Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Golden Living Center – Mountain View
Docket No. A-17-81
Decision No. 2953
July 10, 2019

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Petitioner Golden Living Center – Mountain View (Golden) requests review of the administrative law judge's (ALJ's) August 9, 2017 amended decision, *Golden Living Ctr. – Mountain View*, DAB CR4842 (2017) (ALJ Decision). Following a hearing, the ALJ concluded that Golden, a skilled nursing facility (SNF) participating in the Medicare program, was not in substantial compliance with multiple participation requirements from January 13 through June 10, 2014; Golden's noncompliance from January 13 through April 28, 2014 posed immediate jeopardy to facility residents; Golden remained noncompliant from April 29 through June 10, 2014, after the immediate jeopardy was abated; and the amounts of the civil money penalties (CMPs) imposed by the Centers for Medicare & Medicaid Services (CMS) for Golden's noncompliance were reasonable. Golden's request for review (RR) challenges the ALJ's conclusion that it was not in substantial compliance but does not challenge the ALJ's immediate jeopardy and CMP amount conclusions; nor does Golden challenge the ALJ's conclusions regarding the duration of its noncompliance. As discussed below, we affirm the ALJ's conclusion that Golden was not in substantial compliance with the Medicare requirements. Since Golden's appeal offers no challenges to the ALJ's conclusions regarding immediate jeopardy, the reasonableness of the CMP amounts, and the duration of Golden's noncompliance, we affirm those conclusions as well, without further discussion.

Legal Background

To participate in the Medicare program, a SNF must be in "substantial compliance" with the participation requirements in 42 C.F.R. Part 483, subpart B.[1] Social Security Act (Act) § 1819(h); 42 C.F.R. §§ 483.1, 488.400. State survey agencies, under agreements

[1] On October 4, 2016, CMS issued a final rule that amended the Medicare participation requirements for long-term care facilities in 42 C.F.R. Part 483. Final Rule, *Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities*, 81 Fed. Reg. 68,688 (Oct. 4, 2016). Our analysis and decision are based on the version of the participation requirements that were published in October 2013 and in effect during April 2014, when the compliance survey supporting CMS's enforcement action was performed. *Carmel Convalescent Hosp.*, DAB No. 1584, at 2 n.2 (1996) (applying the regulations in effect on the date of the survey and resurvey).

with the Secretary, conduct surveys at SNFs to determine whether they are in substantial compliance. Act § 1819(g); 42 C.F.R. § 488.300 *et seq*. A SNF is not in substantial compliance when it has a "deficiency" – that is, a failure to meet a participation requirement – that creates the potential for more than minimal harm to one or more residents. *See* 42 C.F.R. § 488.301 (defining "substantial compliance"). The term "noncompliance," as used in the applicable regulations, is synonymous with lack of substantial compliance. *Id.* (defining "noncompliance").

CMS may impose enforcement remedies (such as CMPs) on a SNF that is not in substantial compliance with one or more participation requirements. Act § 1819(h)(2); 42 C.F.R. §§ 488.400, 488.402(b), (c), 488.406. When CMS decides to impose a CMP for a nursing home's noncompliance, it must consider various regulatory factors, including the "seriousness" of the SNF's noncompliance, in setting the amount of the CMP. 42 C.F.R. §§ 488.404(b), 488.438(f). "Seriousness" is a function of the noncompliance's scope (whether it is "isolated," constitutes a "pattern," or is "widespread") and severity (whether it has created a "potential for harm," resulted in "actual harm," or placed residents in "immediate jeopardy"). *Id.* § 488.404(b). The most severe noncompliance is that which puts one or more residents in "immediate jeopardy." *See id.* § 488.438(a) (authorizing the highest CMPs for immediate-jeopardy-level noncompliance); *Woodland Oaks Healthcare Facility*, DAB No. 2355, at 2 (2010) (citing authorities).

Case Background[2]

A. *Summary of Undisputed Facts*

Surveyors from the Tennessee state survey agency completed a survey at Golden on April 11, 2014 for the purpose of determining whether Golden was in substantial compliance with Medicare requirements. ALJ Decision at 2.[3] Based on the survey findings, CMS found Golden noncompliant with multiple regulatory requirements that included, at the immediate jeopardy level, the following:[4] 42 C.F.R. §§ 483.20(d)(3) and

[2] The facts we state here and throughout the decision are taken from the ALJ Decision and, unless we indicate otherwise, are not disputed. We make no new findings of fact.

[3] The parties stipulated that the state survey agency conducted a revisit survey on June 11, 2014, and that CMS determined the facility had returned to substantial compliance. ALJ Decision at 2 n.3. The ALJ inferred from that stipulation that Golden returned to substantial compliance on June 11, 2014, and neither party challenges that inference.

[4] CMS found Golden out of compliance with five additional requirements, but since Golden did not appeal those findings, they are final and need not be discussed here. *See* ALJ Decision at 2-3, 4, 58.

483.10(k)(2) (Tag F280) (periodic review and revision of resident care plans after initial assessments)[5]; 483.25(h) (Tag F323) (nursing homes must "ensure that . . . [t]he resident environment remains as free of accident hazards as is possible" and that "[e]ach resident receives adequate supervision and assistance devices to prevent accidents"); 483.30(a) (Tag F353) (nursing homes must "have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care"); 483.75 (Tag F490) (a nursing home 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 psychosocial well-being of each resident"); 483.75(i) (Tag F501) (requiring appointment of a physician medical director "responsible for . . . [i]mplementation of resident care policies" and "[t]he coordination of medical care in the facility"); and 483.75(o)(1)-(2) (Tag F520) (requiring a "quality assessment and assurance committee" that "[m]eets at least quarterly to identify issues" and which must "[d]evelop[] and implement[] appropriate plans of action to correct identified quality deficiencies").[6] ALJ Decision at 2; CMS Ex. 1 (Statement of Deficiencies (SOD)).

These noncompliance findings involve multiple falls by five residents living in the Alzheimer's Care Units (ACU) (facility wings D and E) at Golden's facility. Resident 28 (R28)[7] fell 15 times between December 22, 2013 and April 5, 2014. ALJ Decision at 11 (citing CMS Ex. 1, at 44-59). R45 fell eight times between December 6, 2013 and February 17, 2014. *Id.* at 16 (citing CMS Ex. 1, at 26-31). R94 fell seven times between

[5] The references to paragraph (3) of section 483.20(d) and to section 483.10(k)(2) appear to be surveyor recording or typographical errors originating on the SOD, under the findings for F-tag 280, that were not discussed or corrected by the parties or the ALJ during the hearing. The ALJ correctly applied the 2013 edition of the regulations since, as we noted earlier, that edition was in effect at the time of the surveys. As discussed on page 38 of the ALJ Decision, section 483.20(d), of the applicable regulations, together with the other subsections of 483.20, impose resident assessment and care plan requirements on long-term care facilities such as Golden. Section 483.20(d), however, does not have a paragraph (3), and section 483.10(k) does not address assessment and care plans. Section 483.**20**(k)(2) does set out requirements for inter-disciplinary development of comprehensive care plans and for periodic review and revision of those plans after each reassessment. While we mention these errors in order to eliminate confusion regarding the record, Golden does not argue that these "errors" affect its case in any way, and they do not affect our decision to uphold the ALJ's determination that Golden failed to comply with the assessment and care planning requirements as set forth on the SOD and discussed in the ALJ Decision.

[6] CMS states the number of unmet federal requirements as "six," which correctly describes the number of F-tags under which the surveyors cited the deficiencies at issue. *See* CMS Brief In Support of Decision No. CR4842 (CMS Br.) at 2. The F-tags, however, are a survey tool for organizing the surveyor findings on the SOD. The number of unmet regulatory requirements corresponding to the F-tags cited in this case is seven. *See* ALJ Decision at 8 (listing the unmet federal regulations and their corresponding F-tags).

[7] We use numerical designations for the residents in order to protect their privacy.

January 4 and January 24, 2014, including three times on January 23, 2014. *Id.* at 19; *see also* CMS Ex. 1, at 31-35. R111 fell seven times between August 16, 2013 and March 27, 2014. ALJ Decision at 21; *see also* CMS Ex. 1, at 20-24. R112 fell six times between December 29, 2013 and March 27, 2014. ALJ Decision at 24 (citing CMS Ex. 1, at 36-38).

There is no dispute about the material facts establishing and surrounding each fall, facts documented in medical and other records provided by Golden and not disputed in the testimony at hearing. *See* ALJ Decision at 8, 10. Nor is there any dispute with the ALJ's finding that all of the falls took place in the ACU. *Id.* Moreover, Golden "stipulated that all five of the residents at issue were assessed by [it] as being at high risk for falls associated with all their activities of daily living[,]" *id*. at 10 (citing Transcript (Tr.) Volume (Vol.) 1 at 168-71), and evidence presented by both parties establishes that falls pose a significant risk of injury or death to the elderly and even to younger residents of institutions, *id*. Indeed, Golden confirms the absence of any dispute about these material facts in its request for review. *See* RR at 3 ("The ALJ Decision describes the evidence relating to the Center's ACU, the five subject residents, and their falls, in considerable detail at pages 11-26, and Petitioner has no significant dispute with that summary. Likewise, the ALJ aptly summarized the Center's data regarding falls at pages 26-27 of his Decision (the spike in falls in question plainly was anomalous).").[8] In light of the absence of any dispute about these material facts, we need not reiterate them here but incorporate by reference the ALJ's statement of facts at pages 9-28 of his decision.

B. ***The ALJ Decision***

The ALJ issued his decision on May 8, 2017, but, on August 9, 2017, replaced that decision with the amended decision we are reviewing.[9] The ALJ discussed the burden of proof as analyzed in Board decisions. ALJ Decision at 43-45 (citing *Evergreene Nursing*

[8] The ALJ's discussion of the evidence related to the ACU actually starts on page 9 of his decision, not page 11, and the ALJ's summary of the falls data does not stop at page 27, but continues onto page 28. The parenthetical is Golden's characterization of the ALJ's summary of the falls data, not part of the ALJ's summary.

[9] The amendment, the ALJ stated in his transmittal letter to the parties, was "to correct a 'scrivener's error' that appeared in the seventh line from the top of page 45 by deletion of the word 'nursing' from that line[,]" and the word "nursing" in that location has a strikeout line through it. As stated in Golden's request for review, Golden had sought, and the Board granted, an extension of time to appeal the ALJ Decision until 60 days after the ALJ ruled on Golden's motion to reopen his decision, which at that time was the decision dated May 8, 2017. The ALJ denied the motion to reopen on July 26, 2017, and Golden filed its appeal with the Board on August 14, 2017, **after** the ALJ issued the amended decision. For simplicity's sake, and since the amended decision made only one change, the aforementioned deletion of the word "nursing" on page 45, we refer to the amended decision as the "ALJ Decision." Golden claims in footnote 5 of its request for review that the "change in wording confuses the discussion [of whether Golden met the minimum staffing requirements for ACUs under Tennessee law] even more" but does not otherwise take exception to the ALJ's having amended his decision. RR at 28 n.5. We discuss the issue involving Tennessee law later but do not agree that the amendment causes confusion; on the contrary, as we discuss, it clarifies what clearly was the ALJ's actual finding based on his discussion of the record evidence.

Care Ctr., DAB No. 2069, at 7 (2007)). CMS has the initial burden to come forward with evidence that, together with any undisputed findings and relevant legal authority, is sufficient to establish a prima facie case of noncompliance with one or more regulatory requirements. *Evergreene*, DAB No. 2069, at 7. Once CMS makes this prima facie case, the SNF has the burden to show, by a preponderance of the evidence on the record as a whole, that it was in substantial compliance. *Id*. With respect to CMS's initial burden, the ALJ stated, "I have no difficulty concluding that CMS has made a prima facie showing of noncompliance under Tags F280, F323, F353, F490, F501 and F520. CMS has presented far more than mere allegations." ALJ Decision at 43. The ALJ cited the undisputed evidence of multiple falls by five residents of Golden's ACU; and a document completed by Golden's Administrator showing that on March 18, 19, 20, 22, 23, 29 and 30, 2014, Golden's staffing for direct care on the ACU fell below the level required for an ACU under a Tennessee regulation which, the ALJ found, "establishes the presumptive standard of practice for an ACU in that state." *Id.* at 45. The ALJ also cited the surveyors' perception during their in-person observations in the ACU "that the staffing level was such that staff on duty were having difficulty delivering the level of care and services residents required during the period of the survey." *Id.* The ALJ then "conclud[ed] that this evidence alone adequately establishes a prima facie showing of noncompliance under all six Tags. Thus, under the prior Board decisions already cited, . . . the burden is upon Petitioner to show it was in substantial compliance with participation requirements." *Id*. (paragraph break omitted).

The ALJ concluded that Golden had not carried that burden. He addressed Golden's argument that the falls were unavoidable because they occurred despite assessments and interventions which Golden argued "were timely and as effective as could be expected considering the state of the residents on the ACU and the operations of the ACU, and that a fall despite the interventions must be found to be unavoidable." ALJ Decision at 48 (citations omitted). While noting that CMS did not concede the implementation or adequacy of the interventions cited by Golden,[10] the ALJ credited Golden with assessing residents and planning timely and appropriate interventions addressing the falls. *Id.* at

[10] CMS continues to not concede the implementation or adequacy of the assessments and interventions the ALJ credited Golden with taking (none of which involved consideration of staffing levels). CMS cites examples where interventions were inappropriate or untimely and "respectfully contends" that the ALJ wrongly discounted "surveyor testimony about the inadequacy of these interventions" and "what the standard of care requires when a resident falls." CMS Br. at 3 n.1. We do not need to resolve this issue since CMS did not appeal the ALJ Decision and, in any case, resolving it would not affect our decision to affirm the ALJ Decision. Our decision is based on our conclusion that substantial evidence and the law support the ALJ's decision that Golden was not in substantial compliance based on its failure to even consider another potentially effective intervention – increasing or reallocating staff to increase supervision of and assistance to the residents who had repeated falls and ACU residents generally. Thus, whether the other assessments and interventions initiated by Golden were timely and appropriate is immaterial.

11, 48. He stated: "The [assessment and intervention] evidence summarized above shows that the residents' IDTs [interdisciplinary teams] were actively involved in assessing, implementing interventions, and evaluating the effectiveness of those interventions." *Id*. at 48.

The ALJ stated that "[t]he focus in this case must be upon the adequacy of ACU staffing in light of the increase in falls beginning in December 2013 and continuing through March 2014." *Id.* After discussing the evidence material to this issue, the ALJ concluded:

> Petitioner's argument that the falls were unavoidable must be rejected. Petitioner cannot establish its defense by a preponderance of the evidence when it cannot show that increased staffing or an adjustment of staffing on the ACU was not an appropriate and effective intervention. Petitioner's defense is even less tenable considering that in the summer of 2013, the QA committee and management actively managed staffing to ensure residents' care planned needs were being met, and successfully, according to Petitioner's records.

Id. at 52. Based on this analysis and Golden's not having disputed that a nursing home resident's fall poses a risk of more than minimal harm, the ALJ concluded that Golden was not in substantial compliance with the regulations CMS cited in connection with the falls. The ALJ noted that Golden did not challenge the duration of the noncompliance, assuming it existed. ALJ Decision at 52. He then stated that the evidence would have supported a conclusion that the noncompliance began "as early as December 2013," but nonetheless accepted CMS's finding that "the noncompliance began January 13, 2014, after Petitioner had a reasonable time to attempt to address the increase in falls on the ACU." *Id.* We too accept and affirm CMS's finding as to the duration of the noncompliance, which Golden does not challenge.

Standard of Review

The Board's standard of review on a disputed conclusion of law is whether the ALJ's decision is erroneous. The Board's standard of review on a disputed finding of fact is whether the ALJ's finding is supported by substantial evidence in the record. Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs, (last visited July 5, 2019), https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/participation/index.html?language=en.

Discussion

A. *Substantial evidence and the law support the ALJ's conclusion that Golden failed to comply with the federal regulations cited at the immediate jeopardy level when it failed to consider adjusting staffing in response to the undisputed significant increase in falls on the ACU, an increase that occurred despite other interventions.*

There is no dispute that five residents of Golden's ACU suffered 43 falls within a several month period.[11] It is also undisputed that most of the falls occurred in December 2013 through March 2014[12] and that this represented a significant increase in falls over the prior period. *See, e.g.*, ALJ Decision at 26-28, 34-36 (citing testimony of Golden's witnesses). The ALJ concluded that Golden was not in substantial compliance with the federal regulations cited by CMS because Golden's response to the increase in falls, as Golden admits, did not include evaluation of whether it should adjust staffing on the ACU in order to provide more supervision of and assistance to its residents, including the five residents who suffered the 43 falls.

The facts material to the ALJ's conclusion are discussed in detail in the ALJ Decision and these material facts are undisputed. Although Golden asserts that the ALJ's conclusion "is based in large part on a significant *mis*interpretation of one bit of the record evidence relating to the Center's staffing pattern" (RR at 2 (italics in original)) – an assertion that is unsupported and not material as we discuss later – Golden does not specifically argue that the ALJ Decision is not supported by substantial evidence. Indeed, in the same sentence in which it asserts the ALJ's alleged "misinterpretation of one bit of evidence," Golden asserts that a "more important" reason for challenging the ALJ's conclusion is that, in Golden's view, "the ALJ's analysis and result has no basis in any regulatory provision or previous Board Decision." RR at 2. Thus, it is clear that we

[11] CMS identifies a total of 45 falls. *See* CMS Br. at 1. However, the ALJ noted that surveyors did not cite two of those falls, sustained by R111 on November 17, 2013 and March 29, 2014. ALJ Decision at 22, 24. Accordingly, we refer to 43 falls.

[12] Several of R111's falls occurred before that period, two as early as August 2013, and two of R28's falls occurred in April 2014, but the marked increase in falls, as shown in the ALJ's chart (and as not disputed), occurred in the period December 2013 through March 2014. *See* ALJ Decision at 15, 22, 27.

can, and do, conclude without further discussion that substantial evidence supports the ALJ Decision on all material factual issues.[13] We discuss below Golden's legal arguments and why we reject them and conclude that the ALJ did not err in concluding that Golden was not in substantial compliance with the cited regulations.

1. *Golden admits not considering staffing adjustments in response to the undisputed increase in falls.*

The ALJ concluded that CMS made a prima facie showing of noncompliance with the regulations at issue and that Golden, therefore, had the burden to show by a preponderance of the evidence that it was in substantial compliance.[14] *See* ALJ Decision at 43-45. The ALJ concluded that Petitioner had not carried its burden because, despite considering and implementing some interventions to address the numerous falls by the five ACU residents, Golden did not consider whether adjusting staffing levels to increase care and supervision of ACU residents might be an appropriate fall prevention intervention. The ALJ explained:

> When the number of falls increased from 8 in November 2013 to 19 in December 2013 and then to 33 in January 2014, it should have been obvious to the QA committee and management that the staffing ratio on the ACU may have required adjustment to provide additional supervision and assistance to the five residents experiencing an increase in falls. *At least that intervention should have been considered and there should have been*

[13] Golden introduces its request for review by stating, "Petitioner actually agrees with nearly all of the Findings of Fact set forth in the ALJ Decision (with one significant exception addressed below)," the exception being a reference to the aforementioned alleged "*mis*interpretation." RR at 2. Despite this statement, Golden then devotes 20 pages to a "Summary of Material Evidence." RR at 11-31. In many instances, this alleged summary does not accurately state the material facts found by the ALJ. We give several examples later in the decision in order to address the "one exception" noted by Golden. However, we need not discuss all of the inaccuracies in Golden's "Summary" because it will be clear from our discussion what the ALJ's findings actually were and which ones were material to his legal conclusion.

[14] In the ALJ proceeding, Golden challenged the legality of allocating the ultimate burden of persuasion to Golden. ALJ Decision at 45 n.16. Golden does not reiterate that challenge here. Nor does Golden specifically challenge the ALJ's conclusion that he "ha[d] no difficulty concluding that CMS has made a prima facie showing of noncompliance . . . ." ALJ Decision at 43. In the concluding paragraph of the request for review, Golden states, "For the reasons set forth above, Petitioner urges the Board to find that CMS did not established [sic] even a prima facie case of noncompliance; or, conversely that Petitioner was in substantial compliance with all pertinent regulatory requirements at all times." RR at 36. However, Golden does not explain how the "reasons set forth above" would support the Board's making either finding urged by Golden, and, as our discussion makes clear, we find no basis for either of the findings Golden urges.

> *documentation of the consideration and any decision to reject that possible intervention.* But [the] Administrator . . . admits that she never saw a possible connection. Thus, the QA and management teams clearly failed in their regulatory duties to consider whether or not increased staff to provide direct care might reduce the number of falls in the ACU.

ALJ Decision at 52 (emphasis added).

Golden does not deny that it did not consider adjusting staffing levels in the ACU to try to eliminate or reduce the falls. Indeed, Golden's Administrator, Medical Director, and Director of Nursing (DON) admitted they did not consider this intervention. *See* ALJ Decision at 50-51 (citing Tr. Vol. 5 at 107-10 – Administrator's testimony that falls were not considered in assessing staffing since she did not believe there was a correlation between staffing and falls); *id.* at 49 (citing Tr. Vol. 3 at 30-31 – Medical Director's testimony that he recognized the declining conditions of the five residents but did not recognize that Golden might need more staff to give those residents more direct care); and *id.* at 35 (finding DON's testimony not credible "to the extent that she failed to explain why a temporary increase in staffing was not considered or deemed an appropriate intervention to address the need to reduce the risk of falls and related injuries to the five residents . . . ").[15]

2. *The reason Golden gives for not considering staffing adjustments – that it did not believe there was a correlation between staffing and falls – is not a valid defense under the regulations and is also undercut by the record of Golden's prior actions.*

Relying on the testimony of its Administrator, DON, and Medical Director that they saw no connection between staffing and falls, Golden argues that the ALJ's finding it noncompliant for its admitted failure to consider adjusting staffing is based on a "flawed premise" or "common-sense notion . . . that more staff might prevent falls . . . ." RR at 33. Golden asserts that this "actually makes no operational sense, and has no legal foundation." *Id*. The ALJ did not find this argument persuasive, and neither do we.

We first note that Golden mischaracterizes the basis for the ALJ's noncompliance conclusion. The ALJ did not find noncompliance based on a premise (assumption) that more staff might prevent falls but, rather, on Golden's failure to **consider whether** adjusting staffing levels might prevent falls. Nor did the ALJ base his conclusion on a

[15] The DON's testimony appears in Transcript Volume 4 at pages 251 through 339.

"common-sense notion." The ALJ specifically stated that "[t]he analysis of the deficiencies must begin with a review and understanding of the regulatory scheme" and then discussed the applicable regulations in his analysis. ALJ Decision at 38-41. Golden does not dispute any of the ALJ's statements of the law, and those statements are correct.

Section 483.20, as the ALJ stated, requires nursing facilities to do an interdisciplinary assessment of each resident on admission, and periodically thereafter (including when there is a significant change in the resident's condition); to develop a comprehensive care plan based on the assessment; and to review and revise the care plan after each assessment. ALJ Decision at 38. Section 483.25 addresses a nursing home's responsibilities regarding the areas of resident care detailed in sections (a) through (n) of the regulation. The opening language of section 483.25, provides 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." Section 483.25(h) provides that nursing homes "must ensure that . . . [t]he resident environment remains as free of accident hazards as possible" and that "[e]ach resident receives adequate supervision and assistance devices to prevent accidents." As Golden does not deny, the accident prevention addressed by this regulation includes prevention of falls. *See, e.g.*, *Buena Vista Care Ctr*. DAB No. 2498, at 9-14 (2013) (finding violations of section 483.25(h)(2) based on failure to adequately address fall risks for multiple residents). Section 483.30 applies the standard of care set out in section 483.25 to staffing: "The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care." To that end, section 483.30(a) "requires [nursing homes] to provide sufficient numbers of licensed nurses and other nursing personnel to provide nursing care 'to all residents in accordance with resident care plans.'" ALJ Decision at 42 (quoting the regulation).

Section 483.75, consistent with the standard of care set out in section 483.25, requires that a nursing home be administered "in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." *Id*. (quoting the regulation) (internal quotation marks omitted). Section 483.75(i) requires that the nursing facility "have a physician serv[ing] as a medical director who is responsible for implementing resident care policies and coordinating medical care in the facility." *Id*. Section 483.75(o) requires the facility to have a Quality Assurance Committee (QA) that, in addition to meeting other responsibilities, "[d]evelops and implements appropriate plans of action to correct identified quality deficiencies." 42 C.F.R. § 483.75(o)(2)(ii).

In applying these regulations, the ALJ followed settled Board precedent addressing the quality-of-care standard that underpins all of these regulatory requirements. This precedent includes *Woodstock Care Center*, DAB No. 1726 (2000), *aff'd*, *Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003), in which the Board stated 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 (in this case, supervision and devices to prevent accidents) designed to achieve those outcomes to the highest practicable degree." ALJ Decision at 40-41 (quoting DAB No. 1726, at 25) (internal quotation marks omitted). The Board held in *Woodstock* and subsequent cases that "[w]hether supervision is 'adequate' depends in part upon the ability of the resident to protect him or herself from harm." *Id.* at 41 (citing, *e.g.*, DAB No. 1726, at 29-30; and *Glenoaks Nursing Ctr*., DAB No. 2522, at 8 (2013)). The Board has repeatedly held that this regulation requires facilities "to take all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents." *Buena Vista Care Ctr.* at 12 (citations and internal quotation marks omitted).

The ALJ acknowledged that Golden had assessed the five residents and tried various interventions to address their falls but concluded that since those interventions were not successful in stemming the number of falls, the regulations required Golden to evaluate other interventions, including the adequacy of staffing on the ACU. ALJ Decision at 48-52.

> The question is whether Petitioner's staffing of the ACU was adequate to attain or maintain the highest practicable physical, mental, and psychosocial well-being of all residents on the ACU as determined by their assessments and plans of care. 42 C.F.R. § 483.30. There is no question that ACU residents had to be ambulatory[16] and many care plans called for the ACU residents to be permitted to ambulate at will. There is no question that ambulating demented residents, many with co-morbidities that affected their stability or safety awareness, were at risk for falling and at even greater risk for falling than non-ambulatory or residents with good safety awareness and physical stability. Given the facts, assessing the adequacy

[16] Being ambulatory was one of the conditions for admitting a resident to the ACU. *See* ALJ Decision at 9; *see also* CMS Ex. 28, at 1-7.

> of staff on the ACU to supervise the residents would certainly be necessary to determine whether inadequacy in number or skills of staff may have affected the rise in falls on the ACU. Once Petitioner identified that the rise in the number of falls could be attributed to five specific residents, the need to assess the adequacy of staffing, both in number and skills, was a necessary line of inquiry or assessment for the resident IDTs, management, and the QA committee.

Id. at 48. This conclusion is consistent with the regulations and Board precedent as discussed above.

We also reject Golden's argument that it "makes no operational sense" to consider adjusting staffing to address the falls. That argument is undercut by Golden's own evidence. As the ALJ discussed, that evidence showed that Golden's management did adjust staff work and activity schedules on the ACU in the summer of 2013 – before the period involving the significant increase in falls – as a way of meeting ACU residents' needs; Golden also evaluated that intervention as successful in August and September 2013. ALJ Decision at 49-50 (citing P. Ex. 17, at 3-10). The reason Golden gave for the summer staffing adjustments was that "staffing on the ACU had to be adjusted daily due to the need for increased supervision for some residents." *Id*. at 50 (citing P. Ex. 17, at 11-12). In contrast, Golden provided no evidence that its staff or management considered adjusting staffing in January, February or March 2014, despite the significant increase in the number of falls on the ACU during that period. As the ALJ said, "there is no indication that adjusting staffing levels on the ACU was even considered and rejected by the QA Committee as an appropriate intervention to address the increase in falls on that unit." ALJ Decision at 50.

Golden provided no explanation, much less evidence, as to why its management, staff, and the QA committee did not consider responding to the significant increase in falls with an intervention – adjusting staff – it had considered necessary, and implemented successfully, to provide more supervision to ACU residents when there were significantly fewer falls on the ACU.[17] If evaluating that intervention (and successfully implementing it) made operational sense in the summer of 2013, prior to the significant increase in falls, evaluating that intervention certainly would have made operational sense in December 2013 through March 2014 when that increase occurred. This is especially true since

[17] We note Golden does not argue that the reason it did not consider adjusting staffing levels in response to the significant increase in falls from December 2013 through March 2014 was because it had adjusted them in the earlier period and concluded that those adjustments were sufficient, without further adjustment, to provide the necessary care and supervision for the five residents who experienced the 43 falls. Nor does the record contain documentation of any such evaluation or conclusion.

many of the falls occurred while the residents were ambulating without assistance and some falls were not observed by staff, circumstances that should have triggered questions about the adequacy of supervision on the ACU during this period. *See* CMS Ex. 5, at 16-22, 23-26, 27-31, 44-48, 69-75 (R28); CMS Ex. 7, at 19-23, 24-28, 29-32, 45-49 (R45); CMS Ex. 8, at 1-6, 26-31 (R94); CMS Ex. 6, at 84, 104, 101-102, 18-2128-3132-3738-42 (R111); CMS Ex. 5, at 1-5, CMS Ex. 9, at 1-5, 41-43, 6-11, 44-46, 12-16, 27-35 (R112).

3. ***There is no basis for Golden's argument that it cannot be found noncompliant because CMS offered no evidence defining the connection between staffing and falls***.

As discussed above, Golden does not challenge the ALJ's statement of the law applicable to the multiple regulatory requirements found unmet in this case. Nor does Golden dispute the evidence that Golden itself, prior to the months in question, had found a relationship between staffing and the facility's ability to assure supervision adequate to meet the needs of ACU residents. Golden also concedes that it has "pointed out throughout this proceeding [that] there undoubtedly is *some* correlation between staffing and resident supervision, as there is between staffing and every aspect of resident care." RR at 32 (italics in original). Indeed, in the ALJ proceeding, Golden stated that it "does not disagree with the proposition that there is *some* relationship between staffing and *every* aspect of resident care, including protection against falls and other hazards" and that "too few staff may be unable to meet resident needs." ALJ Decision at 49 (quoting and citing Pet.'s Post-Hearing Reply at 13) (internal quotation marks omitted). Golden also acknowledged testimony by CMS's witnesses "that there must be some connection between staffing and falls." RR at 32-33. Moreover, Golden's DON, as the ALJ noted, "admitted on cross-examination that the level of staffing does need to be responsive to the needs of residents." ALJ Decision at 50 (citing Tr. Vol. 4 at 323-24).

Despite these concessions of a relationship between staffing and fall prevention, Golden argues it cannot be found noncompliant because CMS "offered no evidence at all of what that connection is, or, more specifically, whether some specific number or configuration of staff is necessary to prevent some or all falls (or, as a practical matter, how they would do so)." RR at 33. The suggestion that CMS was required to offer evidence specifically defining the connection or providing specific numbers for staffing to prevent falls misstates the issue. The ALJ did not find Golden noncompliant because it violated some specifically defined connection between staffing (or the number of staff needed) and falls but, rather, because Golden did not evaluate whether there was a potential connection between staffing and the increase in falls between December 2013 and March 2014 and take action consistent with such an evaluation.

Golden's argument amounts, in essence, to an impermissible attempt to shift its burden of persuasion to CMS. Once CMS had made its prima facie case of noncompliance, as the ALJ found it had, the burden shifted to Golden to show that it had assessed the circumstances surrounding the increase in falls and evaluated all reasonable potential interventions to adequately address that increase. Section 483.30 specifically addresses staffing as part of the overall quality-of-care requirement. This means that adjusting staff is a reasonable potential intervention that should be evaluated when addressing all resident needs identified in the quality-of-care requirements, including the need, addressed in section 483.25(h)(2), to receive supervision adequate to prevent accidents. Thus, it was Golden's duty, not CMS's, to evaluate whether there was a connection between the increase in falls on the ACU and its staffing levels on that unit and, if so, to identify what that connection was and implement the staffing adjustments needed to address it. By the testimony of its own witnesses Golden has admitted it did not do this, even though it had done such an evaluation to address the need for resident supervision in a prior period and had successfully implemented that intervention. Accordingly, Golden did not comply with its regulatory duties.

B. *The ALJ did not err in treating as instructive the Tennessee regulation addressing minimum staffing required for Alzheimer's units, a minimum not always met by Golden.*

Golden does not dispute that its ACU was subject to a Tennessee regulation governing Alzheimer's units that required, among other things, a minimum of 3.5 hours per day of direct care for each resident of the ACU, including 0.75 hours of licensed nursing care.[18] *See* ALJ Decision at 28-32, 35, 51. CMS presented evidence, a form filled out by Golden's Administrator, showing that direct care to each resident on Golden's ACU fell below the minimum daily 3.5 hours per resident on seven of 14 days of the period beginning March 18 and ending March 31, 2014. CMS Ex. 33. The ALJ Decision contains a chart summarizing the data from CMS Exhibit 33, and the chart, like the exhibit itself, confirms the shortfall of direct care staff on the ACU on the 14 days. *See*

[18] The ALJ cited Tenn. Comp. R. & Regs. 1200-08-06 (2000) as the codification of this regulation. It is important to note that "direct care" includes all care directly rendered to residents, not just nursing care; only 0.75 hours of the total 3.5 hours daily per resident needs to be nursing care. On page 45 of the initially issued ALJ decision, the word "nursing" appeared between "direct" and "care." The word "nursing" is crossed out in the amended ALJ Decision we are reviewing. As we noted in note 9, *supra*, the ALJ explained that he crossed out the word "nursing" in order to correct a "scrivener's error." It is clear from the ALJ's comprehensive discussion of the Tennessee regulation and the data related to that regulation, which the ALJ obtained from CMS Exhibit 33, that the ALJ understood that only 0.75 hours of the total 3.5 hours of direct care for each resident each day needed to be rendered by nurses and that Golden's suggestion of confusion is baseless.

ALJ Decision at 26-27. The ALJ noted that Golden did not dispute that its Administrator filled out the form in CMS Exhibit 33 after surveyors gave it to her as a blank form. *Id.* at 31. Nor did Golden dispute that the Administrator derived the data she entered on that form from Golden's payroll records. *Id.* Indeed, the Administrator testified that she had completed the form based on those records. *Id*. (citing Tr. Vol. 5 at 166, 176-91).

The ALJ properly noted that "it is not the responsibility of CMS to enforce the state regulation through the federal survey process" and that "the SOD does not specifically allege that Petitioner violated the Tennessee regulation by falling below the minimum 3.5 hours of direct care [per resident per day] required by the regulation." ALJ Decision at 32. The ALJ found, however, that –

> the data supports findings of fact that [Golden] fell below the minimum 3.5 hours of direct care [per resident per day] required by the Tennessee regulation for its ACU on March 18, 19, 20, 22, 23, 29, and 30, 2014. While the Tennessee regulation may not be subject to federal enforcement, the regulation certainly establishes a minimum standard of care for an ACU operated subject to the Tennessee regulations. Petitioner concedes this fact in post-hearing briefing.

Id. (citing Pet.'s Post-Hearing Reply at 13). The ALJ concluded that "falling below the minimum staffing specified in Tennessee, as Petitioner's evidence shows it did in March 2014, is good evidence of a deviation from the standard of practice in that state." *Id.* at 49.

In the argument section of its request for review, Golden does not challenge the ALJ's treatment of the Tennessee regulation.[19] However, in the "Introduction" section, Golden states that the ALJ "incorrectly asserted that [Golden] agreed that the Tennessee standard created some binding *federal* or professional 'standard of care' for this proceeding, which is not the case." RR at 5 (citing ALJ Decision at 32, 51) (italics in original). This is a mischaracterization of the ALJ's finding by which Golden suggests the ALJ based his conclusion that Golden did not comply with federal regulations on importing into those regulations the minimum staffing requirements of the Tennessee regulation. There is no basis for that suggestion. On the contrary, the ALJ stated, correctly, that the Tennessee regulation could not be federally enforced, a recognition that it did not set an enforceable federal standard of care. As we have discussed, the ALJ found the federal standard of care for the staffing requirements in section 483.30 and in that regulation's incorporation of the standard of care defined in section 483.25. The ALJ found Golden's failure to

[19] Golden's request for review numbers 36 pages, but the argument section of that document takes up less than four full pages. *See* RR at 32-36. The "Summary of Material Evidence" takes up most of the remaining pages.

provide the minimum direct care required by the Tennessee regulation instructive to his analysis, but did not rely on that regulation as the legal basis for his findings of noncompliance. The ALJ explained that he found the Tennessee regulation instructive because it –

> establishes a standard of practice in that state for specific minimum level of staffing for an ACU. Therefore, falling below the minimum staffing specified in Tennessee, as Petitioner's evidence shows it did in March 2014, is good evidence of a deviation from the standard of practice in that state.

ALJ Decision at 49.

There was no error in the ALJ's considering the Tennessee regulation in that manner. Indeed, Golden's Reply stated as much: "Petitioner does not disagree with the proposition that there is *some* relationship between staffing and every aspect of resident care, including protection against falls and other hazards . . . That is why, for instance, Tennessee provides that ACUs must have a certain level of nursing and other staff (a requirement perhaps not binding upon CMS, **but certainly instructive for this Court**)." Pet.'s Post-Hearing Reply at 13 (emphasis added; italics in original).

Golden also asserts, in its "Summary of Material Evidence," that the ALJ "seriously *mis*quoted Petitioner's witnesses and evidence regarding the Center's staffing data," and that the DON "did *not* testify that she planned for a 'total of 3.16 [hours] for *total direct care*' on the ACU, as the ALJ quoted her; she actually testified that this figure was 'hands on nursing' hours only (that is, only licensed nurses and CNAs assigned to the ACU)." RR at 29 (citing Tr. Vol. 4 at 277) (emphasis by Golden). We first note that the ALJ did not quote the witness, as Golden states, but, rather, paraphrased her testimony. It is true that when Golden's attorney asked the DON how many hours of "hands on nurses" she budgeted for, she replied, "Oh total is 3.16 all hands on[,]" rather than using the language "total direct care." Tr. Vol. 4 at 276-277. However, in response to the attorney's immediately prior question, she noted that "[h]ands on nurses [the language used by the attorney in his question] is only 0.75 . . . ." *Id*. at 276. The transcript shows that the DON was referring to the Tennessee requirement, which is that, of the total 3.5 hours per resident per day required minimum**,** only 0.75 hours needs to be provided by nurses. Thus, although the DON did not use the phrase "total direct care" used by the ALJ in his paraphrase, her testimony "Oh, total is 3.16 all hands on[]" is ambiguous, and the ALJ could reasonably have understood that testimony to mean all direct care, not just direct care rendered by nurses.

We need not resolve any ambiguity in this DON testimony because the testimony is immaterial whichever way it is read. The ALJ found that Golden did not provide the minimum 3.5 hours per day of direct care for each resident required by the Tennessee regulation. Even assuming the DON's "3.16 all hands on" response meant only nursing care, the DON did not testify that she budgeted for enough other direct care staff to bridge the difference between the 3.16 hours of nursing care for which she budgeted and the required 3.5 hours per resident per day for all direct care.[20] Moreover, the ALJ's finding that Golden did not meet the Tennessee minimum was based primarily on CMS Exhibit 33 rather than the DON's testimony about how she budgeted for nurses. *Compare* ALJ Decision at 28-32, 45, discussing CMS Exhibit 33) *with* ALJ Decision at 35 (discussing the DON's testimony).

In addition to wrongly claiming that the ALJ misquoted the DON's testimony, Golden misrepresents the ALJ's evidentiary findings on the staffing issue. Golden states (again in its "Summary of Material Evidence): "According to the ALJ, [the] Administrator . . . testified that at the beginning of the survey she filled out and presented to the surveyors a form that listed all of the hours for *nurses* assigned to the ACU on certain days . . . ." RR at 28 (citing Tr. Vol. 5 at 177-79; and CMS Ex. 32) (emphasis by Golden). As a threshold matter, Golden's citation to CMS Exhibit 32 is error, since, as discussed above, CMS Exhibit 33, not CMS Exhibit 32, contains the form the administrator completed and testified about and that the ALJ discussed.[21] Golden also misrepresents the ALJ's statements about the Administrator's testimony on the data in CMS Exhibit 33. Golden knows that the decision before us is the ALJ's *amended* decision (dated August 9, 2017). Yet, Golden cites the word ("nursing") that the ALJ struck on page 45 of the amended decision. Moreover, even in his decision as initially issued (with the exception of the now corrected scrivener's error on page 45), the ALJ referred to all "direct care" (not just direct care provided by nurses) when discussing the data in CMS Exhibit 33 and the

[20] The DON testified that other staff, such as housekeepers, therapists and dietary staff, also spent time on the ACU. *See* ALJ Decision at 34-35; Tr. Vol. 4 at 273-76. She also testified that she took this into consideration when deciding how many nurses needed to be on the ACU. Tr. Vol. 4 at 276. However, the DON did not testify about budgeting for those other staff members or that their direct care hours per day per resident made up the difference between 3.16 and the required 3.5 hours.

[21] Golden, in a different context, refers again to CMS Exhibit 32 but admits that it is an exhibit that "no CMS witness ever identified." RR at 29. Nonetheless, Golden proceeds to speculate that the single page in this exhibit "appears to be a facility-created document" that "purports to set forth 'staffing ratios,' a term that customarily refers to nurse staffing only . . . ." RR at 29. Golden's apparent reason for citing this unidentified exhibit and speculating about its meaning is to try to show that nursing staff ratios for part of the period covered by CMS Exhibit 33 met Tennessee requirements, but that is not a relevant issue since the ALJ did not find or base his decision on a shortage of **nursing** staff. Although Golden accuses the ALJ of "confus[ing] the discussion" of the staffing data, RR at 28 n.5, it is Golden that confuses the issues by not correctly citing exhibits, misrepresenting the ALJ findings, and engaging in speculation about the source and meaning of irrelevant exhibits.

Administrator's testimony. The ALJ Decision reflects a clear understanding by the ALJ that the data on staff hours entered by the Administrator in CMS Exhibit 33 was not limited to the hours of direct care provided by nursing staff. *See* ALJ Decision at 36-37 ("[The Administrator] testified that others are present in the ACU in addition to the licensed nurse and CNAs, including a restorative CNA [certified nurse assistant] and supervisor, the MDS coordinator, the director of clinical education, the [DON], hospice nurse and CNAs, the CNA who was the supply clerk, dietary supervisor and dietary staff, the activities director, the marketing and admissions director, the ACU director and others. She testified that all staff members provided assistance to residents."); *see also* Tr. Vol. 5 at 110-19, 176-79 (Administrator's testimony about staff included in "Other" category on the form in CMS Exhibit 33). The ALJ's stated understanding is consistent with CMS Exhibit 33 itself, which shows that the Administrator listed hours for "Social Service," "Activities," "PT/PT/ST" therapists, "Volunteers," and "Other."

Golden suggests that the data entered on the form in CMS Exhibit 33 understates the direct care hours provided by staff other than the nurses. Golden states that the Administrator testified that her estimate for the 14 hours listed under "Other" "did *not* include services provided by any therapists, and that [the Administrator] 'did not count all the hours that were spent right there' by others, including administrative nurses and managers, dietary, housekeeping, nurse practitioners, hospice, and other staff." RR at 30 (citing and quoting from Tr. Vol. 5 at 178) (emphasis by Golden). This is a misleading description of the Administrator's testimony. The transcript page cited by Golden does show testimony by the Administrator that she did not include therapist services in the 14 hours in the "Other" category. However, the form she filled out contains a separate category for therapists in which the Administrator listed 3.5 hours total for all but two of the seven dates the facility did not meet the Tennessee minimum staffing requirement. *See* CMS Ex. 33. Thus, contrary to Golden's suggestion, its Administrator did count the therapist hours when calculating the number of hours of direct care provided to ACU residents.

As for Golden's citation of the Administrator's testimony that she "did not count all the hours that were spent right there" (which is actually on page 179 of Volume 5 of the Transcript, not page 177), in context, we regard this testimony by the Administrator as meaning that she estimated the 14 hours based on staffing records and that she could not necessarily identify the specific non-nursing staff to whom she attributed those hours on a given day or what part of their time was actually spent providing care in the ACU. Contrary to Golden's suggestion, we do not read the cited testimony as undercutting the completeness or accuracy of the total direct care hours the Administrator listed on the form. The data on the form included licensed nursing staff (Licensed Practical Nurses and CNAs) and five different categories of non-nursing staff who also gave direct care each day. Only one of those five categories was the "Other" category containing the 14

hours that Golden cites as an estimate. Thus, even accepting Golden's assertion that the 14 hours listed in the "Other" category was an estimate, albeit an estimate based on staffing records, that fact is not material because it does not undercut the ALJ's finding that Golden's total direct care hours for the days in question did not meet the Tennessee regulation's minimum of 3.5 hours of direct care per ACU resident on those days. We also note that Golden did not put into evidence any staffing data to rebut the staffing data in CMS Exhibit 33, data which Golden's own Administrator provided to the surveyors.[22]

In summary, we find no error in the ALJ's consideration of Golden's failure to meet the minimum ACU staffing requirements under the Tennessee regulation as a relevant fact relating to his legal determination that Golden did not comply with federal regulations that required Golden to evaluate whether adjusting staffing on the ACU was an appropriate intervention in light of the significant increase in falls on that unit. We also find the ALJ's treatment of Golden's failure to meet the Tennessee minimum staffing level as instructive is consistent with the surveyors' personal observations, which the ALJ credited, that the staffing level in the ACU was such that staff on duty were having difficulty delivering the level of care and services residents required during the period of the survey. *See* ALJ Decision at 45.

C. *Golden cites no basis, and we find none, for its suggestion that the ALJ erred by not specifically addressing how increasing staffing levels on the ACU would have helped prevent the 43 falls sustained by the five residents .*

Golden suggests that the ALJ erred by not specifically addressing how increasing staffing levels on the ACU would have prevented the 43 falls sustained by the five residents. Golden states that "the ALJ acknowledged that the Center's QA Committee determined that the increase in falls related to the circumstances of five specific residents" and "declined to critique" the IDT team's analysis of the falls

[22] Golden asserts that it could have compiled and provided rebuttal data had the ALJ notified the parties that he "considered calculation of compliance with the State ACU staffing requirement to be material to his analysis . . . ." Reply at 7. At the outset, we note an inaccuracy in this statement. As discussed above, while the ALJ considered Petitioner's noncompliance with the Tennessee regulation instructive to his conclusion that Petitioner failed to comply with the federal regulations, he did not find it necessary to that conclusion. Moreover, the record reflects Petitioner's understanding that its compliance or noncompliance with the Tennessee requirement might be an issue in the ALJ proceeding. Indeed, Petitioner acknowledged in its Pre-Hearing Brief that it "ha[d] offered a copy of the pertinent Tennessee ACU staffing requirement as its Exhibit 19." Pet.'s Pre-Hearing Br. at 42. Petitioner also acknowledged, in the context of discussing CMS's allegation of noncompliance with 42 C.F.R. § 483.30(a), that the surveyors had testified during a deposition in a parallel state proceeding that "they had reviewed the Center's staffing data – hundreds of pages of which CMS has . . . produced as CMS Ex. 31-36 – and concluded that the level of ACU staffing violated unspecified Tennessee staffing requirements." *Id.* Finally, Petitioner asserted in the same Pre-Hearing Brief that it would be able to show through the exhibits proffered (including CMS Exhibit 33 and exhibits of its own) as well as through witness testimony that it met the Tennessee requirement, an indication that Petitioner believed the existing record on this issue to be adequate for its case. *Id.* at 42-43.

sustained by those five residents and the interventions adopted in response, "except that it did not address staffing of the ACU as a whole." RR at 34. Golden then states, "But it is not at all clear – and the ALJ does not say – why adding staff would have helped prevent those [five] residents from falling, much less how or why the QA Committee should have reached that conclusion, or under what standard." *Id.*

We find no basis for this suggestion of error. At the outset, Golden's suggestion is based on the faulty premise that the ALJ based his noncompliance determinations on Golden's failure to **increase** staffing on the ACU when, as we have discussed, it was based, instead, on Golden's failure to **consider** adjusting staffing levels. In addition to relying on a flawed characterization of the ALJ's decision, Golden cites no authority for its proposition that the ALJ was required to focus on the five residents in isolation rather than on the facility's practices as they affected all ACU residents. We know of no such authority. The regulations impose on a long-term care facility like Golden the burden of showing that it considered all reasonable means of preventing accidents. *Cf. Woodstock Care Ctr. v. Thompson*, 363 F.3d at 590 (facility must take "all reasonable precautions against residents' accidents"). The regulations focus on what the facility has done to prevent accidents, not the accidents themselves. Indeed, the Board has rejected the notion that the occurrence of an accident is necessarily a basis for finding noncompliance under section 483.25(h) and the notion that the occurrence of an accident is a prerequisite to finding noncompliance under that regulation. *Glenoaks* at 8.

The significant increase in falls that occurred on Golden's ACU identified a dangerous situation for residents involving falls, and Golden needed to evaluate that situation and implement a response that would assure adequate supervision to prevent falls. Golden's noncompliance lies in its failure to consider all reasonable responses to try to prevent falls, not on the falls themselves. That duty extended to all of Golden's ACU residents, not just to the five residents who sustained the falls that apparently accounted for most of the significant increase. Putting it another way, all residents of Golden's ACU, not just the five residents whose falls seem to have accounted for most of the increase, were at risk of accidents, including falls due to Golden's failure to consider the adequacy of staffing on the unit.

Golden notes that section 483.75(o)(2)(i) requires a QA Committee "to meet only every three months to review such trends," and states that its QA Committee met monthly. RR at 35. Golden then argues, "Thus, the regulation contemplates that such analysis [of facility trends] by definition will be retrospective, and the Committee obviously cannot increase staffing retroactively, even if that intervention, even theoretically, might have prevented some of the falls that already had occurred." *Id*. We disagree with Golden's characterization of what

the regulation "contemplates." Section 483.75(o)(2)(i)-(ii) states that the facility must assure that the QA Committee meets "at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary . . . and . . . [d]evelops and implements appropriate plans of action to correct identified quality deficiencies." Thus, what the regulation "contemplates" is that the QA Committee's analysis of past adverse trends – such as the significant increase in falls here – will result in the facility's developing and implementing appropriate action plans to prevent such trends going forward. In other words, while a QA Committee may not be able to prevent past falls, the regulation contemplates that the Committee will be forward-looking in that it will learn from the past and try to prevent such trends in the future.

Moreover, the responsibility to prevent falls did not lie solely with the QA Committee, no matter how frequently it met. The other regulations with which Golden did not comply imposed on facility staff and administration, including Golden's IDT, a duty to assess and develop appropriate responses to the falls as they happened and to respond to the significant upward trend in falls. As discussed, this duty included a duty to consider whether staffing levels on the ACU needed to be altered. The overarching problem here is the admitted failure by Golden staff, administration, the IDT and the QA committee to even consider this intervention during the time period in question.

In essence, it appears Golden is attempting to shift to five of its residents the blame for its own failure to take all reasonable steps to prevent accidents that were foreseeable in light of the undisputed vulnerability of its ACU residents generally, not just these five residents. We must and do reject that attempt as untenable under the regulations. If anything, attributing the significant increase in falls to the five residents compounds Golden's noncompliance by underscoring Golden's awareness of the need to consider adjusting staffing on the ACU while those residents resided there.

Conclusion

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

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Sheila Ann Hegy
Presiding Board Member