Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: March 20, 2002
Westgate Healthcare Center,	
Petitioner,	Civil Remedies CR816 App. Div. Docket No. A-02-6
- v. -	Decision No. 1821
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Westgate Healthcare Center (Westgate) appealed a September 10, 2001 decision by Administrative Law Judge (ALJ) Steven T. Kessel sustaining the determination by the Centers for Medicare and Medicaid Services (CMS) to impose a civil money penalty (CMP) of $3,050 a day for each day of the period that began on June 2, 1999, and ran through September 6, 1999, for a total CMP of $295,850.[1] See Westgate Healthcare Center, DAB CR816 (2001) (ALJ Decision). CMS had imposed the CMP based on surveys conducted by the Michigan Department of Consumer and Industry Services, the State survey agency for Michigan, which found Westgate not in substantial compliance with numerous Medicare requirements, with

[1] CMS was previously named the Health Care Financing Administration (HCFA). See 66 Fed. Reg. 35,437 (July 5, 2001). We use "CMS" in this decision unless we are quoting from documents that refer to HCFA.

some deficiencies constituting immediate jeopardy to resident health and safety.

Below, we discuss all of the arguments raised by Westgate on appeal. We conclude generally that-

- compliance with the federal staffing requirement at 42 C.F.R. § 483.30(a)(1) is determined by whether the numbers of staff are sufficient to meet residents' needs, as determined by resident care plans and, therefore, Westgate's compliance with a minimum resident to staff ratio in state law is irrelevant;
- the ALJ's finding that Westgate failed to comply substantially with 42 C.F.R. § 483.30(a)(1) because it did not have sufficient numbers of nursing staff on duty in its dementia unit during the night shift to meet resident needs is supported by substantial evidence on the whole record;
- the ALJ correctly concluded that the CMS determination that this failure constituted immediate jeopardy was not clearly erroneous; and
- the ALJ's finding that the immediate jeopardy situation existed at least from June 2 through September 6, 1999, is supported by substantial evidence on the whole record.

Accordingly, we sustain the imposition of a CMP in the amount of $295,850 on Westgate.

Statutory and Regulatory Background

Section 1819 of the Social Security Act (Act), as amended by the Omnibus Budget and Reconciliation Act of 1987 (OBRA 87), requires that a skilled nursing facility provide services and activities under a plan of care, based on a periodic assessment of residents' needs. Section 1819(b)(2). The section further provides in general that "[t]o the extent needed to fulfill all plans of care . . . , a skilled nursing facility must provide" the following services, among others:

> Nursing services . . . to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident; . . . .

Section 1819(b)(4)(A)(i). The services must meet professional standards of quality and "must be provided by qualified persons in accordance with each resident's written plan of care." Section 1819(b)(4)(A) and (B). Minimum hours of licensed nursing service and the services of a registered professional nurse are specified in the statute, but may be waived in certain circumstances. Section 1819(b)(4)(C). Required training for nurse aides is also specified in the Act. Section 1819(b)(5). In addition, a facility must be licensed under applicable State and local law, must comply with "Federal, State, and local laws and regulations . . . and with accepted professional standards and principles which apply to professionals providing services in such a facility," and "must meet such other requirements relating to the health, safety, and well-being of residents or relating to the physical facilities thereof as the Secretary may find necessary." Section 1819(d)(2)(3) and (4).

The regulatory requirements for long-term care facilities are set forth at 42 C.F.R. Part 483. The requirement at issue in this appeal concerns nursing services. Section 483.30 provides generally that -

> [t]he 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.

More specifically, section 483.30(a)(1) provides:

> The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
> (i) Except when waived under paragraph (c) of this section, licensed nurses; and
> (ii) Other nursing personnel.

For purposes of surveys of skilled nursing facilities like Westgate, the regulations define "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."

42 C.F.R. § 488.301. "Immediate jeopardy" is defined as "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." Id.

For deficiencies that constitute immediate jeopardy, a CMP in the range of $3,050 - $10,000 per day may be imposed. 42 C.F.R. § 488.438(a)(1). The regulation 42 C.F.R. § 488.430(b)(2) provides that -

> [CMS] or the State may impose a civil money penalty for the number of days of past noncompliance since the last standard survey, including the number of days of immediate jeopardy.

Standard of Review

Before the ALJ, the sanctioned facility must prove substantial compliance by the preponderance of the evidence, once CMS has established a prima facie case that the facility was not in substantial compliance with relevant statutory or regulatory provisions. See Cross Creek Health Care Center, DAB No. 1665 (1998), applying Hillman Rehabilitation Center, DAB No. 1611 (1997) (Hillman), aff'd, Hillman Rehabilitation Center v. HHS, No. 98-3789(GEB), at 25 (D.N.J. May 13, 1999).

Our standard of review on a disputed conclusion of law is whether the ALJ Decision is erroneous. See, e.g., Lake Cook Terrace Nursing Center, DAB No. 1745 (2000). Our standard of review on a disputed finding of fact is whether the ALJ Decision is supported by substantial evidence on the record as a whole. Id. The role of appellate review of factual findings is not to substitute our evaluation of the evidence for that of the ALJ, but only to determine whether the factual findings made by the ALJ are supported by substantial evidence in the record as a whole. See Lake Cook Terrace Center, at 6; Beverly Health and Rehabilitation - Spring Hill, DAB No. 1696, at 40 (1999).

Factual Background

The ALJ Decision contains a full discussion of the undisputed background facts, which we summarize here. ALJ Decision at 3 - 7. Westgate is a long-term care provider located in St. Louis,

Michigan, that participates in both the Medicare and Medicaid programs. In 1999 Westgate was surveyed on four separate occasions by the State survey agency. A standard survey completed on May 28, 1999 found Westgate not in substantial compliance with several requirements, cited at a level constituting no actual harm to the residents but with the potential for more than minimal harm that was not immediate jeopardy. CMS Ex. 2. A revisit survey completed on August 16, 1999 found Westgate not in substantial compliance with two requirements involving staff treatment of residents (Tag F 224) and adequacy of nurse staffing (Tag F 353) at a level constituting immediate jeopardy to resident health or safety, along with deficiencies in other requirements at a lower level of scope and severity. CMS Ex. 4. A revisit survey completed on September 1, 1999 found Westgate still deficient in the two requirements that resulted in findings of immediate jeopardy in the August survey. CMS Ex. 5. Another revisit survey completed on September 9, 1999 found no deficiencies at the immediate jeopardy level. CMS Ex. 6.

By letter dated August 26, 1999, CMS notified Westgate of the following remedies as a result of the August revisit survey: the termination of Westgate's Medicare/Medicaid provider agreement effective September 11, 1999, if immediate jeopardy was not abated by that date; and the imposition of a CMP of $3,050 per day effective June 2, 1999 for the immediate jeopardy and which continued to accrue. CMS Ex. 1, at 2. CMS rescinded the proposed termination after the September 9, 1999 resurvey. Id. at 6. On August 25, 2000, CMS issued a revised notice of the imposition of remedies, imposing a CMP of $3,050 per day from June 2, 1999 through September 6, 1999 (97 days) and of $50 per day from September 7, 1999 through September 9, 1999 (3 days), for a total CMP of $296,000. Id. at 16.

While various deficiencies found in these surveys were at issue before the ALJ, the hearing before the ALJ primarily focused on the August survey finding that Westgate was failing to comply substantially with a requirement at a level of noncompliance that placed Westgate's residents in immediate jeopardy. This deficiency, listed at Tag F 353 on the Form 2567 Statement of Deficiencies, found Westgate out of substantial compliance with the requirement for nursing services set forth at 42 C.F.R. § 483.30(a)(1)(ii). CMS Ex. 4.

The August survey found that Westgate had an inadequate number of nursing personnel for the night shift of its locked specialized dementia unit for residents who suffer from Alzheimer's disease or other dementia.

At the time of the August survey, Westgate staffed its dementia unit at night with one certified nursing assistant (CNA); during the day and afternoon shifts two CNAs staffed the unit. At this time the dementia ward had a population of 10 to 11 residents. The August survey examined in detail the experiences of five residents of the dementia ward, identified as Residents 3, 4, 21, 22, and 25. Four of these residents, as a result of their dementia, had the propensity to wander the ward at night. During their night wandering, some of these residents experienced falls and other accidents resulting in injuries to themselves, and other residents engaged in conduct that resulted in agitated confrontations with other residents. Resident 3 had a propensity for falling, and fell on August 1, 1999, at 1:10 a.m., when he attempted to sit on a bed that moved out from underneath him. Resident 21 also had a propensity for falling and wandering at night; on June 2, 1999, at 2:15 a.m., he was found sitting on the sidewalk in the dementia unit's outdoor courtyard, with scrapes to his right elbow, ankle, hand, and finger. Resident 4 had a tendency to wander into other residents' room and lie in their beds, leading to confrontations with the residents. Resident 22 was found on her floor on June 13, 1999, at 6:30 a.m., with a fracture of her right hip. Resident 25 manifested compulsive behavior that included repeatedly rubbing other residents, often causing them to become agitated which in turn increased her agitation.

The ALJ Decision

In his decision, the ALJ set out a succinct and cogent analysis of the facts as he found them and his reasons for the conclusions he reached and why he rejected the key arguments made by Westgate. We here summarize key points from the decision for purposes of helping the reader to understand Westgate's arguments and our analysis.

The ALJ found that Westgate failed to comply substantially with the staffing requirement at 42 C.F.R. § 483.30(a)(1)(ii) because Westgate did not have an adequate number of nursing personnel on

hand during the night shift in its dementia unit. The ALJ found that from June 2, 1999, through September 6, 1999, Westgate had only one nursing assistant working the night shift in the dementia unit when at least two nursing assistants were needed given the physical layout of the unit, the number of residents, and the residents' mental condition and behavioral habits. Specifically, the ALJ noted that the propensity of some residents to wander at night, in conjunction with how the dementia unit was laid out, with an outdoor courtyard area, rendered it impossible for the one nursing personnel on duty at night to adequately monitor all the residents. The ALJ noted incidents involving five of the residents, in which the residents either experienced injuries as a result of falls or engaged in abusive behavior with other residents. The ALJ found that the conduct of these residents created a high potential for harm both to themselves and to other residents. The ALJ found the testimony of two experts offered by Westgate on nurse staffing in a dementia unit to be generally credible, but unpersuasive on the issue of the adequacy of staffing at Westgate's dementia unit during the night shift. The ALJ also discounted Westgate's reliance on Michigan State law, concluding that the State law governed staffing ratios that must be maintained at an entire facility and did not address specialized units in a facility such as a dementia unit where a smaller ratio of residents to staff might be needed, and that the State law also required Westgate to provide adequate coverage of the residents. Thus, the ALJ said, his determination concerning Westgate's staffing level was "consistent with the requirements of Michigan State law and with the federal requirement." ALJ Decision at 10.

The ALJ stated that, under 42 C.F.R. § 498.60(c)(2), he was required to uphold CMS's determination that the deficiency in the nurse staffing requirement set forth at 42 C.F.R. § 483.30(a)(1)(ii) constituted immediate jeopardy unless that determination was clearly erroneous. The ALJ found that the lack of adequate staffing during the night shift in the dementia unit created the potential for the occurrence of serious injuries to the residents of the unit, with such likelihood for harm comprising immediate jeopardy within the meaning of 42 C.F.R. § 488.301. The ALJ accordingly sustained the imposition of a CMP of $3,050 per day for the period which began on June 2, 1999, and ran through September 6, 1999.

The issues on appeal

On appeal, Westgate challenged each of the following numbered findings of fact and conclusions of law (FFCLs)in the ALJ Decision:

> 1. Beginning June 2, 1999 Petitioner failed to comply substantially with 42 C.F.R. § 483.30(a)(1)(ii).
>
> 2. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.30(a)(1)(ii) from June 2, 1999 until September 7, 1999, when it put a second nursing assistant on duty at night in its dementia unit.
>
> 3. Petitioner did not prove to be clearly erroneous CMS's determination that Petitioner's failure to comply with the requirements of 42 C.F.R. § 483.30(a)(1)(ii) comprised immediate jeopardy for Petitioner's residents.
>
> 4. It is not necessary that I make Findings concerning the presence of or levels of other deficiencies that are alleged to have been present at Petitioner's facility during the period that ran from June 2, 1999, through September 6, 1999.
>
> 5. I sustain civil money penalties of $3,050 per day for each day of the period which began on June 2, 1999, and which ran through September 6, 1999.[2]

In challenging these FFCLs, Westgate raised numerous arguments related to findings and conclusions made by the ALJ but not identified by number. There was a considerable degree of overlap in the assertions and evidence on which Westgate relied for its arguments, and a certain lack of clarity in whether Westgate was challenging the ALJ's legal conclusions or factual findings. In general, Westgate's arguments raised the following issues:

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[2] The ALJ also found that CMS failed to establish a prima facie case to support the imposition of a CMP after September 6, 1999, and accordingly reversed the $50 CMP for the period September 7 through September, 9, 1999. FFCL 6. CMS did not appeal this finding.

- Whether the ALJ applied the proper legal standard in determining that Westgate failed to comply substantially with the requirements of 42 C.F.R. § 483.30(a)(1)(ii);
- Whether the ALJ's factual findings regarding the residents' needs and the staff available were based on substantial evidence in the record or ignored evidence and testimony presented by Westgate;
- Whether the ALJ erred in concluding that the CMS determination that the noncompliance was at the immediate jeopardy level was not clearly erroneous; and
- Whether the ALJ erred in concluding the time period to which the CMP applied.

We discuss each of these issues below, setting out Westgate's more specific arguments as we address them.

Westgate's challenge to FFCL 4 was linked to its challenge to the ALJ's findings and conclusions that the nurse staffing deficiency provided a basis for the imposition of a CMP.[3] Thus, we do not discuss this challenge separately.

Analysis

I. Whether the ALJ applied the proper legal standard in concluding that Westgate failed to comply substantially with the requirement at 42 C.F.R. § 483.30(a)(1)(ii).

Westgate argued that neither the ALJ nor CMS had pointed to any specific staffing standard that Westgate violated. Reply Br. at

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[3] In his decision, the ALJ found that he did not need to address other deficiencies that were found during the period that began on June 2, 1999 and ended September 6, 1999, including a second alleged immediate jeopardy deficiency cited at Tag F 224. This deficiency involved Westgate's alleged failure to implement written policies and procedures to prevent the neglect and abuse of residents as required by 42 C.F.R. § 483.13(c)(1). The ALJ stated that the presence or absence of these other deficiencies in addition to the single immediate jeopardy level deficiency involving nurse staffing would not affect the amount of the CMP imposed, $3,050 per day, which is the minimum for an immediate jeopardy level deficiency. ALJ Decision at 13.

9. According to Westgate, it looked to the "objective" standard in Michigan State law as guidance. Specifically, Westgate argued that its staffing of the dementia unit met or exceeded the standard for resident/nurse staffing ratios under Michigan State law, and, therefore, the ALJ's conclusion that the dementia unit was understaffed at night was incorrect. Id. Westgate further argued that the way the ALJ Decision treated the state standard was "inconsistent with previous rulings on the very same issues by ALJ Kessel" and "provides no standard to which Westgate or any other facility can turn for guidance on its staffing pattern." Reply Br. at 8. Specifically, Westgate relied on the ALJ decisions in Carehouse Convalescent Hospital, CR729 (2001), and Life Care Center of Hendersonville, CR542 (1998). In the former, the ALJ had stated that "in the absence of an explicit standard in the regulation, it is reasonable to assume that facilities which comply with applicable state standards are complying with the staffing requirements of the regulations." CR729, at 23. In the latter, the ALJ had stated that petitioner's evidence that it complied with applicable state requirements was "persuasive evidence that Petitioner's staffing levels were adequate in the absence of proof that there exists any federal staffing standard that would supercede state requirements." CR542, at 46.

Westgate also argued that the ALJ erred by relying on evidence about resident "incidents" as relevant to the issue of whether Westgate had sufficient numbers of staff, where those incidents were normal for the type of residents in the dementia unit, where Westgate had a lower than average rate of incidents, and where no evidence was presented that additional staffing of the dementia unit at night would have prevented those incidents. Westgate maintained that in its supervision of these residents it was trying to maintain "the delicate balance between allowing a resident to maintain their independence while protecting them from harm." Westgate Br. at 6. Westgate asserted that it was not possible to prevent all injuries, given the independence afforded the residents. Westgate asserted that falls and other incidents occur even with a staff member present, and that bumps, bruises, and scrapes are normal in a dementia unit where the residents are not restrained. Westgate asserted that the Board's decision in Carehouse Convalescent Hospital, DAB No. 1799 (2001), required a nexus between the incidents relied on and the numbers of staff and that the ALJ Decision was erroneous because that nexus was not established here. According to Westgate, it was

merely speculation on the part of CMS and the ALJ that the addition of another staff member to the unit's night shift would have prevented the incidents. Westgate further asserted that the CMS position in this case would require one-on-one supervision in the dementia unit, an impossible standard to meet.

Finally, Westgate maintained that the quality and training of its staff was more important than the actual number of staff on duty in the dementia unit, pointing out that the nurse aides in the dementia unit had specialized training. Westgate suggested that the ALJ had erred by focusing solely on the numbers of staff.

We address each of these arguments in this section, as they pertain to the applicable legal standard.

A. The ALJ's conclusion is consistent with the federal regulation, which establishes a staffing requirement that is different from a state standard that relies on a resident to staff ratio and which requires a facility to evaluate the numbers of staff needed by looking at the resident care plans.

As explained above, to participate in Medicare, a long-term care facility must meet both federal standards and state licensing standards. Unlike some state standards, the federal standard at 42 C.F.R. § 483.30(a) ties the sufficiency of staff not to any particular resident to staff ratio but to residents' needs. The preamble to the long-term care facility regulations issued in 1989 explained that the opening statement for section 483.30 was from "the OBRA 87 requirement that a facility have sufficient nursing staff to provide nursing services 'to attain or maintain the highest practicable physical, mental, and psychosocial well-being of such resident.'" 54 Fed. Reg. 5316, 5337 (Feb. 2, 1989). Most of the discussion focused on whether the regulations should require 24-hour coverage by registered nurses (RNs) or merely by licensed personnel. However, in response to comments that "actual, hands-on care is furnished primarily by nurse aides rather than by RNs or LPNs" and that the regulations should "specify aide-patient ratios rather than nurse-patient ratios," the preamble explained that -

> we are amending the regulations to clarify that the requirement in § 483.30(a) for sufficient staff refers to licensed nurses and other nursing personnel, which

> includes nurse aides. We prefer not to rely on nurse-resident ratios because the number and skills of nursing staff depend on the severity of the residents' condition. The severity or case-mix of the resident population is a much better determinant of sufficiency of nursing staff.

Id. Later amendments to the regulations did not change this approach to staffing.

Meeting a state standard that relies on ratios of residents to staff thus does not necessarily establish that the federal standard is met. The federal standard uses a different measure -- the needs of the particular residents who are in the facility. Thus, the relevancy of a state standard in determining whether the federal requirement is met depends on the nature of the state standard relative to the federal standard. For example, a state standard might be relevant evidence of the sufficiency of the staff to meet resident needs if it is based on a particular case-mix and the facility can show that it in fact had that case-mix. On the other hand, failure to meet a state standard might be relevant to show insufficiency if it establishes a minimum, based on the lowest level of care required for any case-mix, and CMS shows that the case-mix at the facility required more than the minimum. Evaluating the effect of the state standard in any particular case thus depends on the nature and basis for the standard and how that relates to the federal standard and the needs of the residents in the facility.

Contrary to what Westgate argued, the resident to staff ratio in state law here was not the only guidance that Westgate had about how to staff its dementia unit. From the federal regulation and its preamble, Westgate had notice of its obligation to staff the unit according to the needs of the residents. Yet, Westgate itself implied that it simply relied on the resident to staff ratio in state law. Westgate did not assert that it set the staffing level based on an evaluation of the residents' needs, as shown in the resident assessments and plans of care.

Thus, the ALJ's conclusion is consistent with the federal regulation since he analyzed the residents' needs, citing the residents' care plans and other relevant evidence in support of his findings.

B. The ALJ did not err in concluding that Westgate was not complying with Michigan State law.

Michigan law provides that "the ratio of patients to nursing care personnel during a nighttime shift shall not exceed 15 patients to 1 nursing care personnel and there shall be sufficient nursing care personnel available on duty to assure coverage for patients at all times during the shift." MCLA § 33321720(a)(2). Westgate asserted that during the period at issue the resident census of its dementia unit ranged from 10 to 11 residents and that its one staff member during the night therefore exceeded the Michigan state staffing requirement by 30 percent, even without considering an additional staff member also assigned to perform bed checks in the unit every two hours.

Westgate's reliance on the resident to staff ratio set forth in Michigan State law overlooks the fact that the Michigan law actually establishes a dual standard, the 15/1 resident to staff ratio relied on by Westgate, plus a care standard that "there shall be sufficient nursing care personnel available on duty to assure coverage for patients at all times during the shift." The ALJ reasonably interpreted this language "as requiring a facility to require a resident/staff ratio of less than 15/1 and as low as may be dictated by the needs of the residents if that is what is required to provide adequate coverage to those residents." ALJ Decision at 11. The ALJ also noted that the Michigan State law referred to the staffing ratio that must be maintained at an entire facility, not the ratio that must be maintained in a discrete and specialized unit within that facility. He concluded with respect to Westgate's dementia unit (with a resident population of 10 to 11 residents who on the average had the developmental abilities of 4- or 5-year-old children) that a staffing ratio that exceeded the Michigan State standard by 30 percent could still not assure that adequate nursing coverage was provided to the residents to prevent serious incidents and accidents. Westgate did not point to any different interpretation of the Michigan State law that would indicate that the ALJ's interpretation was unreasonable nor did Westgate allege that it had performed any evaluation of how many staff would be needed during the night shift in the dementia unit "to assure coverage for patients," as required by the Michigan State law. While Westgate contended that it "more than met" the coverage standard in State law, this contention was based on its view that

there were no indications that staffing was inappropriate or insufficient other than routine, normal, and expected injuries. Westgate Br. at 13. We reject this view for reasons discussed below.

Thus, not only is Westgate's reliance on the State law here misplaced because the federal requirement uses a different measure than a resident to staff ratio, but also because that ratio is not the only requirement in State law.

C. The treatment of the State standard in this case is not inconsistent with the ALJ's past decisions, nor with Board precedent.

With respect to the question of consistency, we first note that the ALJ addressed this argument in his decision. The ALJ distinguished the instant case from both his previous decisions on the basis that in those cases CMS, asserting that the facilities had neglected the needs of their residents, had asked the ALJ to infer from the evidence showing neglect that the facilities had insufficient professional staff, with no proof that the actual number of the facility's professional staff was inadequate. ALJ Decision at 9. The ALJ stated that "in those cases it was not possible to infer an inadequate number of professional staff at a facility solely from evidence that residents were not receiving care of a high quality because factors other than inadequate staffing might account for poor quality of care." Id.

Second, this Board has not held nor implied that there is an absence of a federal standard that requires a decision in a facility's favor if the facility met a state resident to staff ratio standard. The ALJ's Life Care decision was not appealed to the Board. The ALJ decision in Carehouse was appealed to the Board and addressed in Carehouse Convalescent Hospital, DAB No. 1799 (2001). In that decision, the Board upheld the ALJ's conclusion that CMS did not establish a prima facie case of noncompliance with section 483.30. The Board stated that the --

> ALJ could reasonably conclude that the examples of allegedly deficient care remaining at issue did not establish a prima facie case because the survey report failed to allege a link between the alleged deficiency

> and the number of staff that Petitioner provided to care for the residents, which is the essence of the regulation cited for this deficiency.

Carehouse at 39. The Board also discussed CMS's reliance on a State Operations Manual (SOM) provision instructing that a deficiency determination is based on the ability of staff to deliver needed care and on the regulatory provision at 42 C.F.R. § 488.26(c)(2) that the survey process uses resident outcomes as the primary means to establish compliance. The Board stated:

> While the SOM language is phrased in terms of the ability of staff to deliver appropriate care, it does not countermand the regulation's requirement of a nexus between a failure to deliver appropriate care and the number of staff that a facility provides to deliver care to residents.

Carehouse at 40. The Board went on to state that, even under the standard argued by CMS, the ALJ decision would not be erroneous since the one incident of lack of quality care still at issue was a limited example that would not permit an inference of insufficient numbers of staff. Id. The Board further determined that the ALJ did not err in rejecting CMS's arguments and evidence related to California State law staffing ratios since they were not timely made and noted that the ALJ's findings on the California law were dicta. Thus, while the Board's decision in Carehouse does stand for the proposition that CMS may not rely on resident outcomes alone, without showing a nexus to the sufficiency of staff, the issue regarding the state standard was different and was not reached by the Board.

D. Westgate's reliance on the Board's decision in Carehouse is misplaced.

Westgate's argument that the nexus required by the Board's decision in Carehouse was not established was premised primarily on its view that the nexus could be established only by a showing that the "incidents" on which the ALJ and CMS relied would have

been prevented by more staff.[4] Westgate said it had provided evidence that the number of incidents was not reduced when the staff was increased, and would have us infer from this that the requisite relationship was not present. Moreover, according to Westgate, it is impossible to prevent such incidents when the residents' safety must be balanced against the goal of independence from restraints. Westgate also asserted that the numbers of staff were irrelevant to the behaviors which the ALJ described because those behaviors were normal for these residents.

We reject these arguments. Here, unlike Carehouse, CMS presented evidence to the ALJ about how many staff were available on the night shift for the residents and tied the deficiency finding to the inability of that staff to meet residents' needs, as set out in their plans of care. While CMS also relied on incidents in which specific residents were harmed as support for its finding that staff numbers were not sufficient, here CMS was not relying on a single incident, but on a pattern of incidents. Moreover, the incidents were not used solely to support an inference of lack of sufficient staff, but to demonstrate the nature of the residents and the need for staff monitoring and interventions that were required to address residents' behaviors, and to support the determination that immediate jeopardy existed at least as of June 2, 1999. Moreover, the ALJ explained that, in this case, unlike the two previous cases, he could conclude that staffing was inadequate from the evidence that showed what staff was on duty coupled with evidence about: the size and configuration of Westgate's dementia unit; the mental and physical states of the residents; and the behaviors the residents engaged in. ALJ Decision at 9.

Contrary to what Westgate argued, the ALJ was not required to find that having additional staff would have prevented the incidents in which residents were harmed. To establish a failure to comply with the regulation, CMS need only show that the numbers of staff were not sufficient to meet the residents' needs as shown in their care plans. CMS may accept as sufficient a staffing level that might not be able to prevent every incident

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[4] The ALJ did not discuss the Board's Carehouse decision because that decision was not issued until November 2001.

such as those cited, as long as the facility has that staff that is reasonably expected to be needed in order to fulfill the residents' needs, for example, by reducing the number and severity of such incidents to the extent practicable. The requirement is for the highest practicable level of well-being that can be attained or maintained. Thus, contrary to what Westgate argued, the CMS position does not mean that Westgate has to have a one-to-one staff to resident ratio. Indeed, CMS accepted a level of two full-time aides on the night shift for 10 to 11 residents as sufficient.

Finally, we reject Westgate's argument that the ALJ erred because he did not recognize that the number of incidents involving residents of the dementia unit was solely due to Westgate's approach to the care of the residents of using staff interventions rather than restraints to control resident behavior, rather than being an indication that the numbers of staff were insufficient. The residents' rights provisions of the statute and Part 483 make clear that this approach is required. However, the benefits of this approach do not excuse a facility for a failure to have sufficient staff to take the interventions when needed or to monitor the residents when the lack of restraints makes them more vulnerable.

E. The ALJ was not required to consider the qualifications and training of the available staff.

We also reject Westgate's argument that qualifications and training of staff are more important than numbers. The plain language of section 483.30(a)(1)(ii) requires the facility to provide services by "sufficient numbers of staff" in accordance with resident care plans. The statute and regulations treat the need for quality staff as separate from the requirement for sufficient numbers of staff. Indeed, the preamble to the final rule explained the provision here by stating that the "number and skills of nursing staff depend on the severity of the residents' condition." 54 Fed. Reg. at 5337. No matter how qualified a particular staff person or persons may be, that staff cannot reasonably be expected to provide services sufficient to meet residents' needs if the needs are likely to demand more staff than will be available in one area or over a particular period of time.

II. The ALJ's finding that Westgate insufficiently staffed the night shift in its dementia unit is supported by substantial evidence in the record as a whole.

On appeal, Westgate challenged the ALJ's finding that "at least two nursing assistants were needed given the configuration of the unit, the number of residents, and the residents' mental conditions and other associated medical problems." ALJ Decision at 4. Westgate asserted that there was "very little" evidence in the record to support the ALJ's findings about the configuration of the dementia unit and that the ALJ had ignored evidence showing that the courtyard was a "safe environment" and an effective behavior management tool. Westgate Br. at 8, 11; Reply Br. at 7. According to Westgate, it was not reasonable of the ALJ to infer, from testimony that 40 to 70 percent of residents with cognitive difficulties will be wanderers, that all of the residents of the dementia unit would be up at the same time during the night shift, especially in light of testimony that Westgate had presented that most of the time only two residents would be up. Westgate Br. at 5, and 11; Reply Br. at 6. With respect to particular residents, Westgate argued that the ALJ had failed to consider relevant testimony, such as testimony that allowing Resident 3 to move furniture around was a planned intervention for that resident, or had relied on evidence that was irrelevant, such as reports of incidents that occurred during the day shift. To substantiate its claim that the dementia unit was adequately staffed and that the residents of the dementia unit did not receive inferior care as a result of any alleged staffing shortage, Westgate maintained that the ALJ failed to consider evidence it presented at the hearing that the numbers of falls and fractures that occurred in the dementia unit were statistically below the national average for fracture rates at nursing facilities. Westgate further alleged that the ALJ had ignored evidence about the availability of staff from another unit. Westgate Br. at 12.

For the reasons discussed in this section, we conclude that the ALJ's finding that Westgate's dementia unit was understaffed during the night shift was based on substantial evidence in the record as a whole and that the evidence on which Westgate relied does not undercut the ALJ's findings. We discuss each of the arguments below, but note generally that Westgate's arguments were in large part based on the faulty premise that the resident

"incidents" were the primary basis for the finding of noncompliance. The ALJ, however, based his finding on the totality of circumstances present in Westgate's dementia unit during the night shift, including the needs of the residents as shown in their care plans.

A. The ALJ's findings about the configuration of the unit are supported by substantial evidence in the record and are relevant in determining whether the residents' needs could be met by available staff.

The ALJ examined the physical layout of the unit and determined that one CNA could not effectively cover the unit. The record shows that, during the summer of 1999, the alarmed door to the courtyard was propped open during the night because of the heat. Tr. at 73 - 74. Not all the residents had tethers (devices to set off a proximity alarm at the courtyard door) so that a resident could wander out into the courtyard without the knowledge of the CNA. ALJ Decision at 6. The ALJ found that the configuration of the unit, with six rooms, three hallways, and the courtyard rendered it difficult, if not impossible, for the lone CNA on duty to observe the courtyard from the interior of the unit, particularly if the CNA was engaged in another task within the unit. ALJ Decision at 5 and 8, citing CMS Ex. 37. The only windows from the unit into the courtyard were those in the residents' room, where the shades were drawn at night. Id. While Westgate argued that there was "very little" evidence about the configuration, Westgate pointed to no evidence that would contradict the ALJ's findings about the configuration. We find that there was ample evidence in the record to support the ALJ's findings about the layout of the dementia unit.

While Westgate presented testimony that referred to the courtyard as a "safe environment" and indicated that it was a useful tool for managing certain residents' behaviors, Westgate did not explain how this testimony (even if accepted as true) was relevant to the issue of whether the residents' needs for monitoring or interventions could be met if they were out of sight. Moreover, the ALJ properly related the physical layout of the facility as relevant to the issue of staffing because of the propensity of the unit's residents to wander at night, which we discuss next.

B. The ALJ did not find that all of the residents would be up at night simultaneously, and the record supports his finding that one full-time staff person could not meet the needs of all of the residents during the night shift.

The ALJ noted Westgate's expert witness's testimony that it was reasonable to infer that 40 to 70 percent of dementia patients are likely to wander at night. ALJ Decision at 8, citing Tr. at 682. Westgate said that it was not reasonable to infer from this testimony that all (or even seven) of the residents would be up simultaneously. Westgate pointed to testimony by one of its witnesses that she observed only two residents "up" during the night. Tr. at 386.

First, contrary to what Westgate implied, the ALJ did not find that seven or more residents would be up simultaneously. In order to find that the level of staffing was insufficient to meet residents' needs, the ALJ did not need to find that all (or seven) of these residents were up at once. Second, the testimony on which the ALJ relied is relevant to show the number of residents who were <u>likely</u> to wander. Even at the low point of this range, that would mean that at least four of Westgate's dementia unit's residents were likely to be wanderers. Since the ALJ further found, based on their records, that four out of the five residents who were specifically reviewed were wanderers, it is likely that, of the five to six other residents from the dementia unit, others were also wanderers. While this does not mean that all of the residents or even seven of the residents would be likely to be wandering at any one point during the night, the ALJ could reasonably infer from the evidence that there would be times when more than two and up to seven residents would be wandering. The testimony on which Westgate relied does not undercut this inference because, even if most of the time only two residents were up, this implies that other times more than two residents were up. Tr. at 476, 519. Moreover, the surveyor testified that she had observed a time period when four residents were up at once. Tr. at 104. Finally, Westgate's argument ignores the fact that the ALJ's finding that the staff was insufficient was not based solely on the residents' propensity to wander, but on their other needs as well.

C. The ALJ's findings about particular residents are supported by substantial evidence in the record as a whole.

In discussing particular residents, the ALJ focused on the mental and physical states of the residents, along with their behaviors. The ALJ noted evidence that the residents of the dementia units had the developmental abilities of 4- to 5-year-old children, diminished cognitive capacity, and a pattern of agitated behavior with combativeness and aggressiveness. The ALJ called these circumstances "a recipe for injuries resulting from unsupervised wandering." ALJ Decision at 12. He also cited to the residents' care plans.

The record as a whole, including the residents' records cited by the ALJ in his decision, provides ample support for the ALJ's findings about particular residents. Without going into the details of each of the residents of the dementia unit, we can readily agree with the ALJ that the totality of the circumstances surrounding these residents supported a finding that more staff was required in the unit to meet residents' needs as shown in their care plans. For example, the ALJ referred to Resident 21's care plan, which noted that the resident had a potential for falls as a result of the use of psychotropic medicines. ALJ Decision at 7, citing CMS Ex. 19. The care plan provided that the resident should be monitored for an unsteady gait and supervised while he was ambulating. CMS Ex. 19, at 33. The record further supports the ALJ's finding that Resident 21 was permitted to walk unsupervised at night in the unit's courtyard, where he was found on June 2, 1999, on the sidewalk with various scrapes to his body. Id. at 11.[5]

As another example of a resident who was at a high risk for falls, the ALJ referred to the medical records of Resident 22, who was found sitting in her own urine with a fractured hip. ALJ Decision at 8; CMS Ex. 20, at 13. CMS tied this incident to the resident's care plan indication that the resident was incontinent

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[5] CMS pointed out that a similar incident occurred on July 25, 1999, when Resident 21 was observed returning from the courtyard at 1:00 a.m. with new scrapes, indicating that he suffered another fall, and this assertion is also supported by the resident's records. CMS Ex. 19, at 25.

in urination, and inferred that the resident slipped in her own urine, causing the fall and consequent fracture. The ALJ did not draw that inference and it is not the only reasonable inference from the incident, but the ALJ did properly identify the incontinence as a care need and reasonably inferred from the incident the vulnerability of this resident.

The evidence to which Westgate cited in order to overcome the ALJ's findings is not convincing. Westgate discussed each of the residents and the alleged incidents and downplayed their significance. We agree with the ALJ that Westgate's position that it attempted to balance independence for its residents with concerns for their safety is simply not persuasive. The scrapes and bruises in Westgate's dementia unit that were described in the survey reports and before the ALJ, although characterized by Westgate as "normal," had the potential for far more serious injuries, as evidenced by Resident 22's fractured hip. Resident 21's apparent falls -- the exact cause of the injuries he received is unknown because no one witnessed them, in itself a sign of inadequate monitoring -- could well have produced more serious injuries. Even if it is true that falls are commonplace in a dementia unit and that the presence of additional staff would not necessarily guarantee any decrease in accidents or instances of agitated behavior, it is questionable how the needs of 10 to 11 residents, as put forth in their care plans, could be adequately met on any consistent basis with only one CNA on duty, even if that CNA occasionally might have received assistance from other units in the facility. Similarly, the incidents of agitated behavior between residents could well have escalated, with the potential for harm to one or both of the residents involved in an incident, without sufficient staff to intervene. Given the propensity of the residents of the unit to wander during the night, their childlike mental development, their behavioral habits, and other factors, the ALJ properly concluded that it was not reasonable for Westgate to have fewer CNAs on duty at night than during the day.

D. Westgate did not show that less than two full-time CNAs were sufficient.

Westgate contended that it had ways of meeting the residents' needs other than presence of two full-time CNAs during the night shift, such as having a CNA from another unit come to the unit

every two hours and having other staff available. Westgate argued that the ALJ did not take into account, in determining that there was insufficient staff for the dementia unit, testimony from Westgate witnesses that there was other staff in the facility available to the dementia unit during the night shift.[6] Westgate did not, however, show that merely having another CNA come every two hours and other staff available would be sufficient to meet the residents' needs as evidenced in their care plans and found in the ALJ Decision. Westgate did not point to any evidence about how long the extra CNA would stay in the dementia unit and the statements were inconsistent about whether the purpose was to simply help with "bed checks" or to assist in toileting. Also, while some resident needs were around toileting issues, others were not. The CNA who came every two hours could likely not observe wandering residents while assisting with toileting, nor could this CNA or other staff observe wanderers or provide timely interventions to address behavioral issues while not present in the unit.

E. The ALJ did not improperly disregard evidence about the falls and injuries to residents of the dementia unit.

As to Westgate's position that the falls and resulting injuries suffered by the residents were to be expected for a dementia unit and were statistically below the norm for fall and fracture rates at nursing facilities, we note that the ALJ found the testimony of Westgate's experts unpersuasive on the subject of the frequency of falls, although he did not specifically address all of the testimony. ALJ Decision at 10. Westgate's premise on the fall rate of the residents in the dementia unit is undercut by the fact that Westgate's witness, Dr. Naughton, based his calculations on falls that occurred in only the first nine months of 1999; on a yearly basis, the number of falls in the dementia unit would exceed the national average cited by Westgate's witness. To the extent that the testimony might support a conclusion that the rate of fractures was less than the national average, this does not necessarily indicate that the staff was

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[6] A CNA from another unit would go to the dementia unit every two hours to assist the dementia unit CNA in performing bed checks and assisting residents in their toileting. Tr. at 474.

sufficient since, as the ALJ observed, the fracture rate could be explained by other factors.

III. The ALJ did not err in concluding that the CMS determination that the noncompliance constituted immediate jeopardy was not clearly erroneous.

Many of Westgate's arguments regarding the incidents that occurred and whether they were preventable were also used by Westgate to challenge the ALJ's conclusion that the CMS determination about immediate jeopardy was not clearly erroneous. Westgate asserted that the addition of another CNA to the dementia unit's night shift after September 9, 1999 had no effect on the number of incidents within the unit, thus calling into question the ALJ's conclusion that immediate jeopardy resulted from only having one CNA on duty previously.

We first note that immediate jeopardy is defined in the regulations not just as situations where actual harm occurs, but also as situations that are "likely to cause" serious injury or harm. Moreover, in our view, any suggestion by Westgate that the residents of its dementia unit did not suffer any actual harm because of the lack of sufficient numbers of staff and thus were not placed in jeopardy is belied by the facts. Given the factors that led the ALJ to find that Westgate's dementia unit was understaffed during the night shift, and given particularly the hip fracture suffered by one of the residents, we agree with the ALJ that CMS's position on the presence of immediate jeopardy was not clearly erroneous.

IV. The ALJ did not err in concluding that the immediate jeopardy situation existed at least from June 2 through September 6, 1999.

Westgate raised arguments concerning whether it could properly have been considered to have timely notice that a penalty would be imposed starting June 2, the date on which Resident 21 was discovered on the courtyard sidewalk, given that: 1) the prior survey did not cite a staffing deficiency, even though the circumstances in the dementia unit were identical; 2) Westgate exceeded the Michigan resident-to-staff ratio standard in its dementia unit, the only objective guidance available to it; and 3) the incidents cited are normal for residents with dementia

when reducing the use of restraints.[7] Westgate said it did not have notice of the immediate jeopardy until August 26, 1999. Westgate also argued that CMS was arbitrary in determining that two full-time CNAs were needed on the night shift in the dementia unit in order to abate the immediate jeopardy.

First, we note that the regulations specifically permit CMS to impose a penalty "for the number of days of past noncompliance since the last standard survey, including the number of days of immediate jeopardy." 42 C.F.R. § 488.430(b)(2). A per day penalty "may start accruing as early as the date the facility was first out of compliance. 42 C.F.R. § 488.440(a)(1). Contrary to what the ALJ said, however, this does not make the penalty "retroactive" or punitive. As we discussed in Fairfax Nursing Home, Inc., DAB No. 1794 (2001), the preamble to the 1994 regulations explained that Congress wanted to "discourage facility noncompliance that Congress believed to be widely evident between surveys and thereby, to encourage lasting compliance." 59 Fed. Reg. 56,116; 56,175 (Nov. 10, 1994). The preamble further explained that Congress authorized imposing a

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[7] CMS determined that immediate jeopardy commenced with the June 2, 1999 discovery of Resident 21 on the sidewalk of the courtyard of the dementia unit, with scrapes on various parts of his body. The ALJ noted that the regulation governing the imposition of a CMP authorizes CMS to impose a CMP "retroactively." The ALJ noted that the inception date of Westgate's immediate jeopardy level noncompliance predated by nearly three months the notice of Westgate's noncompliance. The ALJ further noted that Westgate acted promptly to correct the staffing deficiency in its dementia unit once it received CMS's August 26, 1999 notice of the deficiency, and that $262,300 of the CMP is attributable to the time predating the August 26 notice. The ALJ stated that he would not have sustained a penalty in this amount if he had the discretion not to do so. ALJ Decision at 14. The ALJ questioned whether the imposition of the retroactive penalties CMS determined to impose served the remedial purposes contemplated by the Act. The ALJ stated that he could not "discern the remedial purpose of civil money penalties if those penalties do not serve as an inducement to a facility to correct its deficiencies." Id. at 15. For reasons explained below, we disagree.

CMP for past noncompliance, even if subsequently corrected, to create "a financial incentive for facilities to maintain compliance." 59 Fed. Reg. at 56,206, quoting H.R. Rep. 391, 100th Cong., 1st Sess. 473-6 (1987). Fairfax at 18.

Consequently, the key issue is when Westgate should have known that it was failing to comply substantially with the requirement at 42 C.F.R. § 483.30(a)(1). The ALJ sustained the CMS finding that the CMP should be imposed starting June 2, 1999. In light of the incident on June 2, in which Resident 21 was discovered at 12:15 a.m. on the courtyard sidewalk, the ALJ could reasonably infer that Westgate should have known at least by then that the existing staff were unable to provide the monitoring Resident 21 required. Moreover, before that incident, Westgate had notice of the factors relied on by the ALJ, such as the configuration of the dementia unit and the federal regulation. That regulation obliges Westgate, in order to ensure that services are provided by sufficient numbers of staff to meet residents' needs in accordance with their care plans, to examine what the plans call for, and to evaluate whether the staff provided is sufficient to meet those needs, to the extent practicable under the facility circumstances. It is obvious that, in making this evaluation, relevant factors such as whether the residents are wanderers and whether they can be observed when out in the courtyard should be considered. Westgate did not assert that it had made that required evaluation, but it clearly had the relevant information and therefore can fairly be charged with knowledge that it had insufficient numbers of staff.

Moreover, Westgate did not deny the State surveyor's testimony that various staff had told her that they had complained about staff shortages in the dementia unit. Tr. at 52 and 107. Westgate's administrator did not deny that he had received such comments, but he labeled such comments as the usual request for more staff that he typically received from all his staff. Tr. at 567. Westgate, however, did not indicate that it had investigated whether these complaints had any validity.

Westgate's reliance on the State resident to staff ratio standard was not reasonable, for reasons explained above. Nor could Westgate reasonably rely on the fact that it was not cited for a deficiency in the earlier survey that took place prior to the June 2 incident involving Resident 21. Aside from questions

about whether a facility can ever rely on a surveyor's failure to cite a deficiency as a basis for thinking it meets the related requirement, at a minimum the facility would have to show that the surveyor was aware of all of the relevant facts and that they were indeed identical despite the passage of time. Yet, Westgate pointed to no evidence to show that in the earlier survey the surveyors evaluated whether the needs of the residents, as evidenced by their care plans, were being met during the night shift as well as the day shift when that survey occurred.

Finally, CMS was not arbitrary to determine that the immediate jeopardy had not been abated until two full-time CNAs were on the night shift for the dementia unit. The record shows that there was a reasonable basis to conclude that the residents' needs could not be met simply by providing a second CNA every two hours and having other staff available.

Conclusion

For the reasons discussed above, we sustain the imposition on Westgate of a CMP of $3,050 per day for the period beginning on June 2, 1999 and ending on September 6, 1999, for a total CMP of $295,850. In doing so, we affirm and adopt all the FFCLs made by the ALJ.

/s/
Cecilia Sparks Ford

/s/
M. Terry Johnson

/s/
Judith A. Ballard
Presiding Board Member