at the front entrance until satisfied that the [alarm and door locking system] worked appropriately." Id. According to the POC, the monitoring was to cover both the front lobby and side door area. CMS Ex. 25. Liberty made the same argument below, but the ALJ rejected it, and Liberty does not even address here, much less challenge, the ALJ's explanation for that rejection.

As the ALJ concluded, the deficiency in Liberty's "24-hour staff monitoring" was that no staff member was dedicated to the task of monitoring the front and side doors. During the day, the receptionist was responsible for monitoring the doors, and at night some other staff member sat at the reception desk near the front doors. ALJ Decision at 9-10; Tr. at 137. However, as the ALJ noted, and Liberty does not dispute, the receptionist had other assigned tasks. Based on these facts, the ALJ concluded,

> Nonetheless, ... I find that it would not appear feasible that the receptionist could handle other duties at the reception desk and simultaneously monitor the front doors. The desired surveillance would be even less likely if the receptionist was also required to monitor the side area door. Thus, Petitioner's assertion that "a 24 hour watch was immediately posted *at the front lobby doors*" is not supported by the credible evidence of record.

ALJ Decision at 10 (emphasis in decision). Liberty cites no basis for disturbing the ALJ's evidentiary finding, which we conclude is supported by substantial evidence in the record in any event. In addition to the evidence discussed by the ALJ, we also note the administrator's testimony that Liberty had no documentation of the alleged 24-hour monitoring, such as a list of what staff members actually participated in the monitoring. Tr. 135.

The ALJ also noted that although Liberty had begun providing in-service training to its staff on wanderguard documentation and monitoring on January 6, 2005, Liberty's POC shows that this training was not completed until January 11, 2005. ALJ Decision at 10; CMS Ex. 25; CMS. Ex. 2, at 2. The ALJ further noted,

correctly, that the POC did not mention providing in-service training on how to respond to alarms and that –

> [t]he staff's lack of appropriate response to alarms was made evident on January 13, 2005, when staff failed to respond to the elevator alarm. It should be noted here, that the alarm on that occasion was triggered by a visitor who was given access to the elevator code by facility staff.

ALJ Decision at 10, citing CMS Ex. 2, at 4; see also Tr. at 61-62 (surveyor testimony that not all staff had been in-serviced on responding to alarms prior to the survey). Although Liberty states on appeal that it did "prompt retraining" of the receptionist and other staff on putting pictures in the "wanderer book," on studying the "wanderer book" at the beginning of each shift and on "basic safety rules," P. Br. at 45, Liberty does not specifically state on appeal that it provided in-service training to all staff on how to respond appropriately when an alarm sounds. The evidence before the ALJ on the issue of whether and when staff were in-serviced on the topic of how to respond to alarms was mixed but as a whole does not conclusively show that all staff were in-serviced on this topic prior to the January 14, 2005 survey.[12] Accordingly, we find that substantial evidence on

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[12] An investigation statement completed by Liberty indicates that on January 5 and 6, 2005, "staff" were in-serviced on "codes and elopement policy" and "new [key pad] codes" and "the importance of alarms going off." P. Ex. 18 at 2. However, it does not state which staff were in-serviced or that all staff were in-serviced on any of these topics. This document also states that the receptionist was "counseled on monitoring the door if alarm activates," id., but does not state that she received in-service training on that topic. The surveyor testified that prior to the survey, "not all of the staff" had been in-serviced on the topic of how to respond to alarms and that the main daytime receptionist "had not been in-serviced." Tr. at 62, 78. She also testified that as a result of the post-elopement "counseling," the receptionist knew that when the alarm went off "she was supposed to have checked it and ... that it meant that someone went through the door." Tr. at 79. However, this hardly indicates a thorough comprehension of procedures to be followed. Liberty's administrator was asked during her testimony about the nature of the in-servicing that was done prior to the survey, and she responded, "re-explaining the codes,

(continued...)

the record as a whole supports the ALJ's finding that the training was not completed by that date. To the extent that the ALJ's finding was based on inference from the fact that staff did not respond when the elevator alarm went off on January 13, 2005, we find that inference reasonable.

Liberty states that in light of the other corrective actions it took within the first 48 hours, the fact that staff were still giving keypad codes to visitors or family is "insignificant." P. Br. at 47. We disagree. Although Liberty states it does not know exactly how Resident No. 4 traveled from the third floor to the lobby undetected, "the likelihood is that she took an elevator with someone who did not recognize her as a new resident." P. Br. at 45. Liberty states that it remedied this problem by programming one elevator to completely bypass the second and third floors and by changing the keypad codes on the second elevator. However, the fact that staff gave the new code to a visitor undermined this corrective action.[13]

Based on the foregoing, we conclude that the ALJ's finding that Liberty did not abate the immediate jeopardy before January 13, 2005 is supported by substantial evidence on the record as a whole and contains no error of law. There is no dispute that Liberty took some corrective actions within a few days of the resident's elopement, such as putting the resident's picture in

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[12](...continued)
talking about service on the elopement policy, the Wanderguards, and the assessments, beginning some of the assessments [on elopement risk]." Tr. at 116-117. She did not specifically mention in-servicing on how to respond to alarms sounding or state that "elopement policy" included that topic.

[13] Liberty also argues that it may be appropriate to share the code with visitors who are volunteers. This seems inconsistent with the fact that after its internal investigation of the elopement, Liberty posted signs informing visitors and family members that they would have to ask staff to get them off the floors. P. Ex. 2, at 15. If there was an exception for volunteers, this apparently was not stated. However, even assuming Liberty actually had such an exception and that it was appropriate from a security perspective, there is no evidence that the visitor who got the new code from staff and used it on January 13 was a volunteer. Furthermore, the visitor told the surveyor that she knew she should not have the code. See CMS Ex. 2, at 4. This indicates an awareness that getting the code from Liberty staff was not consistent with facility policy.

the "wanderer book," training staff on duty at the receptionist's desk to consult this book each shift and reassessing all residents for elopement risk. We assume for purposes of this decision that it also trained some (but not all) of its staff in how to respond to alarms sounding. However, the record as a whole supports the ALJ's determination that the corrective actions taken were not sufficient to abate the immediate jeopardy prior to January 13, 2005, especially in light of the manner in which Resident 4 eloped – by reaching the lobby in an unsecured elevator, exiting doors that were not all alarmed and did not lock automatically when approached by a resident wearing a wanderguard and circumventing staff who were not monitoring the doors and were not adequately trained to respond to alarms.[14]

It was not until January 13, 2005, that Liberty instituted, as verified by the surveyors, a plan for continuous 24-hour staff monitoring of the front doors and side doors until the door alarm and automatic locking system became operational. CMS Ex. 2, at 9; Tr. 61.[15] The record is clear that the measures Liberty took to address these important factors contributing to the elopement of Resident No. 4 were not completed by January 6, 2005, as Liberty asserts. Indeed, CMS did not verify until a follow-up survey on February 10, 2005 that Liberty's door alarm and locking systems were fully operational and that other corrective actions causing CMS to conclude that the facility had corrected the noncompliance associated with the elopement – such as records verifying the interim 24-hour monitoring – had occurred. ALJ Decision at 13; Tr. at 83-84.[16]

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[14] We note in this regard that the surveyor observed the director of nursing walk through the front doors carrying a wanderguard, and no alarm went off, and the doors did not lock automatically. Tr. at 59.

[15] Liberty's administrator testified at the hearing that the facility did 24-hour monitoring for 48 to 72 hours immediately after the elopement but then discontinued it. She also testified that the only way she knew that was done was by "conversation," and that the facility did not create schedules until after the surveyor asked for them during the survey. Tr. at 123-124.

[16] As discussed earlier, we have summarily affirmed the ALJ's finding of noncompliance for the period January 14 through February 9, 2005 and the ALJ's finding that the $100 per day CMP for that period was reasonable and, thus, need not discuss these matters further. However, we note that the regulations provide

(continued...)

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

[16](...continued)
that once CMS finds a facility not in substantial compliance, the facility remains in that status "until the facility has achieved substantial compliance, as determined by CMS ... based upon a revisit or after an examination of credible written evidence [submitted by the facility and found adequate by CMS] that it can verify without an on-site visit." 42 C.F.R. § 488.454(a)(1),(e).