Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Southpark Meadows Nursing & Rehabilitation Center,
(CCN: 67-6299),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-414

Decision No. CR4181

Date: August 31, 2015

DECISION

I enter summary judgment sustaining the determination by the Centers for Medicare & Medicaid Services (CMS) to impose two per-instance civil money penalties, each in the amount of $5000, against Petitioner Southpark Meadows Nursing & Rehabilitation Center.

I. Background

Petitioner, a skilled nursing facility, filed a hearing request to challenge CMS's determination to impose the two civil money penalties that I refer to in this decision's opening paragraph. CMS moved for summary judgment and Petitioner opposed the motion. CMS filed exhibits that are identified as CMS Ex. 1 – CMS Ex. 11. Petitioner filed exhibits that are identified as P. Ex. 1 – P. Ex. 24. I receive these exhibits into the record for purposes of deciding the motion.

II. Issues, Findings of Fact and Conclusions of Law

A. Issues

The issues are whether: Petitioner failed to comply substantially with Medicare participation requirements; and CMS's remedy determinations are reasonable.

B. Findings of Fact and Conclusions of Law

CMS bases its determination to impose two per-instance civil money penalties against Petitioner on allegations that Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.13(c). Among other things, this regulation requires a skilled nursing facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. CMS asserts that Petitioner failed to comply with this regulation in two respects. First, it asserts that Petitioner failed to implement policies that were designed to protect residents against neglect. Second, it contends that Petitioner's staff neglected one of its residents. The term "neglect" is defined at 42 C.F.R. § 488.301 to mean: "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."[1]

I find the following facts to be outcome-determinative and undisputed. On April 1, 2014, Petitioner admitted an individual known as Resident # 1 to its facility. CMS Ex. 2 at 2 – 3; P. Ex. 14; CMS Ex. 8 at 25. At the time of the resident's admission, her daughter completed paperwork that listed the resident as being in "full code status," meaning that every effort would be made to resuscitate her should she experience cardiac arrest. CMS Ex. 2 at 3; CMS Ex. 8 at 32. A hospice agreement dated May 22, 2014, for Resident # 1, which provided for hospice care for the resident while she resided at Petitioner's facility, recited that the resident's family wished that the resident be in full code status. CMS Ex. 2 at 3. The resident's plan of care, dated June 13, 2014, incorporated the resident's family's wishes and recited that the resident was in full code status. *Id.*; P. Ex. 16.

Petitioner has guidelines concerning residents' code status. They specify that Petitioner's staff is to review a resident's code status upon the resident's admission to the facility.

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[1] In its motion for summary judgment CMS seeks a decision that Petitioner also failed to comply with the requirements of 42 C.F.R. § 483.20(k)(3)(i). This regulation requires a facility to provide or arrange services that meet professional standards of quality. However, CMS based neither of the two civil money penalties that are at issue in this case on Petitioner's alleged failure to comply with this regulation. CMS's motion for summary judgment at 2. I decline to consider whether Petitioner failed to comply with this regulation in light of CMS's failure to explain how this alleged noncompliance relates to the remedies that are at issue.

CMS Ex. 2 at 7. The guidelines recite that relevant records pertaining to a resident must match in stating the resident's code status. *Id.* Petitioner has no policy or formal written guidelines that specify how Petitioner's staff is to deal with a person in cardiac or respiratory arrest who is in full code status. *Id.* at 6. However, management's expectation is that the staff will verify the resident's code status, initiate cardiopulmonary resuscitation if indicated, call emergency medical personnel, and notify the facility's director of nursing and the resident's physician. *Id.*

At about 8 p.m. on the evening of July 3, 2014, two certified nursing assistants (CNAs) entered Resident # 1's room in order to provide care to the resident. CMS Ex. 2 at 3. They found the resident unmoving. She was cold to the touch, her eyes were open and not blinking, and she was nonresponsive to stimulus. *Id.* One of the CNAs notified a licensed vocational nurse (LVN), who went to Resident # 1's room. The LVN checked Resident # 1 for a heartbeat and for breathing and found no evidence of either. The LVN did not check the resident's records to determine the resident's code status. Nor did she initiate cardiopulmonary resuscitation. CMS Ex. 2 at 3-5; *see* P. Ex. 11. Rather, the LVN left the resident's room and went to inform the facility's director of nursing of the status of Resident # 1. CMS Ex. 2 at 4.

What these undisputed facts plainly establish is this. Resident # 1 was in full code status at the time of her death, meaning that her family wanted Petitioner's staff to undertake all possible measures to resuscitate the resident in the event that the resident stopped breathing or her heart stopped beating. Petitioner's policy – not reduced to writing, but nevertheless understood – was that in the event of cardiac and/or respiratory arrest, the staff was required to determine the code status of the resident and then to do whatever was necessary to comply with that status. That meant that the staff was mandated to attempt cardiopulmonary resuscitation with a resident who ceased breathing or whose heart stopped beating and who was in full code status. In the case of Resident # 1, the staff failed to comply with that policy. It neither verified the resident's code status nor attempted to resuscitate her on the evening of July 3, 2014, when she was found nonresponsive, not breathing, and with no discernable heartbeat.

Do these facts establish that Petitioner failed to comply substantially with regulatory requirements? Yes, in two respects. First, Petitioner's staff failed to implement Petitioner's policy dealing with residents' code status. That failure constituted a failure to implement a policy that was intended to protect residents against neglect, in contravention of the requirements of 42 C.F.R. § 483.13(c), inasmuch as failure to attempt resuscitation could easily cause physical harm to a resident. Second, the failure to attempt to resuscitate Resident # 1 was an act of neglect, also in contravention of 42 C.F.R. § 483.13(c).

Petitioner asserts several arguments in opposition to CMS's motion. I have considered each of them and I find them to be without merit.

First, Petitioner characterizes the failure to apply its code policy in the case of Resident # 1 to be an isolated error by a single employee. It asserts that it should not be held liable where the truly culpable party is an employee who violates facility policy. This argument often is raised by skilled nursing facilities in cases involving deficient care. Essentially, the facilities assert that they should not be held responsible for errant employees' misfeasance or malfeasance. The argument has been rejected universally. *Emerald Oaks,* DAB No. 1800, at 7 n.3 (2001); *North Carolina State Veterans Nursing Home, Salisbury,* DAB No. 2256 (2009).

Petitioner's argument, if carried to its logical end, would immunize skilled nursing facilities from the unlawful acts of their employees if the employees committed those acts in violation of facility policy. I find this argument to be unpersuasive. A skilled nursing facility is not an entity that can be separated from its staff for purposes of enforcement of Medicare participation regulations. A skilled nursing facility is, in fact, a collection of people, all of whom to one degree or another operate as agents of the facility. The facility must necessarily bear responsibility for the acts of its employees taken on its behalf, even when those acts are in violation of facility policy.

In an analogous setting the United States Supreme Court affirmed these principles in addressing corporate responsibility under the Food and Drug Act. *United States v. Dotterweich,* 320 U.S. 277, 284-85 (1943). In *Dotterweich* the Supreme Court held expressly that, under the Food and Drug Act, corporations are liable for the acts committed by individual employees on their behalf: "[T]he only way in which a corporation can act is through the individuals who act on its behalf." 320 U.S. 277, at 284-85. Moreover, a corporation may not hide behind the defense that it has a policy that prohibits unlawful acts by its employees. Corporations must ensure that their policies are enforced. Failure to do so renders them liable for their employees' unlawful acts. *United States v. Park,* 421 U.S. 658, 672 (1975).

Petitioner asserts affirmatively that it was in substantial compliance with the requirements of 42 C.F.R. § 483.13(c). In support of this argument Petitioner recites the various things that it did to assure compliance. Petitioner's brief in opposition to CMS's motion at 8. But, whatever affirmative steps Petitioner may have taken do not gainsay the undisputed fact that a member of Petitioner's staff blatantly failed to comply with Petitioner's policy in providing care to Resident # 1. That failure cannot be considered as a simple error. It involved fundamental issues of care: what directives a resident or his or her family issues to deal with life-threatening circumstances; and whether care is implemented that is consistent with those directives. Failure to comply with a resident's or his or her family's directives concerning resuscitation could literally mean the difference between life and death. In this case, the nurse's failure with respect to Resident # 1 evidenced an essential failure to carry out facility policy, a failure that could have easily affected other residents in similar circumstances.

Petitioner argues also that there are material facts in dispute whether the LVN's professional actions violated established guidelines concerning whether cardiopulmonary resuscitation should have been administered to Resident # 1. Petitioner's brief in opposition to CMS's motion at 13-14.[2] Petitioner's argument, essentially, is that Resident # 1 was already dead when the staff discovered her and that, consequently, there was no point in initiating resuscitation. As support for this contention, Petitioner cites American Heart Association guidelines for when resuscitation should be initiated. Petitioner's brief in opposition to CMS's motion at 13; P. Ex. 19 at 2. Petitioner contends that Resident # 1's condition matched the exceptions stated by the American Heart Association to the rule that resuscitation should be initiated whenever a person is found to be without pulse or respiration:

> A person lies dead, with obvious clinical signs of irreversible death (e.g. rigor mortis, dependent lividity, decaptitation, or decomposition).

Id. However, Resident # 1's condition at the time that she was discovered to be nonresponsive by Petitioner's staff matched none of the exceptions cited by Petitioner. There are no facts, disputed or otherwise, that support the conclusion that the resident manifested the obvious signs of irreversible death that are cited in the American Heart Association guidelines. Furthermore, even if Resident # 1, at the time she was discovered, was past the point where resuscitation attempts may have benefitted her, there are no facts showing that the staff made an informed judgment to disregard the full code status that had been ordered for the resident. Rather, the undisputed facts establish that the staff was unaware of the code status because it had failed to review that status.

Petitioner also argues that its compliance may have been deficient in that in one instance its LVN failed to implement guidelines and neglected a resident but that this single instance should not detract from its overall good compliance record. *See* Petitioner's brief in opposition to CMS's motion at 7-8. It contends that its compliance was "substantial" in the sense that it mostly complied with participation requirements. However, "substantial" does not mean "mostly." The regulatory definition of substantial compliance means a level of compliance with participation requirements such that any identified deficiencies pose the potential for no more than minimal harm to a resident. 42 C.F.R. § 488.301. Here, the potential for harm was far more than minimal. The decision whether or not to perform cardiopulmonary resuscitation was potentially one of life or death.

The remedies that CMS determined to impose – a civil money penalty of $5000 for each of the two instances of Petitioner's noncompliance with the requirements of 42 C.F.R. §

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[2] This argument is inconsistent because Petitioner also asserts that it terminated the LVN's employment "[b]ecause [she] did not act within her scope of professional nurse practice . . . ." Petitioner's brief in opposition to CMS's motion at 10-11.

483.13(c) – are at the midpoint of the range of permissible per-instance civil money penalties. 42 C.F.R. § 488.438(a)(2). The undisputed material facts establish these penalties to be reasonable.

Establishing a penalty within a permissible range depends on regulatory factors. These factors may include the seriousness of a Petitioner's noncompliance, its culpability, its compliance history, and its financial condition. 42 C.F.R. § 488.438(f)(1) – (4) (incorporating 42 C.F.R. § 488.404 by reference into 42 C.F.R. § 488.438(f)(3)). Here, the seriousness of Petitioner's noncompliance – whether considered in isolation or in the context of evidence pertaining to other factors – is sufficient to justify the penalty amounts. The undisputed material facts establish that Petitioner's staff not only ignored a resident's family's wishes that were documented in the resident's records but failed to administer essential care in a potentially life or death situation. I cannot envision noncompliance that is significantly more serious than that. Given that, the penalty amounts, which are only one-half of the allowable maximum, are actually quite modest.

Petitioner argues, however, that there are disputed facts that call into doubt the reasonableness of the penalty amounts. I find no disputed facts that relate to the seriousness of Petitioner's noncompliance. As to other facts that Petitioner raises, particularly its alleged lack of culpability, I find that they do not derogate in the least from the seriousness of the noncompliance. Thus, I would sustain the penalty amounts even if everything Petitioner says about its lack of culpability were true. Petitioner's other arguments concerning the amount of the penalties reduce to assertions that I have dealt with. Essentially, Petitioner reiterates its contentions that it complied substantially with participation requirements and that it should not be found liable. I have found these arguments to be without merit, as I have explained.

/s/

Steven T. Kessel
Administrative Law Judge