Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of: Eastwood Convalescent Center, Petitioner, - v. - Centers for Medicare & Medicaid Services.	DATE: June 6, 2007 Civil Remedies CR1524 App. Div. Docket No. A-07-39 Decision No. 2088

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Eastwood Convalescent Center (Eastwood) appealed the October 31, 2006, decision of Administrative Law Judge (ALJ) Jose A. Anglada. Eastwood Convalescent Center, CR1524 (2006)(Decision). The ALJ sustained a determination by the Centers for Medicare & Medicaid Services (CMS), based on survey findings by the Michigan Department of Community Health (MDCH or state survey agency), that Eastwood failed to comply substantially with three federal requirements governing the participation of long-term care facilities in the Medicare and Medicaid programs. CMS found, and the ALJ agreed, that Eastwood was not in substantial compliance with (1) the requirement that a facility provide adequate supervision and assistance devices to prevent accidents, 42 C.F.R. §§ 483.25(h)(2)(F324); (2) the requirement that a facility be administered in a manner that enables it to use its resources effectively and efficiently to attain and maintain the highest practicable physical, mental, and psychosocial well-being of its residents, 42 C.F.R. § 483.75(F490); and (3) the requirement that services provided by a facility meet professional standards of

quality, 42 C.F.R. § 483.20(k)(3)(i)(F281). The ALJ also upheld, as not clearly erroneous, CMS's determination that Eastwood's noncompliance with the supervision and administration requirements constituted immediate jeopardy from November 1 through November 2, 2004, and found that the civil money penalty (CMP) in the amount of $4,000 per day that CMS had imposed for those two days was reasonable. Finally, the ALJ found that noncompliance with the professional standards requirement, which was not at the immediate jeopardy level, continued from November 3 through December 4, 2004, and that the CMP in the amount of $250 per day that CMS had imposed was reasonable for that period of noncompliance.

We affirm the ALJ's findings of noncompliance with respect to the supervision and administration requirements and his conclusion that CMS's determination of immediate jeopardy with respect to that noncompliance was not clearly erroneous. As discussed below, the ALJ's findings are supported by substantial evidence, and his conclusions of law are free of error. We also summarily affirm the ALJ's finding of noncompliance with the professional standards requirement, 42 C.F.R. § 483.20(k)(3)(i)(F281) and his finding that the amount of the CMP imposed for that noncompliance is reasonable, inasmuch as Eastwood has not presented on appeal any arguments or grounds for overturning those findings.[1] See Batavia Nursing and Convalescent Inn, DAB No. 1911, at 57 (2004), aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson, No. 04-3687 (6th Cir. Aug. 3, 2005), 2005 WL 1869515; citing Wisteria Care Center, DAB No. 1892, at 10 (2003)("The Board may decline to consider an issue that is 'unaccompanied by argument, record citation or statements that articulate the factual or legal basis for the party's objection to the ALJ's finding.'").[2] We also

---

[1] In its request for review, Eastwood states, "The Petitioner disagrees with the findings of fact and conclusions of law as set forth below." P. Br. at 4. However, the discussion "set forth below" contains no argument opposing the finding of noncompliance with 42 C.F.R. § 483.20(k)(3)(i)(F281), or the amount of the CMP imposed for that noncompliance during the period November 3 through December 4, 2004.

[2] Wisteria Care Center cited the Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting A Provider's Participation In the Medicare and Medicaid Programs of the Departmental Appeals Board (Guidelines), which can be found

(continued...)

summarily affirm the ALJ's finding that the amount of the CMP imposed for the immediate jeopardy noncompliance ($4,000 per day) is reasonable. Eastwood merely disputes the basis for imposing that CMP, not that the CMP is reasonable based on the factors that CMS and the ALJ must consider. Given our affirmance, as discussed herein, of the basis for imposing the CMP, we affirm without further discussion that the CMP is reasonable in amount. See Omni Manor Nursing Home, DAB No. 1920 at 45 (2004) aff'd, Omni Manor Nursing Home v. Thompson, No. 04-3836 (6th Cir. Oct. 11, 2005), 2005 WL 2508547 (summarily affirming reasonableness of CMP when nursing home did not assert that the ALJ erred in considering the regulatory factors but merely claimed that it was in substantial compliance with program requirements, a claim rejected by the ALJ and Board).

Applicable Legal Provisions

Long-term care facilities participating in the Medicare and Medicaid programs are subject to the survey and enforcement procedures set out in 42 C.F.R. Part 488, subpart E, to determine if they are in substantial compliance with applicable program requirements which appear at 42 C.F.R. Part 483, subpart B. "Substantial compliance" means a level of compliance such that "any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. "Noncompliance," in turn, is defined as "any deficiency that causes a facility to not be in substantial compliance." 42 C.F.R. § 488.301.

A long-term care facility found not to be in substantial compliance is subject to various enforcement remedies, including per instance or per day CMPs. 42 C.F.R. §§ 488.402(c), 488.408. CMS may impose CMPs ranging from $3,050 - $10,000 per day for one or more deficiencies constituting immediate jeopardy and from $50 - $3,000 per day for deficiencies that do not constitute immediate jeopardy but that either cause actual harm or create the potential for more than minimal harm. 42 C.F.R. § 488.438(a). The regulations set out a number of factors that CMS considers in determining the amount of a CMP. 42 C.F.R. § 488.438(f).

---

[2](...continued)
at www.hhs.gov/dab/guidelines/prov.html("The Board will not consider issues not raised in the request for review, nor issues which could have been presented to the ALJ but were not.").

"Immediate jeopardy" is defined as "a situation in which the provider's noncompliance with one or more requirement of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination that a deficiency constitutes immediate jeopardy "must be upheld unless it is clearly erroneous." Woodstock Care Center, DAB No. 1726, at 9 (2000), citing 42 C.F.R. § 498.60(c)(2), aff'd, Woodstock Care Center v. Thompson, 363 F.3d 583 (6th Cir. 2003).

One of the participation requirements at issue here, that a facility ensure adequate supervision to prevent accidents, falls under the "quality of care" requirements, which share the same regulatory objective that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." 42 C.F.R. § 483.25. Section 483.25(h) provides in relevant part:

> *Accidents.* The facility must ensure that -
>
> * * * * *
>
> (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

The requirements of this regulation have been explained in numerous Board decisions. See, e.g., Liberty Commons Nursing and Rehab - Alamance, DAB No. 2070, at 3 (2007), citing Golden Age Skilled Nursing & Rehabilitation Center, DAB No. 2026 (2006); Woodstock, DAB No. 1726, at 28. Although section 483.25(h)(2) does not make a facility strictly liable for accidents that occur, it does require that the facility 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. Woodstock, 363 F.3d at 590 (a SNF must take "all reasonable precautions against residents' accidents"). "Facilities have the 'flexibility to choose the methods of supervision' to prevent accidents so long as the methods chosen are adequate in light of the resident's needs and ability to protect himself or herself from a risk." Liberty Commons at 3, citing Golden Age at 11 and Woodstock, 363 F.3d at 590.

Standard of Review

Our standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. Our standard of review on a disputed finding of fact is whether the ALJ decision is supported by substantial evidence on the record as a whole. Guidelines; Batavia, DAB No. 1911, at 7 (2004); Hillman Rehabilitation Center, DAB No. 1611, at 6 (1997), aff'd, Hillman Rehabilitation Ctr. v. U.S. Dep't of Health and Human Servs., No. 98-3789 (GEB) at 21-38 (D.N.J. May 13, 1999).

Case Background[3]

Resident 500, a 57-year-old female, was admitted to Eastwood on October 19, 2004, following inpatient hospitalization for placement of a left groin permacath access site for dialysis treatments "and creation of a new anteriovenous (AV) graft." Decision at 5. Her admitting diagnoses included end stage renal disease, hypertension, diabetes, and heart disease. Decision at 5; CMS Ex. 8, at 3, 59; P. Ex. 9 at 17. Her Minimum Data Set (MDS) assessment indicated that she had some cognitive impairments creating difficulty in new situations, had short-term memory lapses and was confused at times. Decision at 5; CMS Ex. 8, at 6, 57; P. Ex. 9 at 15, 22. She was wheelchair bound and totally dependent upon staff for all activities of daily living (ADLs). Decision at 5-6; CMS Ex. 8, at 58-59, P. Ex. 9 at 17. The admission record identified Resident 500 as her own responsible party, and also identified her husband. Decision at 5.

Resident 500 was assessed on admission as having a feeding tube. Decision at 5; CMS Ex. 8, at 22-23; P. Ex. 9 at 24. Her Medication Administration Record (MAR) indicates that she received accuchecks (blood sugar testing) with sliding scale insulin doses four times daily (6:00 a.m., 12:00 noon, 6:00 p.m., 10:00 p.m.), Heparin (anticoagulant, prophylaxis for deep venous thrombosis/pulmonary embolism) at 10:00 a.m. and 10:00 p.m., Lopressor (antihypertensive) at 10:00 a.m. and 6:00 p.m., Risperdal (antipsychotic) at 10:00 a.m. and 6:00 p.m., and Lantus

[3] The information in this section is drawn from the ALJ Decision and the record before the ALJ and is presented to provide a context for the discussion of the issues raised on appeal. Nothing in this section is intended to replace, modify, or supplement the ALJ's findings of fact.

Insulin at 9:00 p.m. Decision at 5; CMS Ex. 8, at 19-21. Resident 500 received hemodialysis, at an off-site dialysis center, through the permacath site three times a week while the AV site healed, a process that takes two to four weeks. Decision at 5; P. Ex. 9 at 29; CMS Ex. 8 at 8. On October 25, 2004, Resident 500 was transported by van for her regular dialysis treatment. Resident 500's husband was present that day when the facility van arrived to transport her back to Eastwood after dialysis and asked to ride in the van with her. Decision at 5. After speaking by cell phone with his supervisor, the administrator of an affiliated facility (Administrator B), the driver allowed the husband to ride in the van's return to Eastwood that day, but refused his request to stop for a personal banking errand. Id. at 5-6. Administrator B spoke with the husband to convey that he was being permitted to ride in the van one time only and there would be no unscheduled stops. Id. Administrator B later spoke with Eastwood's administrator, Robert Martin (Mr. Martin or administrator) about the incident and asked him to reinforce this policy with the resident's husband, who appeared agitated. Id. at 6.

Two days later, on October 27, 2004, the resident's husband was again present at the dialysis center at completion of the resident's dialysis. Decision at 6; Tr. 158. The husband wheeled the resident from the center and when the driver again told the husband that he could not ride in the van with the resident, the husband stated that he was taking the resident with him and would be back in an hour and a half. Decision at 6; Tr. 142, 158. The van driver called Eastwood's administrator who told him to let them go and to return to Eastwood in the van with the other residents. CMS Ex. 1 at 17; P. Ex. 9 at 43; Tr. 128, 142, 159. This happened between 3:00 and 3:30 p.m. CMS Ex. 1 at 26; Tr. 142.

The Eastwood administrator told the surveyor that the husband was listed on facility records as the resident's emergency contact. Decision at 6; CMS Ex. 1 at 10; P. Ex. 9 at 43. He thought that the husband would return the resident to Eastwood upon finishing "the errand." Decision at 6. The nurse on duty that afternoon told the surveyor that she was not aware that the resident had not returned on the van from dialysis. Decision at 9; CMS Ex. 1 at 11; P. Ex. 9 at 44.[4] She also told the surveyor that she

[4] Eastwood does not dispute the nurse's admission that she (continued...)

received a telephone call from a local hospital around 8:00 p.m. advising that the resident was being evaluated with abrasions and fever. Id. Hospital records indicated that the resident was found after she had fallen out of her wheelchair and suffered a 1.5 cm abrasion on her nose, an abrasion on her inside upper lip and gum, and bilateral hand pain.[5] Decision at 6; CMS Ex. 1 at 11; CMS Ex. 8 at 41, 49.

MDCH completed a complaint survey at Eastwood on November 5, 2004 and reported the results on a Statement of Deficiencies (SOD). CMS Ex. 1; P. Ex. 9 at 38-48 (partial SOD). MDCH found that Eastwood failed to supervise Resident 500 following completion of her off-site dialysis to ensure her safe return to Eastwood and

[4](...continued)
did not know the resident had not returned in the van. The nurse also told the surveyor that since "residents are sometimes late returning from dialysis for a variety of reasons ... Resident 500's absence was not initially a concern ...," and that she "thought perhaps there had been some complication at the dialysis unit." Id.; Tr. 23. The ALJ found the explanation of the nurse's lack of concern "gratuitous in light of the admission that she did not know that the resident had not returned." Decision at 9. We do not rely on this finding because the nurse's statements do indicate that she became aware of the resident's absence at some point before the hospital called at 8:00 p.m., even though she was not aware of the reason for that absence. However, that does not affect our decision since, even assuming she was aware of Resident 500's absence, the nurse admits to not being concerned, and there is no evidence she inquired as to the resident's whereabouts.

[5] The survey report says that the hospital records showed that the resident was about 10 miles from the dialysis center when she fell. The report also states that the resident and her husband walked that distance; however, the hospital records give only the street location where the paramedics found the resident. CMS Ex. 8 at 49. Furthermore, the record contains no evidence as to how she got there, although the facility's lawyer speculated that she and her husband took a bus. Tr. 72-73. At the hearing, the surveyor testified that she must have miscalculated the distance based on the map she was looking at and agreed that she did not know how the resident got to where she was found. Id. However, in response to a question from the ALJ, Eastwood's attorney stated that the location where the resident was found was "seven-plus miles" from the dialysis center.

put the resident in immediate jeopardy resulting in her hospitalization for abrasions and fever. CMS Ex. 1, at 6. MDCH also found that the incident involving Resident 500 demonstrated a failure to administer the facility in a manner that utilized its resources effectively and efficiently to return a resident to the facility following a dialysis treatment and put Resident 500 in immediate jeopardy. Id. at 15-16. On November 18, 2004, based on the State survey results, CMS notified Eastwood that it was not in substantial compliance with the federal requirements at 42 C.F.R. §§ 483.25(h)(2) and 483.75; that its noncompliance constituted immediate jeopardy lasting two days (November 1-2, 2004); that the facility continued to be out of compliance with another federal requirement, 42 C.F.R. § 483.20(k)(3)(i), from November 3 onward; and that CMS was imposing remedies, including a CMP of $4,000 per day for the immediate jeopardy and $250 per day thereafter until the facility achieved substantial compliance. CMS Ex. 3. On January 11, 2005, MDCH completed a follow-up survey at Eastwood and on January 24, 2005, notified Eastwood that it had achieved substantial compliance effective December 4, 2004. CMS Ex. 16.

Eastwood sought a hearing before an ALJ, and one was held on March 14, 2005. The parties submitted post-hearing briefs, and on October 31, 2006, the ALJ issued the decision being appealed here. The decision contains six findings of fact and conclusions of law (FFCLs A-F). On appeal, Eastwood presents argument only on the ALJ's findings of noncompliance with the supervision and administration requirements (FFCLs B and C) and his finding that CMS's determination of immediate jeopardy was not clearly erroneous (FFCL D).

Discussion

I. The ALJ's challenged findings of noncompliance are supported by substantial evidence and reveal no legal error.

A. Eastwood failed to provide adequate supervision to prevent accidents.

Eastwood does not dispute the material facts on which the ALJ relied for this finding. These include the following: that the resident suffered from multiple diseases, including end stage renal disease, hypertension and diabetes; that she had a feeding tube; that she was confined to a wheelchair and totally dependent on staff for care; that she was on a medication schedule that

included blood sugar testing with sliding scale insulin doses four times daily (6 a.m., 12 noon, 6 p.m., 10 p.m.), Heparin and Lantus Insulin at 9 p.m.; that she left the dialysis center with her spouse pushing her wheelchair between 3:00 and 3:30 p.m.; that her spouse told the van driver that he would return the resident to the facility within an hour and a half; that the resident was hospitalized at 5:37 p.m. after falling out of her wheelchair and presenting with abrasions, fever and hand pain; and, that the facility made no attempt to locate the resident when she did not return in an hour and a half and only found out that she was in the hospital when the hospital called the facility at approximately 8:00 p.m. Even if Eastwood did dispute these facts, they are well-supported in the record by Eastwood's own documents, including admissions, assessment and medical records, the resident's care plan and the nurses' notes. Eastwood's witnesses at the hearing, the facility administrator and van driver, did not dispute any of these material facts. In fact, the administrator confirmed the time that Resident 500 left the dialysis center with her spouse (between 3:00 and 3:30 p.m.) and that, after he told the van driver to allow the resident to leave the dialysis center, no Eastwood staff member, including himself, made any inquiry as to her whereabouts. Tr. 142, 144. He also confirmed that he first learned of the resident's whereabouts when he received a call from a nurse the evening of October 27, 2004 notifying him that the resident was in the hospital. Tr. 136.

Eastwood's argument on appeal is that the ALJ's decision is not supported by substantial evidence because the ALJ "fail[ed] to consider certain evidence in the record" and that "failure ... so completely colors the findings of fact and detracts from the weight of the decision, that the ALJ's findings should be reversed." P. Br. at 9. Eastwood points specifically to the ALJ's discrediting of the afternoon nurse's statement to the surveyor that the hospital had called at 8:00 p.m. in light of the fact that the only nursing note written that day stated that the hospital called at 11:20 p.m. P. Br. at 10, citing Decision at 8. Apparently relying on the 11:20 notation, the ALJ stated, "Thus, although it may not have been expected that the facility staff harbor any serious concern if the resident was a half hour or an hour late in returning, it was not reasonable for the facility to totally ignore that she was late by more than five hours." Decision at 8. Eastwood argues from this that "[t]he crux of the ALJ's finding was the length of time that elapsed

before Petitioner knew of Resident 500's whereabouts." P. Br. at 10.

We do not agree that the crux of the ALJ's decision was the amount of time that had elapsed. It is true that the decision suggests some confusion about the ALJ's understanding as to when the facility first learned of Resident 500's whereabouts. On the one hand, the ALJ cited and found more credible the 11:20 p.m. entry in the nurses' notes. ALJ Decision at 8, citing CMS Ex. 8, at 52. On the other hand, the ALJ concluded that "the staff was oblivious to the whereabouts of the resident until a phone call was received from the hospital that [the resident] had been admitted to the hospital at 8:30 p.m."[6] Id. at 9, citing CMS Ex. 1, at 13; CMS Ex. 8, at 52. However, the crux of the ALJ's decision (and our affirmance) is not how long Resident 500 was gone, or the fact that she was injured while gone, but the

---

[6] This can be read as referring to the call that Eastwood says occurred between 8:00 and 8:30 p.m. On the other hand, it could be read as referring to the only call documented in the nurses' notes, the one at 11:20 p.m., since that note does refer to her "admission," albeit not the time of admission. In his subsequent discussion of the administration deficiency, the ALJ refers to the 11:20 p.m. call as the only call that came from the hospital. See Decision at 10 and n.2. However, as discussed in our decision, we find any discrepancy about the time immaterial to the ALJ's decision or to our upholding that decision. We assume for purposes of our decision, that Eastwood received a call from the hospital at 8:00 p.m. as well as at 11:20 p.m. and that the 8:00 p.m. call was the first time Eastwood became aware of the resident's whereabouts after she left the dialysis center. CMS does not dispute on appeal that the facility learned of the resident's whereabouts at around 8:00 p.m. Furthermore, the Incident/Accident report completed by Eastwood, which the ALJ does not discuss, suggests that the facility learned she was in the emergency room about 8:00 p.m., because that report states that the incident occurred at 8:00 p.m. and that staff notified the resident's physician at 8:30 p.m. and her family at 8:45 p.m. CMS Ex. 8 at 27. However, we also note that, while the report bears what looks like the initials of a "person completing the report," the lines for signatures of the director of nursing, the administrator, and medical director are blank. Id. Thus, while we accept for purposes of our decision Eastwood's claim that the hospital called at 8:00 p.m., we do not necessarily regard the Incident/Accident Report as conclusive evidence of that time.

evidence that "the facility fail[ed] to take further action to determine the whereabouts of the resident after she did not return to the facility within the hour and a half as indicated by her husband." Decision at 7. The ALJ later reiterated the basis for his decision. The ALJ discussed the administrator's failure to communicate to staff his knowledge, obtained around 3:30 p.m., that Resident 500 would not return to Eastwood in the van and the fact that staff remained oblivious to Resident 500's whereabouts prior to the phone call from the hospital. The ALJ then stated, "In the intervening period of time, the facility did nothing to ensure the well-being and safety of R500." Decision at 9.

But even assuming the ALJ was influenced by the amount of time that had elapsed, it is not material to his decision (or to our affirmance) whether the facility learned where she was at 8:00 p.m. or 11:20 p.m. The ALJ reasoned that because of Resident 500's "compromised medical condition" and her medication schedule, "especially insulin," the facility should have been concerned when Resident 500 did not return within a half hour or hour after the time her spouse said she would return. The parties agree that the resident left the dialysis center with her spouse between 3:00 and 3:30 p.m. CMS Ex. 1 at 26; Tr. 142. For purposes of this decision, we assume she left at 3:30, the time most favorable to the facility. Thus, Resident 500 should have returned to the facility by 5:00 p.m. Applying the ALJ's statement that Eastwood should have been concerned if the resident was more than an hour late, the facility should have been concerned enough to begin trying to ascertain her whereabouts no later than 6:00 p.m. Yet, as discussed, Eastwood's own administrator conceded that Eastwood took no steps to learn of the resident's location or well-being before being called by the hospital. Tr. at 143-44. Indeed, aside from the possibility that the afternoon nurse was vaguely aware of the resident's absence at some point, there is no evidence that staff (including the administrator) were even aware that Resident 500 had not returned by 6:00 p.m. It is clear that they found out where she was only because the hospital called at 8:00 p.m., not because Eastwood was looking for her. That phone call came four and a half hours after the resident left the dialysis center; three hours after the time her husband indicated to the driver that she would return; and two hours after the scheduled 6:00 p.m. blood sugar testing, sliding scale insulin injections, and antipsychotic medication required by physician orders.

Furthermore, according to the 11:20 p.m. nursing note, which Eastwood does not dispute as to time or content, Eastwood did not fax the resident's medication list to the hospital until eight hours after she left the dialysis center. Thus, it is entirely possible (and Eastwood has presented no evidence to the contrary) that Resident 500 also missed her 10:00 p.m. blood sugar testing with sliding scale insulin dose and her 10:00 p.m. doses of Heparin and Lantus Insulin. Clearly, Eastwood did not take all reasonable steps to ensure that Resident 500, a highly compromised, totally dependent resident in its care, received supervision and assistance devices that met her assessed needs and mitigated foreseeable risks of harm from accidents. See Woodstock, DAB No. 1726.

Eastwood argues, "There must be a sensitivity to the fact that [the resident] was her own responsible party and competent to make her own decisions" and that federal regulations guarantee the resident's right "to accompany her husband to the bank." Request for Review at 13, citing 42 C.F.R. § 483.10. This misses the point. The resident's right to go to the bank with her spouse is not at issue. Instead, the issue before the ALJ and the Board is what Eastwood did to mitigate the foreseeable risk of Resident 500 having an accident, in light of her highly compromised health (including end-stage renal disease and diabetes), need for multiple medications (including insulin as frequently as four times a day) and total dependency for her care, once the administrator decided to let her leave with her husband rather than return to the facility in the van.

In Woodstock, the Board noted that "[i]rreducibly hard choices exist between preserving freedom and dignity and preserving health and safety," but concluded that "Woodstock abdicated its responsibility to its residents to engage in the struggle to optimize both aspects of their well-being to the maximum extent practicable" by not pursuing all reasonable approaches to prevent resident-to-resident assaults and elopements. DAB No. 1726 at 35. Here, Eastwood's administrator chose to allow Resident 500 to go with her spouse rather than return from dialysis in the van, but did not take even the minimally reasonable steps of informing staff of her absence or the promised time of return so that staff could take steps to ascertain her location if she did not return on time. Neither did the administrator himself take the minimally reasonable step of following up to make sure she had returned as promised. Furthermore, there is no evidence that the administrator conveyed any instructions to the resident's

spouse regarding her medication schedule before they left or that he inquired by what means the spouse would return Resident 500 to the facility.

Eastwood also argues that the resident's departure fell under its leave of absence (LOA) policy for residents and that it complied with that policy. Request for Review at 13-14. The ALJ fully considered that argument but concluded that Eastwood had departed from its own LOA procedures, stating in part:

> [I]t is clear that the facility's prerogative to declare a resident as having left the nursing home AMA [against medical advice] is not a substitute for taking steps to ensure that a resident continues with the required medication regimen even when on LOA, for knowing where to locate a resident in case of emergency, and for taking diligent steps to locate a resident who fails to return at the expected time. The policy does not say that if the resident is his or her own responsible party, the facility has no duty whatsoever to ascertain the resident's whereabouts and make diligent efforts to ensure his or her well being ... In this case, the onus on the facility to be vigilant regarding the resident's timely return to the facility was even more crucial than the cautionary measures outlined in its policy, inasmuch as the LOA occurred in a manner that was out of the ordinary, and critical safeguards were not established at the time of her departure.

ALJ Decision at 9, citing P. Ex. 10. Although Eastwood challenges on appeal the ALJ's summary of its LOA policy, P. Br. at 13, we find no error in that summary or in his analysis of what the policy required. Further, assuming for purposes of this argument that an "absence" under the circumstances presented here is covered under the facility's LOA policy, we find particularly persuasive the ALJ's last statement that those circumstances required even greater vigilance than the procedures provided for in the LOA policy. We also note that Resident 500's departure was from an off-site medical treatment, and that the facility had assumed the responsibility for transporting her to and from that treatment. Thus, we find inapt Eastwood's comparison to an "LOA

... of short duration such as out to lunch," for which Eastwood says no notice is necessary under its LOA policy. See P. Br. at 14.

For all of the stated reasons, the Board upholds FFCL B as supported by substantial evidence and consistent with applicable law.

B. Eastwood failed to administer the facility in a manner that enabled it to use its resources effectively and efficiently to attain the highest practicable physical, mental, and psychosocial well-being of its residents.

Eastwood makes essentially the same arguments in contesting this FFCL that it made for contesting the FFCL regarding its noncompliance with the supervision requirement. Eastwood challenges the ALJ's conclusions with respect to when the facility first learned of the resident's whereabouts and his finding that it did not comply with its LOA policy. Eastwood also reiterates its argument that the FFCL is not consistent with the federal requirement regarding resident rights. We reject these arguments here for the same reasons we rejected them in the prior section. We note in this respect that the administration deficiency can be a derivative deficiency based on findings of other deficiencies. Cross Creek Health Care Center, DAB No. 1665, at 18-19 (1998). In this case, the administration deficiency is derivative of the supervision deficiency.

We recognize that in this section of his decision, the ALJ appears to have clearly construed the 11:20 p.m. call as the first time Eastwood became aware of the resident's whereabouts. "It is obvious that the administration of staff resources was so grossly inept that no follow-up was given to the whereabouts and well-being of [the resident] to the point that the staff was unaware that she had not returned to Eastwood until contacted by the hospital at 11:20 p.m." Decision at 11. However, as previously stated, we assume for purposes of our decision that the hospital first called the facility at 8:00 p.m. Nonetheless, we find that the ALJ's conclusion about the ineptness of the facility's administration is supported by substantial evidence because whether the facility realized she was absent at 8:00 p.m. as opposed to 11:20 p.m. is immaterial. The point, once again, is that the resident was supposed to return by 5:00 p.m. but did not, and the staff and administrator took no action to locate her. Furthermore, the only staff member who might have become

aware of the resident’s absence at some point, the afternoon nurse, did not know where she was or when she was supposed to return and stated that she was not concerned about the absence.

In addition, assuming Eastwood’s LOA policy applies here, we agree with the ALJ that the facility did not follow that policy. We have discussed why we agree with that conclusion in the prior section and need not repeat that discussion here. However, we note with approval the ALJ’s reference in this section to the surveyor’s testimony, that while Eastwood had a LOA policy, as well as an elopement policy, it did not implement either plan in this instance because, with respect to following up on Resident 500's absence under the unusual circumstances present here, “[t]here was no plan to do anything, and nothing was done.” Decision at 11. Either the LOA policy was inadequate because it did not provide a plan of action for this circumstance (which could arise whenever a resident was transported off-site for treatment) or Eastwood did not implement the policy because it did not take steps to assure that it would know where the resident was during her absence and that she would receive her medications on schedule while she was gone or begin to inquire into her whereabouts when she did not return as scheduled. Indeed, the administrator did not even communicate to staff that she was gone or when she was supposed to return. Staff awareness and the ability of staff to address safety concerns and medication issues is a pervasive concern of the policy and does not disappear simply because the resident is not required to give the 42-hour or 24-hour advance notice generally required by the policy. We agree with the ALJ that “[t]he deficiency discussed here denotes the absence of aggressive administration of facility resources to provide for the well-being of its residents.” Id.

The Board thus upholds FFCL C as supported by substantial evidence and consistent with applicable law.

II. We affirm the ALJ’s finding that CMS’s determination of immediate jeopardy is not clearly erroneous.

The ALJ correctly stated and applied the law governing immediate jeopardy, including the regulation providing that the petitioner has the burden of showing that CMS’s determination of immediate jeopardy is clearly erroneous. Decision at 12, citing 42 C.F.R. § 498.60(c)(2). Our decisions make it clear that this is a heavy burden. E.g. Daughters of Miriam Center, DAB No. 2067 at 7

(2007; Liberty Commons Nursing Center - Johnston, DAB No. 2031 at 18 (2006). We agree with the ALJ that Eastwood failed to meet that burden. Although Resident 500 was, in fact, injured here, the ALJ correctly pointed out that actual harm is not required to support an immediate jeopardy determination; by definition, the likelihood of serious harm is sufficient. Woodstock, DAB No. 1726 at 39. The ALJ concluded that, even assuming an immediate jeopardy determination could not be based on the facility's allowing Resident 500 to leave the dialysis center with her spouse or on the fall from her wheelchair, an immediate jeopardy determination is supported by the facility's failure, discussed earlier, to make any attempt to determine her whereabouts when she did not return as promised. Decision at 12-13.

Like the ALJ, we can find no error, much less clear error, in CMS's determination that there was a likelihood that serious harm would befall Resident 500 under the circumstances. The resident was highly compromised medically and totally dependent on nursing staff for her care, including care of her dialysis access site and the administration of multiple medications on schedule. The resident was gone for four and one-half hours, by Eastwood's own calculations, without staff awareness of where she was,[7] and the

---

[7] Eastwood cites the administrator's testimony that "[t]he DON [director of nursing] and I talked about that situation" as evidence that the administrator informed someone at the facility. P. Br. at 7, citing Tr. 128. However, the administrator also testified that he did "not know if [the DON] called me first or if she was there." The surveyor testified that the DON told her that she "listened in on a conversation, I think, with the van driver, and then he [the administrator] was taking care of it, so she didn't get involved." Tr. 76. Given her acknowledgment that she did not get involved, none of this testimony establishes that the DON knew that the administrator decided to allow the resident to leave with her spouse rather than return in the van. Even assuming the DON knew this, there is no evidence that she or the administrator conveyed this information to the staff on duty. The administrator agreed that the nurse on duty is responsible for documenting when a resident leaves for and returns from a clinical appointment. Tr. 144. However, the surveyor reported, and Eastwood does not dispute, that there was no information to that effect on the 24-hour report for the afternoon shift on October 27, 2004. See CMS Ex. 1 at 28. While the afternoon nurse indicated that she became aware at some point that the

(continued...)

resident missed doses of her insulin, hypertension and antipsychotic medications. It was certainly foreseeable that serious harm could befall Resident 500, whether by way of the accident that actually occurred or by way of another accident caused by outside forces (e.g. a traffic accident) or by her own, highly compromised medical condition.

Eastwood argues that CMS's finding of immediate jeopardy was clearly erroneous, given "elements of reasonableness and practicality" required in dealing with human beings and their rights. Request for Review at 19. We disagree. As the ALJ concluded, regardless of whether the resident had a right to go with her husband, Eastwood still had the responsibility to take adequate measures to ensure her safe return to Eastwood. As we discussed earlier, a resident's rights must be addressed in the context of the facility's duty to provide adequate supervision to ensure the resident's safety, a duty that Eastwood undertook with respect to Resident 500 when it admitted her to its facility. Eastwood apparently understood this duty and foresaw a possible risk of harm to the resident because the administrator was concerned enough about her leaving the dialysis center with her spouse that he "continued to have second thoughts about his decision [to let her go and] contacted his licensing officer at MDCH."[8] P. Br. at 7. He also filed a complaint as advised. Id. at 8. Yet, neither the administrator nor any member of Eastwood's staff did anything to determine the resident's whereabouts when she did not return as promised; indeed, the administrator did not even initiate contact with staff to see if

---

[7] (...continued)
resident was absent, she did not attribute this awareness to any communication from the DON or administrator, and, indeed, told the surveyor that "she had no idea that the resident had been taken by her husband from the dialysis center." Tr. 23.

[8] The administrator actually testified that the licensing officer was out of the office but that he talked to her assistant who told him that "she did not see anything wrong with" allowing the resident to go with her spouse, although she advised the administrator to inform the "complaint department," which he did. Tr. 129-130. Although Eastwood cites these contacts as evidence that the administrator did something, that is not the issue. There is no dispute that the administrator took these particular actions, but the material fact is that he took no action to ascertain the resident's whereabouts or whether she had returned at the time promised.

she had returned. Clearly this was not adequate supervision or administrative procedure and exposed Resident 500, or any other resident similarly situated, to a foreseeable risk of serious harm.

Conclusion

Based on the above analysis, we uphold the ALJ Decision and affirm all of the ALJ's FFCLs.

/s/
Donald F. Garrett

/s/
Leslie A. Sussan

/s/
Sheila Ann Hegy
Presiding Board Member