Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Southpark Meadows Nursing & Rehabilitation Center
Docket No. A-16-17
Decision No. 2703
May 20, 2016

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Southpark Meadows Nursing & Rehabilitation Center (Southpark), a Texas skilled nursing facility (SNF), has appealed the August 31, 2015 decision by an administrative law judge (ALJ), *Southpark Meadows Nursing & Rehabilitation Center*, DAB CR4181 (2015) (ALJ Decision). The ALJ addressed two issues in his decision: (1) whether the record supported the determination of the Centers for Medicare & Medicaid Services (CMS) that Southpark was not in substantial compliance with 42 C.F.R. § 483.13(c) on July 3, 2014; and (2) assuming the first issue was decided in CMS's favor, whether the two $5,000 "per-instance" civil money penalties (CMPs) imposed by CMS for Southpark's noncompliance were reasonable in amount. On both issues, the ALJ granted summary judgment to CMS.

We agree with the ALJ that CMS was entitled to summary judgment on the first issue. However, because the record reveals only one instance of noncompliance with section 483.13(c), we hold that CMS was permitted to impose only one per-instance CMP. We therefore vacate one of the $5,000 CMPs imposed by CMS. We conclude that there is no dispute of material fact regarding the amount of the remaining $5,000 CMP and that that amount is reasonable.

Legal Background

CMS may impose enforcement "remedies," including CMPs, on a SNF found to be not in "substantial compliance" with Medicare participation requirements in 42 C.F.R. Part 483, subpart B. *See* 42 C.F.R. §§ 488.400, 488.402(b), (c), 488.406.

A SNF is not in "substantial compliance" when it has a "deficiency" (a failure to meet a participation requirement) with the "potential" for causing more than "minimal harm" to one or more residents. *Id.* § 488.301 (definitions of "deficiency" and "substantial compliance"). As used in CMS's regulations, the term "noncompliance" is synonymous with lack of substantial compliance. *Id.* (definition of "noncompliance").

A SNF may appeal a CMS determination of noncompliance that has resulted in the imposition of a CMP or other enforcement remedy. *Id.* §§ 488.408(g)(1), 498.3(b)(13), 498.5(b). In challenging a determination of noncompliance, a SNF may contend that the amount of the CMP imposed is unreasonable. *Lutheran Home at Trinity Oaks*, DAB No. 2111, at 21 (2007).

The participation requirement at issue in this case – 42 C.F.R. § 483.13(c) – states that a SNF "must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property."

Case Background

Between July 8 and July 10, 2014, the Texas Department of Aging and Disability Services (the state survey agency) performed a Medicare compliance survey of Southpark. CMS Ex. 2, at 1. Afterward the state survey agency issued a Statement of Deficiencies which cited Southpark, under deficiency tags F224 and F226, for noncompliance with section 483.13(c). CMS Ex. 2, at 14, 21; CMS Ex. 1, at 4. Both citations concern a 78 year-old woman identified as Resident 1, who died at Southpark on July 3, 2014. The Statement of Deficiencies narrates the following facts about Resident 1, the circumstances surrounding her death, and the subsequent investigation by the state survey agency.

Resident 1 was admitted to Southpark in April 2014. CMS Ex. 2, at 15. In accordance with her family's instructions, Resident 1 was assigned "full code" status. *Id.* "Full code" means that Resident 1 was a person for whom Southpark's nursing staff was expected to attempt life-saving measures, including cardiopulmonary resuscitation (CPR), in the event she stopped breathing or her heart stopped. *See* CMS Ex. 8, at 3. Resident 1's full code status, which did not change during her residence at Southpark, was noted in various facility records, including a nursing plan of care and a May 2014 hospice service agreement. CMS Ex. 2, at 15-16.

At approximately 8:05 p.m. on July 3, 2014, a certified nurse assistant notified a licensed vocational nurse (identified as "LVN A") that Resident 1 was "unresponsive." *Id.* at 16. The following then occurred:

> LVN A immediately went to Resident # 1's room and found her to be unresponsive. Her eyes were open and her body was cold to touch, pale and the lower extremities were stiffening. LVN A . . . assessed Resident # 1 and she could not hear a heartbeat and there were no respirations. LVN A then left Resident # 1's room and telephoned the DON [Southpark's Director of Nursing] who informed her to call the hospice service RN for the death pronouncement.

Id. at 16-17.

In her survey interview, Southpark's Director of Nursing recalled that she had just returned home at "around 8:00 pm" on July 3, 2014 "when she received a call from LVN A stating [that] Resident #1 [had been] found unresponsive, cold to touch and without a pulse or respirations." *Id.* at 18. At that point, the Director of Nursing instructed LVN A to "telephone the hospice RN on call to make the pronouncement of death." *Id.* The Director of Nursing did not ask LVN A about whether she had checked Resident 1's code status. *Id.*

At 9:15 p.m. the same evening, the Director of Nursing received a second telephone call from LVN A, who stated that Resident 1 had a full-code directive and that she (LVN A) had not verified the resident's code status or initiated CPR after finding Resident 1 in an unresponsive state. *Id.* After the second call from LVN A, the Director of Nursing "immediately returned to the facility and called her nurse managers to come in to in-service [train] staff on verification of code status when a resident is found unresponsive without a pulse and/or respirations." *Id.* LVN A was suspended after the incident and fired on July 10, 2014. *Id.* at 21; P. Ex. 24, ¶ 13.

LVN A, who began working at Southpark in April 2014, told the state survey agency that Resident 1's death was the "first . . . she had been involved in since becoming a nurse and [that] it was upsetting for her"; that "she had been trained during [Southpark's new employee] orientation to verify code status when a resident becomes unresponsive and without a pulse and/or respirations"; but that "in the midst of everything she had made the assumption that Resident #1's code status was DNR [do not resuscitate] because she was receiving hospice services and did not initiate CPR." CMS Ex. 2, at 16, 17.

The Director of Nursing informed the state survey agency that Southpark did not have a written policy defining the licensed nursing staff's obligation to a full-code resident who is found "unresponsive." *Id.* at 18, 20. However, the Director of Nursing stated that it was Southpark's "expectation" that staff would, in that circumstance, "verify the [resident's] code status and initiate CPR if indicated[,] followed by calling EMS and then notify[ing] the physician and [Director of Nursing] after EMS arrives and takes responsibility."[1] *Id.* at 18.

[1] The Statement of Deficiencies mentions that Southpark had an undated written policy titled "Advance Directive Guidelines." CMS Ex. 2, at 20. The policy required staff to review a resident's code status, as reflected on the "Advanced Care Planning Acknowledgement Form," to ensure that the code status noted on the acknowledgment form matched the status noted in physician orders for the resident and to ensure that the resident's code status did not change upon "readmission" (unless the resident requested a change using the Advanced Care Acknowledgment Form). *Id.*

Based on these facts, the state survey agency found, under deficiency citation F224, that Southpark was noncompliant with section 483.13(c) because LVN A had "failed to comply with Resident # 1's Advance Directive when the resident was found unresponsive without a pulse or respirations and did not initiate CPR." *Id.* at 14-15. The state survey agency further found, under citation F226, that Southpark was noncompliant with the same regulation because it had "failed to implement written policies and procedures that prohibit neglect of residents[.]" *Id.* at 22.

CMS concurred with both citations and imposed two $5,000 "per-instance" CMPs, one for each citation. CMS Ex. 1, at 5.

Southpark then appealed CMS's action by requesting a hearing before the ALJ. After the parties exchanged documentary evidence and witness declarations, CMS moved for summary judgment. Southpark filed a response to the motion based on evidence that it had already submitted. That evidence included a declaration from the registered nurse who was Southpark's Director of Nursing at the time of Resident 1's death. P. Ex. 24.

The ALJ granted CMS's motion and entered summary judgment for CMS. He held that undisputed facts established that Southpark had violated section 483.13(c) in "two respects." ALJ Decision at 3. First, the ALJ held that Southpark had violated section 483.13(c) by failing to "implement" an unwritten policy, "intended to protect residents against neglect," requiring the nursing staff, in the event of a resident's cardiac or respiratory arrest, "to determine the code status of the resident" and "to attempt cardiopulmonary resuscitation with a [full code] resident who ceased breathing or whose heart stopped beating[.]" *Id.* Second, the ALJ held that Southpark violated section 483.13(c) when LVN A "fail[ed] to attempt to resuscitate Resident #1," a failure that he called an "an act of neglect . . . in contravention of" that regulation. *Id.* In addition to sustaining CMS's determination of noncompliance, the ALJ found that the CMP amounts ($5,000 for each deficiency citation) were reasonable based on the regulatory factors he was obliged to consider. *Id.* at 5-6.

Southpark then filed this appeal. Regarding the citations of noncompliance with section 483.13(c), Southpark argues that summary judgment was improper because it produced evidence that it had policies designed to prevent neglect of residents, that it implemented those policies when it hired and trained LVN A, and that it "had no reason to believe [prior to July 3, 2014 that] LVN A would not provide CPR to Resident #1 consistent with

the resident's Advanced Directives and Full Code Status."[2] Request for Review (RR) at 15. Southpark also contends that the ALJ improperly granted summary judgment to CMS on the issue of the CMPs' reasonableness. RR at 19.

Discussion

"Whether summary judgment is appropriate is a legal issue the Board addresses de novo." *West Texas LTC Partners, Inc.*, DAB No. 2652, at 5 (2015). "Summary judgment is appropriate when the record shows there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law." *Id.* In deciding whether there is a genuine dispute of material fact, we view proffered evidence in the light most favorable to the non-moving party. *Id.* The applicable "substantive law will identify which facts are material," and "[o]nly disputes over facts that might affect the outcome of the [case] under the governing law will properly preclude the entry of summary judgment." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986); *see also Livingston Care Ctr.*, DAB No. 1871, at 5 (2003) (stating that "[t]o defeat an adequately supported summary judgment motion, the non-moving party . . . must furnish evidence of a dispute concerning . . . a fact that, if proven, would affect the outcome of the case under governing law"), *aff'd, Livingston Care Ctr. v. U.S. Dept. of Health & Human Servs.*, 388 F.3d 168 (6th Cir. 2004); *Kingsville Nursing & Rehab. Ctr.*, DAB No. 2234, at 3 (2009) (stating that summary judgment is warranted when "'the record taken as a whole could not lead a rational trier of fact to find for the nonmoving party'" (*quoting Matsushita Elec. Industrial Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986)).

Before we consider the issues raised by Southpark, we observe that it offered no evidence contradicting the Statement of Deficiencies' findings about the events in July 2014, description of facility nursing policies, or accounts of employee interviews. *Compare* P. Ex. 24 (¶¶ 7-13), CMS Ex. 2 (at 14-29), and Southpark Response to CMS's Motion for Summary Judgment (SJ Response) dated Aug. 18, 2015. In responding to the summary

[2] Southpark also asks the Board to rule on the merits of a deficiency citation, F281, which alleged noncompliance with 42 C.F.R. § 483.20(k)(3)(i). Request for Review at 16. Southpark made the same request to the ALJ, who rejected it because "CMS based neither of the two civil money penalties that are at issue in this case on [Southpark's] failure to comply with the regulation." ALJ Decision at 2 n.1. The ALJ correctly refused to consider the merits of the F281 citation. With irrelevant exceptions, a SNF has a right to appeal only those findings of noncompliance "leading to the imposition of enforcement actions specified in § 488.406[.]" 42 C.F.R. § 498.3(b)(13). Because there is nothing in the record indicating that the F281 citation was the basis for a CMP or other enforcement action specified in section 488.406, neither the ALJ nor the Board has the authority to review it. *See Columbus Park Nursing & Rehab Ctr.*, DAB No. 2316, at 7 (2010) (stating that "the Board has long held that a [long-term care facility] has no right to an ALJ hearing to contest survey deficiency findings where CMS has not imposed any of the remedies specified at section 488.406 based on those findings, or where CMS imposed, but subsequently rescinded, any such remedies").

judgment motion, Southpark characterized the factual findings in the Statement of Deficiencies as "allegations." SJ Response at 3. However, the Board has held that the Statement of Deficiencies "may constitute prima facie *evidence* of the undisputed facts asserted in it." *The Peaks Care Ctr.*, DAB No. 2564, at 6 n.4 (2015) (italics added). Consequently, in order to create disputes about those findings and defeat what we believe to be (for reasons stated in the following section) an adequately supported summary judgment motion, Southpark needed to do more than simply deny the findings; it needed to submit relevant counter-evidence. *St. Catherine's Care Ctr. of Findlay, Inc.*, DAB No. 1964, at 8 (2005) (stating that a Statement of Deficiencies "may constitute evidence on specific disputed facts as to which, if material, the facility must proffer sufficient evidence to show a genuine dispute requiring a hearing"); *Livingston Care Ctr.*, DAB No. 1871, at 5 (stating that the non-moving party "may not rely on the denials in its pleadings or briefs" to defeat an adequately supported motion for summary judgment). Southpark did not do that. Instead, as we discuss below, to the extent Southpark disputed any of the factual findings, Southpark submitted evidence only about facts that we consider immaterial to the outcome.

1. *Undisputed facts demonstrate that Southpark was not in substantial compliance with 42 C.F.R. § 483.13(c) as of July 3, 2014.*

Section 483.13(c) requires a SNF to "develop and implement written policies and procedures that prohibit . . . neglect . . . ." Neglect is defined in the regulations to mean the "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 42 C.F.R. § 488.301.

A facility may be noncompliant with section 483.13(c) when it either "fail[s] to develop policies or procedures adequate to prevent neglect" or "fail[s] to implement such policies." *Glenoaks Nursing Ctr.*, DAB No. 2522, at 14 (2013). In applying section 483.13(c), the Board has emphasized that an incident or episode of neglect (or suspected neglect) does not, in isolation, constitute a violation of that regulation. "The focus . . . is not simply on the number or nature of the instances of neglect (i.e., failure to provide necessary care or services) but on whether the facts . . . surrounding such instance(s) demonstrate an *underlying breakdown* in the facility's implementation of the provisions of an anti-neglect policy." *Oceanside Nursing & Rehab. Ctr.*, DAB No. 2382, at 11 (2011) (italics added). The Board therefore will consider circumstances surrounding an incident of neglect to determine whether they "demonstrate a systemic problem in implementing policies and procedures" intended to prevent neglect. *Columbus Nursing & Rehab. Ctr.*, DAB No. 2247, at 27 (2009). "Circumstances the Board has found relevant [to that inquiry] have included factors such as how many staff members were involved in incidents of neglect and whether staff members' actions or inactions were directly contrary to directions in care policies adopted by the facility." *Hanover Hill Health Care Ctr.*, DAB No. 2507, at 9-10 (2013).

When Resident 1 died, Southpark had a general anti-neglect and anti-abuse policy. P. Ex. 3. It is also undisputed that Southpark had a tacit or unwritten policy, which we will call the "resuscitation policy," that specified how the nursing staff was supposed to respond when discovering a resident without heartbeat or respirations. Nurses in that situation were expected to verify the resident's code status, initiate CPR "if indicated," call EMS, and then notify the physician and Director of Nursing "after EMS arrives and takes responsibility." CMS Ex. 2, at 18. Because that policy specified services "necessary to avoid physical harm" (including death or lesser harm resulting from cardiac or respiratory arrest), a failure to carry out that policy is one fact that may support a finding that Southpark failed to implement its anti-neglect policy. *Avalon Place Kirbyville*, DAB No. 2569, at 9-10 (2014) (holding that the facility's failure to follow its "emergency response policy" supported a conclusion that the facility "did not implement its anti-neglect policy").

A Southpark employee, LVN A, did not carry out the resuscitation policy on July 3, 2014, as Southpark essentially admits.[3] In particular, LVN A did not verify Resident 1's code status when she found the resident unresponsive. As a result, Southpark withheld CPR from Resident 1 based on the erroneous assumption that she did not want life-saving measures in that situation.

At least three undisputed facts related to that incident reveal an "underlying breakdown" in the implementation of Southpark's resuscitation policy (which was a policy intended to prevent neglect). First, when Resident 1 died, Southpark had not reduced that policy to writing, a fact that raises doubt about whether the policy had been effectively disseminated to the licensed nursing staff. Second, when LVN A *first* called the Director of Nursing ("around 8:00 pm") after finding Resident 1 unresponsive, the Director of Nursing did not ask LVN A about Resident 1's code status and instructed LVN A to have the hospice nurse make a "death pronouncement." CMS Ex. 2, at 18. That a *nursing supervisor* failed to inquire about Resident 1's code status, upon learning that the resident had been found unresponsive only minutes earlier, strongly suggests that the policy's applicability and requirements were poorly understood by all nurses in the facility (in addition to LVN A). Third, there is no evidence that Southpark communicated the resuscitation policy to its staff in *systematic* fashion prior to July 3, 2014. The only evidence of staff training regarding the policy was LVN A's survey statement (discussed in the next paragraph) and the training that occurred in the immediate wake of Resident 1's death.

[3] In her declaration, the Director of Nursing stated that Southpark "had no reason to believe LVN A would not provide CPR to Resident #1 consistent with the resident's Advanced Directives and Full Code Status" and that LVN A was immediately suspended for failing to verify the resident's code status on July 3, 2014. P. Ex. 24, ¶ 13. In addition, Southpark asserts that "Resident #1 was deceased *at the time CPR was not given by LVN A on July 3, 2014.*" RR at 18 (italics added).

Southpark emphasizes that LVN A reportedly told the state survey agency that "'she had been trained during [new employee] orientation to verify code status when a resident becomes unresponsive and without a pulse and/or respirations.'" RR at 14, *quoting* CMS Ex. 2, at 17. While we accept, as true, LVN A's statement that she was trained, at hire, to verify an unresponsive resident's code status, Southpark produced no evidence that, prior to July 3, 2014, *other licensed nurses* routinely received such training. Indeed, the available evidence suggests precisely the opposite. According to the report that referred LVN A to the Texas Board of Nursing for unprofessional conduct, the Director of Nursing told the state survey team that Southpark had performed "multiple in-services [training sessions] on abuse and neglect" during the 12 months preceding Resident 1's death but "*none specific to code status verification until 07/03/14.*" CMS Ex. 8, at 5 (italics added). In her declaration, the Director of Nursing did not rebut her reported assertion that staff training "specific to code status verification" did not occur prior to July 3, 2014. P. Ex. 24, ¶¶ 7-13. Furthermore, there is no evidence that, prior to July 3, 2014, staff received guidance or instructions about *other* elements of the resuscitation policy, particularly the instructions to initiate "CPR as indicated" and to contact EMS and the unresponsive resident's physician.

In short, the undisputed facts surrounding the failure to check Resident 1's code status and give her the care the facility says it required for full-code residents found non-responsive show an underlying breakdown in Southpark's implementation of its anti-neglect policy and, thus, a violation of section 483.13(c). That violation posed a risk of more than minimal harm to any full-code resident of Southpark needing emergency resuscitation. The violation also posed a particular risk to residents who, like Resident 1, were in hospice but nonetheless chose to be on full-code status because other staff members might make the same mistake LVNA did and assume without checking that these residents did not have full-code status since they were in hospice. The violation also created the risk of another type of harm: deprivation of a full-code resident's right to direct (though her advance directive) the course of her care at the facility. *See* 42 C.F.R. § 483.10(b)(4), (8).

Southpark's evidence and argument in this appeal do not undermine these conclusions or create a genuine dispute of material fact. In opposing summary judgment, Southpark submitted evidence which, it says, demonstrates that it had general anti-abuse and anti-neglect policies in place at the time of Resident 1's death; that those policies complied with regulatory standards; that the policies included procedures for performing background checks and other screening of new employees; and that it followed those procedures when it hired LVN A, whom it verified as having received CPR training and certification from the American Heart Association. RR at 12-13. Southpark says that its evidence also shows that LVN A was educated about all resident care and resident rights policies during her new-employee orientation and that she acknowledged receiving and understanding those policies. RR at 13-15. Southpark further alleges that prior to Resident 1's death, LVN A was "never . . . counseled or accused of violating any of

Southpark['s] policies or nurse practice standards or failing to comply with a resident's Advanced Directives or Southparks's Advanced Care Planning Policy." RR at 15. In short, Southpark contends that LVN A "was fully trained and educated on [its] resident care policies at the time she was hired in April 2014" and that it had "no reason to believe [she] would not provide CPR to Resident #1 consistent with the resident's Advanced Directives and Full Code Status." *Id.* Finally, Southpark asserts that it took "reasonably necessary steps to avoid further conduct by LVN A by promptly suspending LVN A, conducting an investigation and taking appropriate disciplinary action against LVN A (i.e., termination of her employment)." RR at 15-16 (internal quotation marks omitted).

Even if we credit all of Southpark's evidence, it does not alter the outcome under the governing law. It is immaterial that Southpark had general anti-neglect and anti-abuse policies and arguably took some steps to implement those particular policies because, as we held in *Avalon Place Kirbyville*, a finding of noncompliance with section 483.13(c) may be based on "a facility's failure to follow" *other policies* (such as the resuscitation policy) "where . . . those other policies determine what the facility deems the 'goods and services necessary to avoid physical harm.'" DAB No. 2569, at 9-10 (*quoting* the regulatory definition of "neglect"). The fact that Southpark took remedial steps *after* Resident 1 died (such as investigating the incident and terminating LVN A's employment) is also immaterial. Southpark was cited for noncompliance that occurred or existed prior to Southpark taking those steps.

Southpark contends that it should not be "liable" for an "error" by LVN A that was "unforeseeable" in light of her "work history, training and prior conduct" and for which it took prompt and effective disciplinary action. RR at 42. We agree with the ALJ that this contention is essentially a claim that a SNF "should not be held responsible for errant employees' misfeasance or malfeasance." ALJ Decision at 4. However, as the ALJ noted, the Board has consistently rejected that proposition:

> The facility acts through its staff, and is correspondingly responsible for their actions as employees. . . . [W]hen a nurse acts within the scope of her employment, the employer cannot disown the consequences of the inadequacy of the care provided by the simple expedient of pointing the finger at her fault, since she was the agent of her employer empowered to make and carry out daily care decisions. It is the facility that executes a provider agreement and undertakes to provide services of the quality mandated by the participation requirements. If the professional staff hired by the facility is, as proved to be the case here, not adequately skilled, trained, or equipped to provide those services, the facility must answer for, and correct, that failure through the survey and certification process, no matter what other disciplinary actions may also appropriately be taken . . . against the individual staff members.

Royal Manor, DAB No. 1990, at 12 (2005). Furthermore, as explained earlier, LVN A's error is not, in itself, the basis for the finding of noncompliance. Rather, the bases for Southpark's noncompliance with section 483.13(c) are the circumstances surrounding that error which show a breakdown in Southpark's implementation of its anti-neglect policies.

Southpark asserts that Resident 1 was "not subjected to neglect." RR at 13. However, it does not state reasons for that assertion. RR at 13. As its own policy (and federal regulations) indicate, neglect is a failure to provide necessary goods or services to a resident. By its own admission, Southpark had decided that checking code status and providing CPR to full-code residents if they were found unresponsive were necessary services; thus, failure to provide those services is neglect. *See Ross Healthcare Ctr.*, DAB No. 1896, at 8 (2003) (holding that the nursing facility's failure to administer CPR to a resident "constituted neglect within the meaning of the regulation at 42 C.F.R. § 488.301 since [the facility] had a policy to provide CPR to any patient without a DNR [do-not-resuscitate order]"). One might argue that Resident 1 was not neglected if there was evidence that the nursing staff withheld CPR based on proper medical decision-making about the procedure's futility. *Cf. id.* (indicating that the failure to withhold CPR constituted neglect because, "as far as [the facility] knew, [the resident] might have been resuscitated"). But there is no such evidence in this case: as the ALJ aptly noted, "there are no facts showing that [LVN A or other] staff made an informed judgment" or decision, based on a proper assessment of Resident 1, to withhold CPR from her on July 3, 2014. ALJ Decision at 5. To the contrary, undisputed facts indicate that staff withheld CPR based on the mistaken assumption that Resident 1 had a do-not-resuscitate order. *See* CMS Ex. 2, at 17 (recounting LVN A's admission during the survey that she did not initiate CPR because she assumed that Resident 1's "code status was DNR").

Even assuming, for the sake of argument, that factors other than the mistaken assumption contributed to the staff's decision to withhold CPR, Southpark has not shown that those factors made the decision appropriate. In her declaration, Southpark's Director of Nursing suggested that withholding CPR was proper based on the findings of LVN A's clinical assessment of Resident 1. Quoting the 2005 American Heart Association *Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care*, the Director of Nursing stated that "CPR may be withheld when '[a] person is dead'" and that "Resident #1 was deceased at the time CPR was not given by LVN A on July 3, 2014." P. Ex. 24, ¶ 16. The Heart Association guidelines state that CPR may be withheld from a person "with obvious clinical signs of irreversible death (eg, rigor mortis, dependent lividity, decapitation, or decomposition)." P. Ex. 19, at 2. However, the record does not show that Resident 1 manifested those "obvious signs" when she was discovered unresponsive on July 3, 2014. According to the Statement of Deficiencies, LVN A reported that Resident 1 was "cold to touch" with "glossed over" eyes, white lips,

and "stiffened" or "stiffening" lower extremities (in addition to being without pulse or respirations). CMS Ex. 2, at 19, 25. Neither the Director of Nursing nor any other medical professional stated that these conditions were "obvious signs of irreversible death" or that LVN A performed an assessment of Resident 1 adequate to determine that the guideline conditions for withholding CPR were met.

Because undisputed facts demonstrate an "underlying breakdown" in Southpark's implementation of an anti-neglect policy, we affirm the ALJ's conclusion that Southpark was not in substantial compliance with 42 C.F.R. § 483.13(c) and that CMS was entitled to summary judgment on the noncompliance issue. *Avalon Place Kirbyville* at 11-12 (affirming a grant of summary judgment to CMS based on undisputed facts showing an "underlying breakdown" in the implementation of an emergency response policy).

2. *CMS was permitted to impose only one per-instance CMP based on Southpark's noncompliance with 42 C.F.R. § 483.13(c).*

CMS's regulations authorize it to impose a CMP of between $1,000 and $10,000 for each "instance of noncompliance." 42 C.F.R. §§ 488.408(d)(1)(iv), 488.408(e)(1)(iv), 488.438(a)(2). As noted, CMS imposed two per-instance CMPs on Southpark based on its noncompliance with section 483.13(c). CMS Ex. 1, at 5. That action implies that there were two distinct instances of noncompliance with that regulation. The policy implementation "breakdown" discussed in the previous section is obviously an "instance" of noncompliance. However, CMS does not point to, or claim to rely upon, a second, distinct instance to support its remedies.[4]

The ALJ may have thought that LVN A's "act of neglect" qualified as the second instance of noncompliance. ALJ Decision at 3. However, the Board has held that "an isolated instance of neglect, per se, is not sufficient" evidence of noncompliance with section 483.13(c) because "the plain language of [that regulation] refers to developing and implementing policies and procedures" to prevent neglect. *Hanover Hill Health*

[4] CMS asserts that Southpark's mere "expectation" that staff would verify a resident's code status and initiate CPR for a full-code resident "would seem to violate" section 483.13(c)'s requirement that a SNF develop "written" policies and procedures. Response Br. at 7 n.3. This statement falls short of an argument that its noncompliance determination can be sustained based on the absence of a written resuscitation policy, and CMS has made no showing that it, in fact, based its determination on the facility's failure to have a *written* policy requiring staff to verify code status and provide resuscitation for full-code residents found unresponsive, much less that the failure to reduce the policy to writing amounted to a second instance of noncompliance with the regulation, as opposed to (as we have found) evidence of the systemic breakdown on which the noncompliance finding we have upheld was based.

Care Ctr. at 9. "CMS must establish some relationship between the failure to provide [the specified] services and a failure to implement polic[ies] or procedures to prevent neglect in order to support a noncompliance finding under section 483.13(c)." *Id.* (internal quotation marks omitted).[5]

Because the record shows only one instance of noncompliance with section 483.13(c), CMS was authorized to impose only one per-instance CMP. Consequently, we vacate one of the $5,000 CMPs imposed by CMS. We next consider whether the amount of that CMP was reasonable.

3. A per-instance CMP of $5,000 is reasonable based on the undisputed facts in the record.

In deciding whether the CMP amount is reasonable, an administrative law judge or the Board may consider only the factors specified in 42 C.F.R. § 488.438(f). *See* 42 C.F.R. § 488.438(e)(3); *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 19-20 (2010), *aff'd*, *Senior Rehab. & Skilled Nursing Ctr. v. Health & Human Servs*., 405 F. App'x 820 (5th Cir. 2010). Those factors are: (1) the SNF's history of noncompliance; (2) the SNF's financial condition; (3) the "seriousness" of the noncompliance; and (4) the SNF's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. 42 C.F.R. §§ 488.438(f), 488.404(a)-(c).

We review the reasonableness of the CMP de novo, based on the facts and evidence contained in the appeal record. *Emerald Oaks*, DAB No. 1800, at 13 (2001); *CarePlex of Silver Spring*, DAB No. 1683, at 17-18 (1999). We also presume that CMS considered the regulatory factors in choosing the CMP amount and that those factors support the penalty imposed. *Coquina Ctr.*, DAB No. 1860, at 32 (2002); *Brenham Nursing & Rehab. Ctr.*, DAB No. 2619, at 18 (2015), *aff'd*, *Brenham Nursing & Rehab. Ctr. v. U.S. Dept. of Health & Human Servs.*, ___ F. App'x ___, 2016 WL 454320 (5th Cir. 2016). "Accordingly, the burden is not on CMS to present evidence bearing on each regulatory factor, but on the SNF to demonstrate, through argument and the submission of evidence addressing the regulatory factors, that a reduction is necessary to make the CMP amount reasonable." *Oaks of Mid City Nursing & Rehab. Ctr.*, DAB No. 2375, at 26-27 (2011); *see also Brenham Nursing & Rehab Ctr.*, DAB No. 2619, at 18 (holding that it was the SNF's burden to "introduce evidence or argument challenging specific regulatory factors" (internal quotation marks omitted)).

[5] It is not necessary to establish such a relationship in order to conclude that a failure to provide needed care or services or to follow a resident's care plan violates section 483.25, the quality of care regulation, but CMS did not cite Southpark for a violation of that regulation.

The ALJ held that the "seriousness of [Southpark's] noncompliance – whether considered in isolation or in the context of evidence pertaining to other factors – is sufficient to justify the penalty amount[ ]." ALJ Decision at 6. We conclude that the undisputed facts support that legal conclusion.[6]

"Seriousness" is a function of "severity" (whether the noncompliance has created a "potential" for "more than minimal" harm, resulted in "actual harm," or placed residents in "immediate jeopardy") and "scope" (whether the noncompliance is "isolated," constitutes a "pattern," or is "widespread"). 42 C.F.R. § 488.404(b). "Immediate jeopardy" is the highest level of severity.[7] *See id.* §§ 488.404 (setting out the levels of scope and severity that CMS considers when selecting remedies) and 488.438(a) (authorizing the highest civil money penalties for immediate jeopardy-level noncompliance); 59 Fed. Reg. 56,116, 56,183 (Nov. 10, 1994) (scope-and-severity grid).

CMS determined that Southpark's noncompliance with section 483.13(c) placed residents in immediate jeopardy and was more than "isolated," constituting a "pattern" of noncompliance. CMS Ex. 1, at 4 (indicating that the deficiencies were cited at scope-and-severity level K); *Cedar Lake Nursing Home*, DAB No. 2344, at 3 (2012) (noting that scope-and-severity level K designates a pattern of deficiencies posing immediate jeopardy). A $5,000 CMP, which is slightly less than the mid-point of the applicable penalty range, is manifestly reasonable given that level of severity and scope. *Cf. Brian Ctr. Health & Rehab./Goldsboro*, DAB No. 2336, at 12-13 (2010) (upholding a $4,550 *per-day* CMP for immediate jeopardy-level noncompliance involving a failure to perform CPR); *Lakeridge Villa Healthcare Ctr.*, DAB No. 2396, at 15-16 (2011) (holding that immediate jeopardy findings justified per-instance CMPs substantially higher than the regulatory minimum of $1,000).

Southpark contends that its noncompliance was "isolated" and did not place residents in immediate jeopardy. RR at 24. That contention overlooks regulations which provide that a SNF may appeal a finding concerning the severity and scope of its noncompliance "only if a successful challenge on th[ose] issue[s] would affect – (i) [t]he range of [CMP] amounts that CMS could collect ...; or (ii) [a] finding of substandard quality of care that results in the loss of approval" for the facility's Nurse Aide Training Competency Evaluation Program. 42 C.F.R. § 498.3(b)(14); *see also* 42 C.F.R. § 498.3(d)(10) (immediate jeopardy determination or determination of level of noncompliance is not an

[6] "The determination of whether a CMP amount is reasonable is a conclusion of law, not a finding of fact." *Cedar Lake Nursing Home*, DAB No. 2344, at 12 (2010).

[7] The term "immediate jeopardy" refers to "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301.

appealable action except as provided in paragraph (b)(13)). The "net effect of . . . these regulations is that challenges to scope and severity are limited to *only* situations where the determination of immediate jeopardy results in a higher range of CMP or the loss of approval of a NATCEP program." *Fort Madison Health Ctr.*, DAB No. 2403, at 12 (2011) (italics in original).

In this case, CMS's findings concerning the level of Southpark's noncompliance did not result in a "higher range of CMP" because per-instance CMPs are selected from one penalty range ($1,000 to $10,000) that applies to any instance of noncompliance, regardless of its severity and scope. *Id.*; 42 C.F.R. § 488.438(a)(2). In addition, Southpark has not asserted that it lost approval of a nurse aide training program based on a finding of substandard quality of care. For these reasons, CMS's findings regarding the level of noncompliance are not reviewable. *Fort Madison Health Ctr.* at 12; *NMS Healthcare of Hagerstown*, DAB No. 2603, at 6-8 (2014). Because those findings are unreviewable, they are "final" as a matter of law and may be considered in assessing the reasonableness of the CMP amount. *White Sulpher Springs Ctr.*, DAB No. 2520, at 17-18 (2013).

Southpark also contends that summary judgment on the reasonableness issue is improper because its "degree of culpability" is in dispute. RR at 22-24. Southpark submits that a decision-maker could reasonably conclude, based on the evidence submitted, that it had "no significant degree of culpability." RR at 23.

Only *material* disputes of fact preclude summary judgment, and Southpark's degree of culpability is not material to our legal conclusion regarding the CMP's reasonableness. Even assuming Southpark was entirely without fault, we would sustain the $5,000 CMP as reasonable (based on CMS's unappealable findings concerning the severity and scope of the noncompliance) because "[t]he absence of culpability is not a mitigating circumstance in reducing the amount of the penalty" selected by CMS. 42 C.F.R. § 488.438(f)(4); *Alexandria Place*, DAB No. 2245, at 26-27 (2009).

Southpark complains that there is "no evidence" that CMS considered all the regulatory factors. RR at 21. There is such evidence, however: the September 17, 2014 notice of noncompliance states that CMS considered all of the regulatory factors, including Southpark's degree of culpability, compliance history, and financial condition. CMS Ex. 1, at 5. How or whether CMS considered the factors is irrelevant in any event. "[T]he Board has repeatedly made clear that the ALJ (and the Board) consider de novo whether the amount of a CMP is reasonable in light of the regulatory factors and, thus, do not review whether or how CMS considered those factors in setting the proposed amount." *River City Care Ctr.*, DAB No. 2627, at 18 (2015). Although the burden was on

Southpark to show that the regulatory factors merited a reduction in the penalty amount, it did not produce evidence concerning any factor (apart from its alleged non-culpability, which, we have said, is immaterial) that would justify reducing the penalty amount below $5,000. We therefore conclude that a per-instance CMP of $5,000 for Southpark's noncompliance with section 483.13(c) is reasonable and that CMS was entitled to summary judgment concerning the penalty's reasonableness.

Conclusion

For the reasons set out above, we affirm the ALJ's conclusion that Southpark was not in substantial compliance with 42 C.F.R. § 483.13(c) as of July 3, 2014. We vacate one of the two per-instance CMPs imposed by CMS for Southpark's noncompliance with section 483.13(c). Finally, we hold that the amount of the remaining per-instance CMP ($5,000) was reasonable.

/s/
Leslie A. Sussan

/s/
Susan S. Yim

/s/
Sheila Ann Hegy
Presiding Board Member