Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Lopatcong Center
Docket No. A-12-7
Decision No. 2443
March 6, 2012

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Lopatcong Center (Lopatcong, Petitioner) appealed the August 26, 2011 decision of Administrative Law Judge (ALJ) Keith W. Sickendick, *Lopatcong Center (CCN: 31-5202)*, DAB CR2420 (2011) (ALJ Decision). The ALJ concluded that Lopatcong was not in substantial compliance with Medicare program participation requirements from November 6 through December 23, 2008, due to violations of 42 C.F.R. §§ 483.70(f) (resident call system) and 483.75 (administration). The ALJ also concluded that CMS's determination that Lopatcong's violation of these requirements posed immediate jeopardy during this period was not clearly erroneous. In addition, the ALJ found CMS's imposition of a $3,050 per-day civil money penalty (CMP) for this period was reasonable. Lopatcong contends that the ALJ Decision contains both factual and legal errors.

For reasons explained below, we affirm the ALJ Decision.

Legal and Factual Background

As noted, there are two participation requirements at issue here. One requirement appears in 42 C.F.R. § 483.70 ("Physical environment") and states:

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

The other requirement consists of the introductory paragraph of 42 C.F.R. § 483.75 ("Administration"), which states:

> A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychological well-being of each resident.

The ALJ Decision describes other applicable law at pages 3-5.

The following facts are drawn from both the record and the ALJ Decision and, except as noted, are undisputed.

Lopatcong is a long-term care facility located in Phillipsburg, New Jersey that participates in both Medicare and Medicaid. ALJ Decision at 1. Each resident's room and bathroom was equipped with a call bell button that, when pressed, caused a light to go on in the hallway above the door of the room. At the same time, a light (which was associated with the resident's room) on the control panel at the nurse's station went on, and the control panel emitted an audible signal. The audible signal could be heard around the nurse's station but not in the hallway. ALJ Decision at 7, 11; Tr. at 209. Staff at the nurse's station could not see all the lights above the room doors due to the configuration of the first floor, which had an "L" shaped hallway. ALJ Decision at 11, 13.

From November 6-17, 2008, the State survey agency conducted a survey of Lopatcong. ALJ Decision at 7; P. Ex. 6, at 1. On November 6, the resident call system for Lopatcong's 60-bed first floor unit malfunctioned. When a call bell button was pressed, the call light in the hallway above the room door went on but there was no light or audible signal on the control panel at the nurse's station. ALJ Decision at 7, 11; Tr. at 27, 209.

On November 6, Lopatcong's director of maintenance contacted a vendor who came to assess the call system the same day. ALJ Decision at 7. The ALJ found that the vendor advised Lopatcong that the system needed to be replaced. *Id*. According to Lopatcong, however, the vendor advised Lopatcong that only the control panel at the nurse's station needed to be replaced, that the manufacturer had gone out of business, and that it would try to locate replacement parts elsewhere. Further, according to Lopatcong, the vendor did not advise Lopatcong until about November 16 (10 days later) that it was unable to locate replacement parts so that the entire system would have to be replaced. Lopatcong Request for Review (RR) at 10-11, citing Tr. at 163 (testimony of Lopatcong's administrator) and 244-277 (testimony of maintenance director). Lopatcong subsequently obtained several quotations for a new system. ALJ Decision at 9-10. Installation of the new system was completed on December 31, 2008. *Id*. at 10.

During the State agency survey, Loptacong's administrator prepared a document listing what she referred to in her testimony as the "remedial measures" Lopatcong took after its call system malfunctioned. *Id*. at 8. Captioned "First Floor Call Bell Action Plan," the document states:

> Since 11/6/08 call bells have been monitored visually to ensure resident's needs are being met.
>
> Oliver Alarm Systems representative visited on 11/6/08 to assess & troubleshoot. Main Nurses Station call bell box on 1st floor was found to be inoperable.
>
> All call bells in resident rooms were checked to ensure visual functioning in hallways.
>
> Staff was educated on the need to observe for any activated call bells.
>
> 4PM-11PM Daily an additional CNA has been assigned to monitor call bells.
>
> 11PM-7AM Staff are conducting rounds on floor to ensure all call bells are answered.

CMS Ex. 8 (quoted in ALJ Decision at 8).[1] In addition, the "24-hour report" prepared at the end of each shift for the incoming shift was annotated to indicate that staff should be alerted to the need to monitor the call lights above residents' doors due to the malfunctioning call system. ALJ Decision 8, citing P. Ex. 8 (24-hour reports for 11/12/08 and 11/13/08); Tr. at 165, 217. Finally, Lopatcong offered "tap bells" to the first floor residents who were alert and oriented (approximately 90% of the residents, according to Lopatcong), but only four residents accepted the tap bells. ALJ Decision at 8, citing Tr. at 29, 36, 108, 164-165, 206.

The State survey agency did not find any deficiency related to the malfunction of the call system. ALJ Decision at 8, citing P. Ex. 6 and Tr. at 218.

From December 18-24, 2008, the Centers for Medicare and Medicaid Services (CMS) conducted a federal comparative monitoring survey of Lopatcong. ALJ Decision at 6; CMS Ex. 2, at 1. The purpose of such a survey is to evaluate the performance of the state surveyors as well as the performance of the facility in meeting the participation requirements. Tr. at 61-62, 81, 94. On December 23, the CMS surveyors notified Lopatcong's Administrator of their determination that the malfunctioning call system posed immediate jeopardy beginning November 6. ALJ Decision at 9. The CMS surveyors found that immediate jeopardy was abated on December 24 when Lopatcong designated two staff members on every shift to sit in the hallway with two-way radios, watch for call lights above doors, and advise nursing staff members--who were also equipped with two-way radios--if a call light went on in the hallway. *Id.*

[1] The statement that "call bells have been monitored visually" appears to mean that the lights above residents' doors that were activated by pressing a call bell button were monitored.

CMS imposed a $3,050 per-day CMP for the period November 6 through December 23, 2008 based on its determination that Lopatcong failed to comply substantially with the participation requirements at 42 C.F.R. §§ 483.70(f), 483.75 and 483.25 and that its noncompliance posed immediate jeopardy. ALJ Decision at 2. CMS also imposed a $200 per-day CMP for the period December 24, 2008 through January 29, 2009 based on its determination that Lopatcong failed to comply substantially with other participation requirements at the non-immediate jeopardy level. *Id*. at 2, 6. Lopatcong requested a hearing by an ALJ on CMS's determination of immediate-jeopardy level noncompliance.

The ALJ Decision

The ALJ concluded that Lopatcong violated section 483.70(f), stating in part as follows:

> The participation requirement established by 42 C.F.R. § 483.70(f) requires that: (1) the nurse's station be equipped to receive resident calls; (2) through a communication system from resident rooms; and (3) through a communication system from toilet or bath facilities. The evidence shows that Petitioner had a centralized nurses' station on the first floor. Under the interpretive guidance of the SOM [State Operations Manual], app. PP, Tag F463, the means of communication could be by audible or visual signals. The evidence shows that Petitioner had no audible or visual communication between resident rooms and bath/toilet facilities [and the nurse's station] between November 6 and December 31, 2008, a violation of the regulation. Petitioner's instructions to monitor call lights above doors, the use of tap bells, and the subsequent use of walkie-talkies did not remedy the regulatory violation as neither approach satisfied the requirement of the regulation that the nurses' station be equipped to receive resident calls from their rooms, bathrooms, or toilet rooms.

ALJ Decision at 11.[2] The ALJ further stated that "[t]he regulatory violation standing alone . . . does not amount to noncompliance as Petitioner remains in substantial compliance so long as no deficiency, *i.e.*, violation of a condition of participation, poses a risk for more than minimal harm to one or more residents. 42 C.F.R. § 488.301." *Id*. at 13. However, the ALJ found that the "unrebutted and credible testimony of the surveyor is that long-term care facility residents are subject to more than minimal harm if they require assistance with toileting, transfers, or other activities of daily living but are unable

[2] The ALJ stated in addition that the "evidence also shows that there was no system for resident calls to be made directly to nursing staff, the alternative permitted by the more liberal interpretation of the regulation found in the SOM." ALJ Decision at 11. This appears to refer to language added to CMS's State Operations Manual effective June 12, 2009, after the period in question here. Lopatcong does not contend that it had such a system.

to call for and receive assistance" (*id*. at 11-12) and that "Petitioner has failed to show by a preponderance of the evidence that its remedial measures, from November 6 through December 23, 2008, ensured that there was no risk for more than minimal harm" (*id*. at 13).

The ALJ gave the following reasons for finding that the remedial measures were inadequate:

- "Issuing tap bells was not an effective intervention in this case as too few residents accepted the bells, and the evidence does not show whether those bells were placed in the residents' rooms and toilet and bath facilities." ALJ Decision at 13.
- Assigning a CNA "to walk the halls" during the 4 pm to 11 pm shift to monitor the lights above residents' doors was an "ineffective" intervention because "[w]hile the CNA walked in one leg of the "L" shaped hallway, he or she could not observe rooms in the other leg of the hall." *Id*. That intervention was ineffective for the additional reason that Lopatcong "did not show that the CNA was not allowed or expected to deliver care in addition to monitoring the lights and "the CNA delivering care in a room could not reliably monitor lights in the hallway." *Id*. at 14.
- The other remedial measures identified by Lopatcong – checking to ensure call lights above resident doors functioned, instructing staff to monitor call lights above doors, and instructing staff on the 11 p.m. to 7 a.m. shift to conduct rounds and monitor call lights – were measures that Lopatcong should have taken "even when the call bell system functioned properly." *Id*. at 13.
- The testimony of the Administrator and the Director of Nursing that reminding staff to pay particular attention to the lights above the doors was an effective intervention "was effectively rebutted, as the surveyors testified that they . . . observed several times during the day shift that there were no staff present in the hallways to observe call lights." *Id*. at 14.

The ALJ also concluded that Lopatcong violated section 483.75, stating in part:

> In this case, there is no dispute that it took 56 days for Petitioner to replace the malfunctioning call bell system on the first floor. Petitioner used 29 days to collect bids or quotations for repair or replacement, but then it took only 27 days for funding to be approved, the contract to be awarded, and installation to be completed. The fact that it took 29 days for Petitioner to decide the system was broken beyond repair and to collect bids shows that Petitioner was not proceeding diligently, effectively, or efficiently. Petitioner's lack of diligence, effectiveness, and efficiency, following the state survey, is particularly apparent when one

> considers that Petitioner only required 27 days to fund, contract for, and install the new system when the federal surveyors expressed interest. Petitioner's evidence does not show it was impossible to proceed more expeditiously with replacement of the call bell system. Furthermore, the evidence shows that between November 6 and December 24, 2008, Petitioner failed to devise and adopt an adequate alternative system for direct communication to the central nurses' station or between residents and caregivers. The risk for more than minimal harm was present to the same extent and for the same reason it was present due to the violation of 42 C.F.R. § 483.70(f).

ALJ Decision at 12. The ALJ did not address whether Lopatcong failed to comply with section 483.25, stating that the alleged deficiencies under sections 483.25 and 483.70(f) "are based on the same alleged facts, and a single deficiency that poses immediate jeopardy is a sufficient basis for imposing the CMP proposed by CMS in this case." *Id*. at 6-7.

The ALJ further concluded that Lopatcong failed to show that CMS's determination of immediate jeopardy was clearly erroneous, stating in part:

> The surveyor's testimony establishes that there was a likelihood of serious injury, harm, or death of a resident due to the resident's and/or staffs' inability to summon help when the call bell system malfunctioned. The surveyor's testimony is credible and unrebutted. I conclude that there was a likelihood of serious harm or death, if a resident was unable to summon staff via the call bell system in case of an emergency medical situation.

Id. at 15.

Standard of Review

The Board's standard of review on a disputed finding of fact is whether the decision is supported by substantial evidence on the record as a whole. *Appellate Review of Decisions of Administrative Law Judges Affecting* a *Provider's Participation in the Medicare and Medicaid Programs*, available at http://www.hhs.gov/dab/divisions/appellate/guidelines/index.html. The Board's standard of review on a disputed conclusion of law is whether the ALJ's decision is erroneous. *Id.*

"Substantial evidence" is "more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971), *quoting Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938). Under the substantial evidence standard, the reviewer must examine the record as a whole and take into account whatever in the record fairly detracts from the weight of the evidence relied on in the decision below. *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 488 (1951).

Analysis

Below, we address the principal arguments Lopatcong made on appeal.[3] We note preliminarily that Lopatcong also states that its hearing request "preserved numerous procedural and constitutional challenges to the Board's current operation of the appeal process, and Petitioner specifically preserves those issues for judicial review." RR at 15, n.9. "Most important," Lopatcong says, it "questions the Board's informal rule that assigns the burden of proof to the petitioner challenging CMS action." *Id*. The Board "has consistently held, based on analysis of the applicable statutory and regulatory provisions, that allocating the burden of persuasion to the [facility] does not violate APA [Administrative Procedure Act] procedural requirements." *Azalea Court*, DAB No. 2352, at 16 (2010), quoting *Carrington Place of Muscatine*, DAB No. 2321, at 24 (2010). In doing so, the Board relied on *Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 F. App'x 181 (6th Cir. 2005), in which it concluded that, under the statutes and regulations governing nursing home participation in the Medicare program, a facility is the proponent of an order finding it in substantial compliance. In any event, the ultimate burden of persuasion is relevant only if the evidence is in equipoise. *Azalea Court* at 16; *see also Fairfax Nursing Home v. Dep't of Health & Human Servs.*, 300 F.3d 835, at 840 n.4 (7th Cir. 2002), *cert. denied*, 537 U.S. 1111 (2003) (declining to address Board's rejection of APA arguments where evidence not in equipoise). The ALJ here specifically concluded that "the evidence is not in equipoise in this case, the allocation of burden of persuasion did not affect my decision, and Petitioner suffered no prejudice." ALJ Decision at 15. None of Lopatcong's arguments on appeal warrant a different conclusion.

1. The ALJ did not err in concluding that Lopatcong's malfunctioning call system constituted a *per se* violation of 42 C.F.R. § 483.70(f).

As indicated above, the ALJ concluded that Lopatcong violated section 483.70(f) based on the undisputed fact that, beginning November 6, 2008, there was no direct means of communication from resident rooms and toilet or bath facilities to the nurse's station. Addressing Lopatcong's complaint that "CMS seeks to hold Petitioner strictly liable for the failure of its call bell system," the ALJ wrote:

> The regulation clearly requires that Petitioner have a resident call system with nurses' stations equipped to receive resident calls through a communication system from resident rooms and toilet and bath facilities. There are no exceptions to the requirement listed in the regulation. . . .Whether or not failure of the call system was

[3] We have fully considered all of Loptacong's arguments on appeal, regardless of whether we have specifically addressed particular assertions or documents.

> due to some neglectful act, intentional act, or unintentional act or failure by Petitioner is not the issue. . . . Petitioner violated the regulatory requirement, when the call bell system malfunctioned. The regulatory violation continued until the new system was installed and became operational on December 31, 2008.

ALJ Decision at 12-13.

Lopatcong argues that it was error for the ALJ to "read[] the regulation to require a nursing facility to maintain an operable electronic call system at all times, . . . so any failure of that system is a per se violation, regardless of whether the facility was at fault (for instance, for failing to maintain the system), the facility's efforts to repair it, or its efforts to protect residents." RR at 10; *see also id.* at 24 ("[a]s a matter of law, . . . there is no basis for the ALJ's interpretation and application of Section 483.70(f) to provide for strict liability in the case of even an unanticipated mechanical problem, regardless of the facility's response").

In support of this argument, Lopatcong asserts that the ALJ's reading of the regulation is based on the statement in CMS's State Operations Manual (SOM) that "this requirement is met only if all portions of the system are functioning" and that the ALJ could not properly rely on the SOM because it was not adopted pursuant to notice and comment rulemaking. RR at 18, quoting P. Ex. 10, at 2. However, the mere fact that the SOM expressly states that all portions of the system described in section 483.70(f) must be functioning in order to meet the requirements of section 483.70(f) does not mean that this is not already clear from the regulation. Plainly, a call system that does not work as described in the regulation does not meet the requirements of the regulation even if it has all of the necessary components. Thus, even if the ALJ had stated that he was relying on the SOM, which he did not, we would conclude that a malfunctioning call system violates the clear requirements of the regulation.[4]

Lopatcong also argues, in effect, that the ALJ's reading of the regulation is unreasonable because it would penalize a facility for a failure of its call system regardless of the facility's response to this failure. This argument has no merit. Because the language of the regulation is clear on its face, both the ALJ and the Board are bound by it. In any event, as the ALJ Decision correctly points out, under the regulatory scheme, a facility

[4] Lopatcong also argues that the ALJ improperly relied on the SOM in reading section 483.70(f) to require the call system to be electronic. RR at 17-18. However, the ALJ Decision nowhere states that an electronic call system is required by the regulation. In addition, the decision indicates that appropriate non-electronic measures could have been a basis for finding Lopatcong in substantial compliance with section 483.70(f). *See* ALJ Decision at 13 ("The remedy of having a CNA roam the halls may have been sufficient, if done for every shift by two CNAs (one for each leg of the "L" shaped hall), and the CNAs were given no duties other than watching for call lights and alerting nursing staff of calls.").

could violate section 483.70(f) and still remain in substantial compliance with this regulatory requirement. *See* ALJ Decision at 13. Section 488.301 of 42 C.F.R. defines the term "substantial compliance" as "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." A long-term care facility is subject to enforcement remedies, including CMPs, only if it is not in substantial compliance with a participation requirement. 42 C.F.R. §§ 488.402(c), 488.406, 488.408. It follows that Lopatcong could avoid a CMP if it could show that, despite its violation of section 483.70(f), there was no potential for more than minimal harm. Thus, contrary to what Lopatcong asserts, a facility would not necessarily be penalized for a *per se* violation of section 483.70(f).

Accordingly, we find no error in the ALJ's conclusion that Lopatcong's malfunctioning call system constituted a *per se* violation of section 483.70(f).

The ALJ did not err in concluding that Lopatcong's remedial measures were inadequate to establish that Lopatcong was in substantial compliance with 42 C.F.R. § 483.70(f).

As indicated above, the ALJ concluded that Lopatcong was not in substantial compliance with section 483.70(f) because it failed to show that the remedial measures it took from November 6 through December 23, 2008 ensured there was no risk for more than minimal harm to residents from the malfunctioning of its call system. Lopatcong disputes this conclusion on the ground that the situation after its call system malfunctioned was "no different than is the case when the call system is completely operable[.]" RR at 21, n.14. According to Lopatcong, even with a fully functioning call system, facility staff could not instantaneously respond to resident calls. *See* RR at 20. Thus, in Lopatcong's view, instead of considering whether the malfunctioning call system had a potential for more than minimal harm, the ALJ should have considered whether it "created or enhanced any hazard, or any resident's risk of harm, beyond what it otherwise would have been even if the call system had remained fully functional." RR at 26; *see also* P. Reply Br. at 14. Lopatcong argues that the record shows that there was no increased risk, stating in relevant part:

> CMS did not dispute Petitioner's evidence that during the entire period that the call system was broken, there were no incidents of unattended residents; no resident or family complaints that resident needs were unmet or that it took longer to respond to call lights; and that the President of the Resident Council actually wrote a memo to the effect that she was aware of no complaints or delays in responses to call lights during this period. . . . Administrator Bell testified that

> residents told her that call lights actually were answered *quicker* during that period because of the extra attentiveness of staff. And Director Sysock testified that the quality assurance data she routinely collects and analyzes indicate that there actually were *fewer* falls, and *fewer* adverse outcomes, during the time the call system was down, which she also attributed to the extra attentiveness of her staff. . . .

RR at 11-12 (italics in original; citations omitted); *see also* RR at 25-26 ("during the time that part of the first floor call system was broken, not a single resident or family member complained about slow or inadequate responses to resident needs; not a single resident experienced any fall, unusual wetness, etc[.]").

We are not persuaded that the absence of complaints about responses to call lights or the perception of some residents that staff responded to call lights more quickly after the call system malfunctioned is sufficient to establish that there was in fact no increased risk after the call system malfunctioned. In any event, Lopatcong's argument that it complied substantially with section 483.70(f) because there was no increased risk of harm after its call system malfunctioned is based primarily on its assertion that "the nursing station sometimes is vacant." RR at 20.[5] (According to Lopatcong's Administrator, "You can go any hour of the day and not find anybody at the nurses' station . . . [b]ecause nurses are out passing medication, nurses are assessing residents and . . . nurses' assistan[ts] do not sit at the nurses' station." Tr. at 170.) Responding to the same argument below, the ALJ stated:

> The fact that Petitioner, as a matter of practice, did not ensure that the nurses' station was staffed, and the call bell system monitored and responded to when it was working, is no excuse for Petitioner not promptly repairing or developing an appropriate remedy to minimize the risk for harm associated with residents being unable to contact nursing staff. Certainly, the regulatory requirement that Petitioner have a system includes the requirement that the system be appropriately monitored.

ALJ Decision at 14.

[5] Lopatcong also points out that a nurse "cannot always interrupt a task to answer a call, and frequently must prioritize responses." RR at 20, n.13. If a call comes into the nurse's station, however, the nurse there would presumably locate someone who is available to answer the call. Lopatcong also points out that some residents might "be unable to use a call bell." *Id.* However, a call system is not designed to protect such residents.

We agree with the ALJ that section 483.70(f) requires that a facility monitor the call system described in that section. While the regulation does not specifically require that a facility have someone at the nurse's station at all times, any meaningful call system must include some means of ensuring that staff know right away that a resident has called for assistance if there is no one at the nurse's station to see or hear the control panel. We need not determine, however, whether Lopatcong provided monitoring sufficient to comply with section 483.70(f) before its call system malfunctioned. Instead, the salient question in this case is whether, after its call system malfunctioned, Lopatcong had other means of ensuring that staff knew right away that a resident had called for assistance. As noted above, the ALJ found that the remedial measures Lopatcong took did not ensure this. *See* ALJ Decision at 13-14. Lopatcong does not directly dispute that finding.

Instead, much of the evidence Lopatcong cites addresses whether there was actual harm to any resident after its call system malfunctioned, not whether there was an increased risk of harm. Thus, Lopatcong appears to argue that there was no actual harm to residents while its call system was malfunctioning. This argument is unavailing because it is based upon a misreading of the regulatory standard. As noted above, section 488.301 defines "substantial compliance" as "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." Based on this provision, the Board has previously rejected a facility's contention that CMS may not cite noncompliance unless it finds that actual harm resulted from the facility's violation of a participation requirement. *See, e.g., Oaks of Mid City Nursing and Rehabilitation Center*, DAB No. 2375, at 17 (2011). In addition, actual harm is not required to support a determination of immediate jeopardy, which requires only that the facility's noncompliance has caused or i**s likely to cause serious injury**, harm, impairment, or death to a resident. 42 C.F.R. § 488.301 (definition of "immediate jeopardy" (emphasis added)); *see also Care Center of Opelika*, DAB No. 2093, at 14 (2007) (upholding ALJ's conclusion that absence of effective substitute for malfunctioning call system posed immediate jeopardy even in the absence of actual harm).

Here, the ALJ found "credible and unrebutted" the federal surveyor's testimony that "there was a likelihood of serious injury, harm or death of a resident due to the resident's and/or staffs' inability to summon help when the call system malfunctioned." ALJ Decision at 15. Regarding the ALJ's finding, Lopatcong merely states: "The obvious threshold question is how could CMS conclude that Petitioner's residents were at risk of 'likely' death or serious injury when its survey team knew that no one actually had been injured during the preceding seven weeks?" RR at 28. As the Board has observed in cases involving other participation requirements, however, the fact that no harm actually ensues from a violation may be simply fortuitous and does not determine whether there is

a likelihood of serious harm. *See, e.g., Elgin Nursing and Rehabilitation Center*, DAB No. 2425, at 11 (2011) ("If true, th[e] fact [that no residents were harmed by eating undercooked unpasteurized eggs] is merely fortuitous and does not detract at all from the severity finding because an immediate jeopardy situation may exist even when the noncompliance has not harmed residents."); *Southridge Nursing and Rehabilitation Center*, DAB No. 1778 (2001) (upholding immediate jeopardy determination despite the lack of serious actual harm and noting that it was merely "fortuitous" that such harm did not occur) .

Lopatcong further argues that the decision of ALJ Smith in *Lake Shore Inn Nursing Home, Inc.*, DAB CR1361 (2005), supports its position that "the ALJ should have examined the *actual* effectiveness of the communication system Petitioner substituted while the electronic system was being assessed, and ultimately replaced." RR at 19 (italics in original); *see also* RR at 3. According to Lopatcong, "Judge Smith held that the facility's response assured that residents could communicate with staff, and this is all that the regulation reasonably can require." *Id*. As an initial matter, it is important to emphasize that ALJ decisions do not carry precedential weight and are not binding authority on the Board or even other ALJs. In any event, *Lake Shore Inn* is distinguishable from the case before us on its facts. In that case, five or more simultaneous calls on the facility's call system would cause the system to shut down. ALJ Smith found that the evidence established that when the system shut down, which occurred "about once a week to once every three weeks," "staff were aware of the situation [and] took immediate and effective measures to correct it by visiting all residents and resetting the system[.]" DAB CR1361, at 7. The ALJ further found that "[w]ithin five or 10 minutes [staff] knew where the problem was" and that "there was never a time when Petitioner's nursing staff had no idea how to reset the system." *Id*. ALJ Smith concluded that the facility was in substantial compliance with section 483.70(f) because it "had a system in effect where residents were dependably able to convey messages and that the amount of time that the system was down was adequately addressed by staff." *Id*. at 9. In contrast, Lopatcong's call system did not function as required at any time for a period of almost seven weeks, and during this period Lopatcong failed to take measures that ensured that residents would be able to immediately communicate their need for assistance to facility staff.

Lopatcong also argues that the fact that the State survey agency did not find a deficiency under section 483.70(f) indicates that the remedial measures Lopatcong took beginning on November 6 when its call system malfunctioned were adequate to establish that it was in substantial compliance. RR at 25. Lopatcong alleges specifically that the State surveyors approved the "First Floor Call Bell Action Plan" (CMS Exhibit 8) quoted above. RR at 9; Tr. at 166. The ALJ did not accept Lopatcong's previous allegation to this effect, stating instead that "[t]he evidence does not establish why no deficiency was

cited" by the State survey agency. ALJ Decision at 14. We need not reach this issue here because, as the ALJ pointed out and Lopatcong acknowledges, a determination by the State survey agency that Lopatcong was in substantial compliance with section 483.70(f) is not binding on CMS. *See* ALJ Decision at 14, citing 42 C.F.R. § 488.452(a) (providing that CMS's findings of noncompliance take precedence over the State's findings that it was in substantial compliance with participation requirements). Because substantial evidence supports the ALJ's conclusion that the remedial measures listed in Lopatcong's action plan were not adequate to establish that Lopatcong was in substantial compliance with section 483.70(f), any contrary conclusion by the State survey agency is irrelevant.

Accordingly, we conclude that the ALJ did not err in concluding that Lopatcong's remedial measures were not adequate to establish that it was in substantial compliance with section 483.70(f).

2. The ALJ did not err in concluding that Lopatcong was not in substantial compliance with 42 C.F.R. § 483.75.

As indicated above, the ALJ concluded that Lopatcong was not in substantial compliance with section 483.75 both because Lopatcong did not "proceed more expeditiously with replacement of the call bell system" and because Lopatcong did not "devise and adopt an adequate alternative system" until the system was replaced. ALJ Decision at 12. Lopatcong argues that the ALJ's conclusion that Lopatcong did not act expeditiously to replace its malfunctioning call system was based on several erroneous findings of fact. *See* RR at 10, 12-14, 21-22.

As discussed above, we agree with the ALJ that Lopatcong's remedial measures were not adequate. That conclusion alone is a sufficient basis for concluding that Lopatcong failed to comply substantially with section 483.75 as well as section 483.70(f). The Board has held that where a deficiency finding under section 483.75 was derivative, "i.e., was based on the surveyors' identification of other deficient practices," the existence of those separately identified deficiencies "may constitute a prima facie case that a facility has not been administered efficiently or effectively as required by section 483.75." *Odd Fellow and Rebekah Health Care Facility*, DAB No. 1839, at 17 (2002), citing *Asbury Center at Johnson City*, DAB No. 1815 (2002). Lopatcong advances no reason why its failure to ensure that, despite the malfunctioning call system, facility staff were aware right away that a resident had called for assistance does not show that Lopatcong was not "administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychological well-being of each resident" as required by section 483.75.

Accordingly, we uphold the ALJ's conclusion that Lopatcong was not in substantial compliance with section 483.75 based on Lopatcong's failure to take adequate remedial measures after its call system malfunctioned without considering the other basis stated by the ALJ for this conclusion.[6]

3. The ALJ did not err in concluding that a CMP was properly imposed beginning November 6, 2008.

Lopatcong argues that the ALJ erred in concluding that a CMP was properly imposed beginning November 6, 2008, the first day Lopatcong's call system malfunctioned. *See* RR at 4, 29. According to Lopatcong, there is "a significant notice issue" because "there is no way Petitioner's staff could have anticipated that the CMS surveyors would require" the use of two-way radios (walkie-talkies) to achieve substantial compliance after the call system malfunctioned. RR at 21; *see also* P. Reply Br. at 4 (stating that there is no evidence that CMS "or any other authoritative agency ever promulgated any specific steps that a nursing facility must take to protect residents when parts of a call system fail.").

This argument has no merit. As discussed above, section 483.70(f) on its face requires "a resident call system with nurses' stations equipped to receive resident calls through a communication system from resident rooms and toilet and bath facilities" (ALJ Decision at 12). In addition, under section 488.301, a facility may comply substantially with section 483.70(f) even if its call system malfunctions as long as there no potential for more than minimal harm. Lopatcong therefore had notice that it could maintain substantial compliance if it had in place measures that enabled residents to immediately alert facility staff of their need for assistance. The facility was free to select particular measures to achieve that end, whether continuous observation of each leg of the hallway, use of two-way radios, or other means, so long as the steps chosen achieved the required result.

Lopatcong also argues that "the SSA (State survey agency) informed Petitioner during the state survey that its response to the problem was appropriate, so it is unclear how Petitioner could be held to be on notice that it actually was noncompliant, or that some 'corrective' action was necessary (at least until the CMS survey team so notified them weeks later)." RR at 29-30; *see also* RR at 4 (asserting that "*as a matter of law*, CMS may not impose a sanction for the period of time during which the SSA had approved Petitioner's response to the partial failure of its call bell system, and Petitioner relied on that approval" (italics in original)); P. Reply Br. at 4-5. As noted above, however, section 488.452(a) provides that CMS's findings of noncompliance take precedence over the State's findings of substantial compliance. Thus, Lopatcong was not justified in relying on the State surveyors' alleged approval.

[6] No additional findings are necessary to support the $3,050 per-day CMP imposed here because this is the minimum CMP amount for immediate jeopardy-level noncompliance.

Finally, Lopatcong appears to suggest that the CMP was not properly imposed beginning November 6 because there is no evidence that it "could have anticipated the failure" of its call system. RR at 29; *see also* RR at 30 (referring to its "response to the sudden and unexpected failure of part of its electronic call system"). We find no merit in this suggestion. The ALJ considered all of the remedial measures in Lopatcong's First Floor Call Bell Action Plan in concluding that Lopatcong was not in substantial compliance with section 483.70(f). Lopatcong does not allege that it would have instituted other remedial measures if it had anticipated that its call system might malfunction. Moreover, nothing prevented Lopatcong from implementing other remedial measures during the nearly seven weeks that its call system was malfunctioning. Thus, the fact that the malfunction was unanticipated is irrelevant.

Conclusion

For the reasons stated above, we affirm the ALJ Decision.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Stephen M. Godek
Presiding Board Member