Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

The Retreat at Brightwater,
(CCN: 42-5395),

Petitioner

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-775

Decision No. CR4545

Date: March 10, 2016

DECISION

Petitioner, the Retreat at Brightwater (Petitioner or "the facility"), is a long-term care facility that participates in the Medicare program. Based on a survey that was completed on September 12, 2014, the Centers for Medicare & Medicaid Services (CMS) determined that Petitioner was not in substantial compliance with multiple Medicare participation requirements. CMS imposed against Petitioner a civil money penalty (CMP) of $3,700 per day, effective July 19 through September 11, 2014, and a CMP of $200 per day effective September 12 through October 11, 2014, for a total CMP of $209,500.

Petitioner contests three deficiencies cited at the "J" level for immediate jeopardy to resident health or safety with an isolated scope relating to quality of care, facility administration, and quality assurance and quality assessment, all of which involved Resident # 188. Petitioner also contests a deficiency that was cited at the "D" level as having the potential for more than minimal harm, with an isolated scope, relating to the requirement to notify a physician of a change in Resident # 163's condition.

For the reasons set forth below, I sustain CMS's determinations with respect to the immediate jeopardy level deficiencies related to Resident # 188. However, I find that Petitioner was in substantial compliance with respect to the care of Resident # 163 and did not fail to make the required notification regarding that resident's change in condition. I find the penalty imposed for the deficiencies is reasonable.

I. Background

The Social Security Act (Act) sets requirements for skilled nursing facility (SNF) participation in the Medicare program. The Act authorizes the Secretary of the United States Department of Health & Human Services (Secretary) to promulgate regulations implementing those statutory provisions. Act § 1819 (42 U.S.C. § 1395i-3). The Secretary's regulations are found at 42 C.F.R. part 483.

A facility must maintain substantial compliance with program requirements in order to participate in the program. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state agencies to conduct periodic surveys to determine whether SNFs are in substantial compliance with the participation requirements. Act § 1864(a) (42 U.S.C. § 1395aa(a)); 42 C.F.R. §§ 488.10, 488.20. The Act and its implementing regulations require that facilities be surveyed on average every twelve months, and more often if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A) (42 U.S.C. § 1395i-3(g)(2)(A)); 42 C.F.R. §§ 488.20(a), 488.308.

Petitioner is an SNF that operates in Myrtle Beach, South Carolina. Surveyors from the South Carolina Division of Health Services Regulation (state agency) completed a periodic survey of Petitioner on September 12, 2014. The state agency found that the facility was not in substantial compliance and the conditions constituted immediate jeopardy. CMS Exhibit (CMS Ex.) 3 at 1. Based on the survey findings, CMS determined that, among other deficiencies, the facility was not in substantial compliance with the following participation requirements: quality of care (Tag F309, 42 C.F.R. § 483.25); administration (Tag F490, 42 C.F.R. § 483.75); quality assurance and quality assessment (Tag F520, 42 C.F.R. § 483.75(o)(1)); and notification of changes in a resident's condition (Tag F157, 42 C.F.R. § 483.10(b)(11)). Further, CMS determined that the noncompliance for the first three deficiencies constituted immediate jeopardy and substandard quality of care to residents' health and safety from July 19 through September 11, 2014, and the noncompliance for the fourth deficiency posed a potential

for more than minimal harm.[1] Petitioner returned to substantial compliance on October 12, 2014. CMS Ex. 4. By letter dated October 24, 2014, CMS imposed a CMP in the amount of $3,700 per day effective July 19 through September 11, 2014, and a CMP in the amount of $200 per day effective September 12 through October 11, 2014. CMS Exs. 3, 4, and 13.

On December 24, 2014, Petitioner requested a hearing. On January 6, 2015, Administrative Law Judge (ALJ) Joseph Grow issued an acknowledgment and pre-hearing order establishing a briefing schedule. In accordance with the schedule, CMS and Petitioner filed pre-hearing exchanges, including pre-hearing briefs (CMS Br. and P. Br., respectively), exhibit and witness lists, proposed exhibits, and written direct testimony.[2] CMS submitted CMS Exs. 1 to 17, and Petitioner submitted P. Exs. 1 to 8. As neither party has objected to any of the proposed exhibits, I admit all of them into the record.[3] The prehearing order explained that a hearing to cross-examine witnesses would be necessary only if a party filed admissible, written direct testimony, and the opposing party asked to cross-examine any witness. Neither party has requested the opportunity to cross-examine any witnesses at a live hearing. This matter is therefore ready for a decision on the merits.

II. Issues

The following issues will be addressed in this decision:

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[1] Petitioner does not dispute the remaining deficiencies and related CMPs, which include findings that it was not in substantial compliance with the following five other standards at a scope and severity level of either "D" (isolated - no actual harm with potential for more than minimal harm that is not immediate jeopardy), "E" (pattern - no actual harm with potential for more than minimal harm that is not immediate jeopardy), or "F" (widespread - no actual harm with potential for more than minimal harm that is not immediate jeopardy): 42 C.F.R. § 483.10(b)(4) (Tag F155, relating to the right to refuse or reformulate advance directives); 42 C.F.R. § 483.25(h) (Tag F323, relating to ensuring that the resident environment is as free of accident hazards as possible); 42 C.F.R. § 483.25(m)(2) (Tag F333, relating to residents being free of significant medication errors); 42 C.F.R. § 483.35(i) (Tag F371, relating to food procurement and the storage, preparation, distribution, and service of food under sanitary conditions); and 42 C.F.R. § 483.75(b) (Tag 492, relating to compliance with federal, state, and local regulations and codes and with acceptable professional standards).

[2] The case was reassigned to me on December 29, 2015.

[3] In some instances, when referring to identical documents submitted by both parties, I have identified the document by only one party's exhibit number, and not by both exhibit numbers.

1) Whether Petitioner failed to comply substantially with the participation requirements of quality of care (42 C.F.R. § 483.25); administration (42 C.F.R. § 483.75); and quality assurance and quality assessment (42 C.F.R. § 483.75(o)(1)).

2) Whether CMS's finding that deficiencies posed immediate jeopardy to resident health and safety was clearly erroneous.

3) Whether CMS's determination regarding the duration of the period of immediate jeopardy and noncompliance was clearly erroneous.

4) Whether Petitioner failed to comply substantially with the participation requirement of notification of changes in a resident's condition (42 C.F.R. § 483.10(b)(11)).

5) Whether the CMP that CMS imposed is reasonable.

III. Findings of Fact and Conclusions of Law

A. Petitioner did not adhere to its own policies and did not resolve conflicting information regarding the resuscitative measures that were required to be provided to Resident # 188, and as a result, the facility was not in substantial compliance with 42 C.F.R. §§ 483.25 and 483.75.[4,5]

The opening provision of 42 C.F.R. § 483.25 (quality of care), which implements section 1819(b)(2) of the Act, requires:

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[4] My findings of fact and conclusions of law are set forth in italics and bold.

[5] It is not necessary to address the facility's compliance with 42 C.F.R. § 483.75(o)(1) because I find that the other cited deficiencies, alone, are sufficient to support the remedies imposed. (42 C.F.R. §§ 483.25 and 483.75, which are addressed in this section, along with the deficiencies that Petitioner did not appeal (42 C.F.R. §§ 483.10(b)(4), 483.25(h), 483.25(m)(2), 483.35(i), and 483.75(b)). *See Claiborne-Hughes Health Ctr., No. 09-3239 at 11, aff'd Claiborne-Hughes Health Ctr. v. Sebelius,* 609 F.3d 839 (6th Cir. 2010)*; Carrington Place of Muscatine*, DAB No. 2321 at 20-21 (2010).

> Each 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.

The quality of care legislation and regulatory requirements are "based on the premise that the facility has (or can contract for) the expertise to first assess what each resident's needs are (in order to attain or maintain the resident's highest practicable functional level) and then to plan for and provide care and services to meet the goal." *Spring Meadows Health Care Ctr.*, DAB No. 1966 at 16 (2005). The regulation thus "imposes on facilities an affirmative duty designed to achieve favorable outcomes to the highest practicable degree." *Windsor Health Care Ctr.*, DAB No. 1902 at 16-17 (2003), *aff'd, Windsor Health Care Ctr. v. Thompson*, No. 04-3018 (6th Cir. 2005). The facility must take reasonable steps and all practicable measures to achieve that regulatory end. *Clermont Nursing & Convalescent Ctr.*, DAB No. 1923 at 21 (2004), *aff'd, Clermont Nursing & Convalescent Ctr. v. Leavitt*, 142 F. App'x 900 (6th Cir. 2005).

The Departmental Appeals Board (Board) has concluded that the language of 42 C.F.R. § 483.25 not only requires skilled nursing facilities to furnish the care and services set forth in a resident's care plan but also to implement doctors' orders, monitor and document the resident's condition, and follow its own policies. *See, e.g., Alexandria Place*, DAB No. 2245 at 7-8 (2009) (upholding a deficiency when a petitioner did not provide care in accordance with a doctor's order); *Oxford Manor*, DAB No. 2167 at 5-6 (2008) (affirming an ALJ's reliance on a facility's policy as evidence of the standard of care the facility expected its staff to provide). The quality of care provision also implicitly imposes on facilities a duty to provide care and services that, at a minimum, meet accepted professional standards of quality "since the regulations elsewhere require that the services provided or arranged by the facility must meet such standards." *Spring Meadows*, DAB No. 1966 at 17, *citing* 42 C.F.R. § 483.25.

Additionally, a facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. 42 C.F.R. § 483.75.

The immediate jeopardy deficiencies concern Resident # 188. On July 19, 2014, Petitioner's staff found Resident # 188 not breathing and without a pulse. After reviewing his chart, the facility's staff did not attempt to resuscitate Resident # 188, and staff pronounced the resident dead shortly thereafter. CMS Ex. 7 at 12.

I make the following factual findings that will be addressed more fully below:

1. ***Facility Policy 1.3 states that the facility's social worker or designee will notify the physician if a resident submits a do not resuscitate (DNR) order or advance directive. There is no evidence that the facility's social worker or a designee notified Resident # 188's attending physician, Dr. C.B., that a North Carolina portable DNR order form (herein "portable DNR order") and a North Carolina Medical Orders for Scope of Treatment form (herein "MOST form" or "advance directive") for Resident # 188 had been received on or about July 7, 2014.***

2. ***Facility Policy 1.3 states that the physician should review a resident's advance directive, discuss it with the resident or health care decision maker, and that physician orders "will be written/obtained based on the discussion and documented in accordance with state law." There is no evidence that Dr. C.B. discussed Resident # 188's advance directive with either the resident or a health care decision maker.***

3. ***Dr. C.B. issued a full code order for Resident # 188 on July 7, 2014. Dr. C.B. treated Resident # 188 for twelve more days after he ordered that the resident was status "full code" and signed 17 more physician orders without amending the full-code status order. On July 19, 2014, resuscitation was not provided when staff discovered Resident # 188 without a pulse and not breathing.***

4. ***A January 7, 2014 interim care plan directing that Resident # 188 should be resuscitated was in effect at the time of Resident # 188's death.***

5. ***Three facility staff members, including the Executive Director/Administrator, Director of Nursing, and a nurse-in-charge, provided written direct testimony stating that based on both the portable DNR order and MOST form, Resident # 188 had a DNR order and the facility DNR policy applied to Resident # 188.***

6. ***The North Carolina MOST form is not dated, does not have an effective date, and does not list the date of any annual reviews.***

7. ***Resident # 188's MOST form, which was signed by both the resident and a physician, directed that if he had a pulse and was breathing, or had a pulse <u>or</u> was breathing, he desired the full scope of treatment, to include***

intubation, advanced airway intervention, mechanical ventilation, cardioversion[6] as indicated, medical treatment, IV fluids, and transfer to a hospital if indicated.

8. ***Facility Policy 6.6 states that if a Resident has a DNR order, CPR will not be initiated and advanced life support will not be activated. Facility Policy 6.6 indicates that its DNR policy is applicable to someone who is in cardiac <u>or</u> respiratory arrest.***

9. ***Three facility staff members, including the Executive Director/Administrator, Director of Nursing, and a Nurse-in-Charge, provided written direct testimony stating that based on the wishes expressed in the MOST form, Resident # 188 did not want to be resuscitated if he stopped breathing.***

10. ***At the time of Resident # 188's death, his chart contained the following documents: A July 7, 2014 facility attending physician's order directing that he had "full code" status; a July 7, 2014 interim care plan directing that Resident # 188 did not have DNR status; a March 16, 2012 portable DNR order that was signed by a doctor directing that Resident # 188 should not be resuscitated if he had no pulse and/or was not breathing; and, an undated North Carolina MOST form, signed by Resident # 188 and a doctor, directing "DNR/no CPR" if he had no pulse and was not breathing and otherwise directing the full scope of treatment if he had either a pulse or was breathing.***

Petitioner has written policies addressing advance directives and resuscitation. Facility Policy 6.6 ("Cardiac and/or Respiratory Arrest") contains the following relevant guidance to Petitioner's employees:

> Senior Living Communities Centers supports the right of every patient to accept or decline cardiopulmonary resuscitation in the event of cardiac or respiratory arrest.
>
> * * *

[6] The National Institutes of Health reports that cardioversion is a means of returning an abnormal heart rhythm back to normal, and can be performed using an electric shock or drugs. External electric cardioversion is performed with a defibrillator. *See https://www.nlm.nih.gov/medlineplus/ency/article/007110.htm* (last visited February 26, 2016).

> If a patient has a Do Not Resuscitate Order (DNR), CPR will not be initiated and Advanced Life Support (ALS) will not be activated.

CMS Ex. 8 at 1.

> DNR orders may be changed at any time by the patient/health care decision maker.
>
> * * *
>
> If a patient has a DNR order, clearly identify the DNR status on the patient's medical record.

CMS Ex. 8 at 2.

> If there is a DNR order . . . Do not initiate CPR/AED.[7]

CMS Ex. 8 at 3.

Policy 1.3 ("Health Care Decision Making") provides additional guidance:

> It is the physician's responsibility to participate in the health care decision making process.
>
> * * *
>
> The Center will comply with state law as it relates to advance directives. Within the boundaries of all applicable laws, regulations, and Company policies, the Center staff will make every effort to honor the wishes of residents regarding the use of procedures and other health care treatments. Advance directives executed in others states will be honored per state regulations.

CMS Ex. 9 at 2.

Further, Facility Policy 1.3 states:

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[7] The American Heart Association states that "AED" is the abbreviation for "automated external defibrillator," which is a portable medical device that delivers an electric shock that can stop an irregular heart rhythm and allow a normal rhythm to resume following sudden cardiac arrest. *See http://www.heart.org/idc/groups/heart-public/@wcm/@hcm/documents/downloadable/ucm_300340.pdf* (last visited February 26, 2016).

4. **If an advance directive has been executed and the resident/responsible party has brought it with them to the meeting,** copies will be made and placed immediately in the resident's medical record and given to the Social Worker. Nursing staff will be notified regarding the document.

5. **If an advance directive has been executed but has not been brought to the Center,** the Center Admissions Designee will advise the resident/responsible party that the advance directive cannot be honored without a copy in the medical record.

   5.1 The Center Admissions Designee will:

      5.1.1 Request that the resident/responsible party bring the documents to the office as soon as possible and deliver to the Social Worker, and

      5.1.2 Notify the Social Worker of the name of the person to whom the request was made.

   5.2 The Social Worker will follow up with the resident/responsible party to obtain a copy of the advance directive and document accordingly.

6. **If a capable resident does not have an advance directive upon admission,** the resident will be approached by the Social Worker or another designated staff person to discuss whether he/she wishes to consider developing an advance directive.

   6.1 The resident's decision will be documented on the chart and will be reviewed by the Social Worker at the first care plan conference, with change in condition, and annually thereafter.

   6.2 If there's a question regarding the resident's capacity, refer to "Determining Decision Making Capacity" section of this policy.

7. The Social Worker or designee will notify the attending physician regarding the resident's Advance directive or wishes to initiate or modify an advance directive.

Health Care Instructions:

Upon admission, annually, and with a change in condition, the physician, in collaboration with designated Center staff, will meet with the resident/Member/Resident or health care decision maker to complete or review health care instructions.

8.1 Review the resident's advance directive if available.
8.2 Discuss the following health care instructions with the resident or health care decision maker if the resident is unable.

8.2.1 Resuscitation status:

8.2.1.1 Resuscitation orders must be obtained upon admission or as soon as possible thereafter (telephone or fax orders are acceptable per state regulation);

8.2.2 Level of medical interventions and treatments;

8.2.3 Future hospitalization.

8.3 Document the discussion of the resident's wishes by using state specific forms, sample forms, or entering a progress note. (Refer to sample "Resident/Member/Resident Health Care Instructions.")

8.4 Physician orders will be written/obtained based on the discussion and documented in accordance with state law.

9. The resident/Member/Resident or health care decision maker is able to review, update, or revoke health care instructions at any time.

CMS Ex. 9 at 5-7 (emphasis in original).

Treatment records dated July 1, 2014, prior to his admission to the facility, document that Resident # 188's daughter, R.D., had requested "DNR status" when he was being treated at another facility. CMS Ex. 7 at 18-19. There is no documentation in the file showing that Resident # 188's daughter was his health care proxy or had been designated as his decision maker.[8]

[8] I have no basis to discredit R.D.'s assertion that she provided a "Medical POA" for Resident # 188. CMS Ex. 5 at 6. In fact, Resident # 188's daughter is the only family

Resident # 188 was admitted to the facility on July 7, 2014 for short-term therapy following a hip fracture. CMS Ex. 7 at 4, 16; P. Ex. 5 at 2. Resident # 188 was listed as having the following diagnosed medical conditions: left hip fracture, atrial fibrillation, Alzheimer's dementia, gastro-esophageal reflux disease, and hypothyroidism. CMS Ex. 7 at 4. A July 7, 2014 clinical note by K.K., a licensed master social worker, indicated that Resident # 188 was "[f]ull code status at admission pending DNR paperwork completion."[9] CMS Ex. 7 at 15. In physician's orders dated July 7, 2014 that were valid through July 31, 2014, Dr. C.B., Resident # 188's attending physician, directed that Petitioner's code status was "Full Code." CMS Ex. 7 at 4. In 17 other orders signed by Dr. C.B., there are no revisions of the order that Resident # 188 had full-code status. CMS Ex. 7 at 21-26. An unsigned interim care plan dated July 7, 2014 indicates "NO" in response to a question regarding whether "Resident is a DNR." CMS Ex. 7 at 8.

A July 18, 2014 nursing note documents that R.D. and the facility's social worker had discussed a referral for hospice care that would take place on Monday, July 21, 2014. CMS Ex. 7 at 12. At that time, Resident # 188's daughter was crying and stated that "I know he's getting ready to go." CMS Ex. 7 at 12. A social services note authored by K.K. reports that "family is requesting that therapy be discontinued and hospice services started on Monday 7/21." CMS Ex. 7 at 15. While this conversation and request took place on July 18, 2014, it appears that the social worker did not enter the note into the facility's computerized record system until July 21, 2014, following Resident # 188's death on July 19, 2014. CMS Ex. 7 at 15.

The North Carolina portable DNR order is included in Resident # 188's chart. CMS Ex. 7 at 2. The form lists a March 16, 2012 effective date and a block is checked indicating that the order had no expiration date.[10]

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member referenced in the facility's treatment records. Further, a health care power of attorney document is referenced in the Potential Citation Report. CMS Ex. 10, at 1, 6. However, no health care power of attorney document is included in the parties' exhibits, nor is such a document referenced in the briefs. I observe that R.D. is listed as a "responsible party" on a July 16, 2014 care plan meeting attendance record. CMS Ex. 7 at 11.

[9] It appears that this note was not entered into the facility's computerized record system until September 7, 2014, which is more than six weeks following Resident # 188's death. CMS Ex. 7 at 15.

[10] While the portable DNR order did not list an expiration date, North Carolina law provides that a portable DNR order can be revoked. N.C.G.S § 90-21.17(c).

The North Carolina MOST form is also included in Resident # 188's chart. The MOST form directed that if Resident # 188 had no pulse and was not breathing, he desired that medical personnel "Do Not Attempt Resuscitation (DNR/no CPR)." CMS Ex 7 at 3 (emphasis in original). However, the form also specified that Resident # 188 otherwise wanted to receive the "full scope of treatment" if he had either a pulse or was breathing, meaning that he wanted resuscitation if *either* his heart had stopped beating or he had stopped breathing, but not both. CMS Ex. 7 at 3. I also observe that the form included a section to fill in the effective date, and instructed that the "[f]orm must be reviewed at least annually." CMS Ex. 7 at 3. However, there is no effective date listed on the form and the form is otherwise not dated. [11] As a result, I cannot ascertain whether Resident # 188 and his physician signed this advance directive contemporaneously with the implementation of the portable DNR order, or if the advance directive was signed prior, or subsequent, to the physician completing the portable DNR order form.

The MOST form included a facsimile header indicating that it was received from Brunswick County Hospital on September 12, 2014, which is the same date the survey was completed. There is no indication in the facility's records regarding the actual date of receipt of this form; facility records do not address the date of receipt of the portable DNR and MOST forms. The facility's witnesses have stated, under penalty of perjury, that the MOST form was in Resident # 188's chart prior to his death, and CMS has not asked to cross-examine the witnesses nor argued that the MOST form was not in the chart prior to September 12, 2014. P. Exs. 5, 6, and 7. Therefore, I will accept the unrefuted written direct testimony that nursing personnel reviewed the MOST form on July 19, 2014 in determining that Resident # 188 had DNR status pursuant to facility policy. *See* P. Exs. 5, 6, and 7.

A declaration from J.J., the facility's administrator and executive director, reports the following:

> When he was admitted to Brightwater, Resident 188's daughter provided the facility's staff with Resident 188's DNR Order and MOST Form. Brightwater staff reviewed the forms, determined they were valid, and included them in Resident 188's medical record. They then forwarded

[11] The law implementing the North Carolina MOST form mandates that, at a minimum, the form include a field for, *inter alia,* the effective date of the form and review dates. NCGS § 90-21.17(c). The law also indicates that the form should contain a prominent advisory that directions in a MOST form may suspend, while those MOST directions are in effect, any conflicting directions in a patient's previously executed declaration of an advance directive for a natural death ("living will"), health care power of attorney, or other legally authorized instrument and include an advisory that the MOST form may be revoked by the patient or the patient's representative. *Id.*

> copies of the forms to Brightwater's social worker and notified the facility's nursing staff that Resident 188 had a DNR order.

P. Ex. 5 at 2-3. Neither J.J.'s declaration, nor any other declaration or other record before me, provides the name of the staff member who accepted these two documents from R.D. While J.J. asserts that the MOST form was received from Resident # 188's daughter at the time of his admission, the only documentary evidence regarding its receipt bears a facsimile date of September 12, 2014, which is the date of the survey. Although J.J. reported that the forms were provided to the social worker, the social worker's notes do not document receipt. CMS Ex. 7 at 15. The social worker's notes even suggest that these two forms had not been received at the time of admission. CMS Ex. 7 at 15 (stating "[f]ull code status at admission pending DNR paperwork completion."). Furthermore, while J.J. asserts that unnamed Brightwater staff "reviewed the forms" and "determined they were valid," he does not address the lack of an effective date on the MOST form or the apparent scope of treatment conflict between the portable DNR order and the MOST form, which will be addressed more fully below.

In an October 7, 2014 letter to the facility that Petitioner's daughter submitted subsequent to the September 12, 2014 survey, R.D. wrote that Resident # 188's "desires were that he be allowed to expire" and that she "conveyed these desires to the staff at Brightwater as [she] was designated as [her] father's representative within his Medical POA document." CMS Ex. 5 at 6. R.D. added "[i]n that document it clearly stated his DNR wishes." CMS Ex. 5 at 6. It is unclear whether R.D. was referring to the portable DNR order, the MOST form, or some other document, as neither the portable DNR order nor the MOST form directs that she had been designated as having power of attorney for Resident # 188's health care decision-making.

Regardless of when, or if, the portable DNR order and MOST form were received by the facility and associated with the file, there is no indication in the record that the facility notified Resident # 188's attending physician, Dr. C.B., that the facility had received a portable DNR order and MOST form. This contravened Facility Policy 1.3, which requires that "[t]he Social Worker or designee will notify the attending physician regarding the resident's Advance directive or wishes to initiate or modify and advance directive. " Policy 1.3, CMS Ex. 9 at 5. Dr. C.B. signed 17 more orders and the facility implemented an interim care plan directing that Resident # 188 be resuscitated, yet Dr. C.B. and the facility never modified the order and care plan prior to Resident # 188's death. The social worker entered several notes in the facility's electronic records system, with one note submitted as late as six weeks following Resident # 188's death. Yet, the social worker never documented that she had received an outside DNR order and advance directive, nor did she document that she had notified Dr. C.B. or the nursing staff that a portable DNR order and advance directive had been received.

Dr. C.B., Resident # 188's attending physician at the facility, directed upon admission on July 7, 2014, after apparent ambivalence, that Resident # 188 had full code status.[12] CMS Ex. 7 at 4. In contravention of facility policy, the facility either did not notify Dr. C.B. of the portable DNR and MOST forms, or if it did, it did not ensure that Dr. C.B. discussed the advance directive with Resident # 188 or his health care decision maker. Nor did Dr. C.B. update his orders to reflect that Resident # 188 was not a full code or indicate in progress notes why the July 7, 2014 full code order would not be updated. Resident # 188's MOST form was signed by Resident #188 and his then-physician, but does not bear an effective date. North Carolina specifies that a MOST form should include an effective date and review dates. *See* N.C.G.S. § 90-21.17(c). Consequently, the MOST form at issue was invalid. *Id.* Furthermore, it does not appear that the facility (or likewise the surveyors and CMS) considered whether these omissions invalidated the form even though the facility relied on it in determining that Resident # 188 had DNR status.[13] *See* P. Exs. 4, 5, 6, and 7. The lack of an effective date on the form not only compromises its validity, but also makes it impossible to determine when it had been executed and whether it had been reviewed on an annual basis. N.C.G.S. § 90-21.17(c). The lack of an effective date also makes it impossible to know whether Resident # 188 signed this advance directive prior to, contemporaneously with, or subsequent to his physician signing the portable DNR order.

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[12] Dr. C.B. initially directed that Resident # 188 was a full code. The full code instruction is crossed out and replaced with a notation of "DNR." The DNR order was then crossed out and replaced with a third notation that Resident # 188 had "full code" status. CMS Ex. 7 at 4.

[13] The parties dispute whether the North Carolina forms were valid out-of-state documents at Petitioner's facility in South Carolina. See CMS Ex. 7 at 2-3 and P. Ex. 4 at 9-10. For purposes of this decision, I accept the premise that an out-of-state DNR order and advance directive, under certain circumstances, may be valid in a South Carolina skilled nursing facility setting. *See* S.C. Code Ann. § 44-77-30 ("When life-sustaining procedures may be withheld")(stating "[i]f a person eighteen years of age or older adopts a declaration that is substantially in the form provided in Section 44-77-50 . . . that on it its face is in compliance with the law of the state of the declarant's domicile at the time the declaration is adopted, if the declaration provided for by the law expresses an intent that is substantially the same as the intent of the declaration provided in Section 44-77-40 . . . then life-sustaining procedures may be withheld or withdrawn upon the direction and under the supervision of the attending physician.") However, even assuming that the forms, when properly executed, could be recognized in the State of South Carolina, I nonetheless conclude that the facility was not substantially compliant with the requirements for quality of care and administration for the reasons discussed in this decision.

While the facility submitted written direct testimony from three staff members in which each declarant averred that he or she relied on *both* the portable DNR order and the MOST form in honoring Resident # 188's wishes, I find it troubling that none of these three senior staff members questioned the validity of the MOST form or recognized the conflict between MOST form, if presumed to be valid, and the portable DNR order. J.J., the Executive Director and Administrator, stated the following in his written direct testimony:

> Prior to his admission to Brightwater, Resident 188 expressed a desire not to receive CPR if he went into cardiac *or* pulmonary arrest, which was reflected on *two* advanced directive forms executed when he resided in North Carolina . . . The MOST form was signed by both Resident 188 and his attending physician. *It instructed not to attempt resuscitation or perform CPR if Resident 188 was not breathing.*

P. Ex.5 at 2 (emphasis added). Likewise, J.Y., the Director of Nursing, stated the following in her written direct testimony:

> Prior to his admission to Brightwater, Resident 188 had already executed and secured documents regarding his advanced directives. Thus, when he arrived at Brightwater, Resident 188 had a North Carolina Do No Resuscitate Order ("DNR Order") and a North Carolina Medical Orders for Scope of Treatment form (the "MOST Form"). (True and correct copies of these forms can be found at CMS Ex. 7, pp. 2-3). The DNR Order, which was dated March 16, 2012, was signed by Resident 188's attending physician and instructed not to perform CPR if Resident 188 went into cardiac or pulmonary arrest. The MOST form was signed by both Resident 188 and his attending physician. *It instructed not to attempt resuscitation or perform CPR if Resident 188 was not breathing.*

P. Ex. 6 at 2 (emphasis added). J.Y. added that "I told the survey team that I regarded Resident 188 as 'DNR' and accordingly would not provide CPR if he suffered cardiac *or* respiratory arrest," and "the medical record did not include any documentation indicating that Resident 188 was incompetent at the time he executed the MOST Form and his Physician issued the DNR Order." P. Ex. 6 at 3-4 (emphasis added). P.G., a licensed practical nurse (LPN) who was the nurse-in-charge on the evening of Resident # 188's death, stated the following in her written direct testimony:

> In fact, Resident 188's medical record contained two advanced directive forms, a North Carolina Do Not Resuscitate Order ("DNR Order") and a North Carolina Medical Orders for Scope of Treatment form (the "MOST Form"). (True and correct copies of these forms can be found at CMS Ex. 7, pp. 2-3). The DNR Order, which was dated March 16, 2012, was signed

> by Resident 188's attending physician and instructed not to perform CPR if Resident 188 went into cardiac or pulmonary arrest. The MOST Form was signed by Resident 188 and his attending physician. *It instructed not to attempt resuscitation or perform CPR if Resident 188 was not breathing.*

P. Ex. 7 at 2 (emphasis added). Similarly, in its brief, Petitioner states:

> When he was admitted to Brightwater, Resident 188 had not one—but two—advanced directives signed by his physician, instructing medical personnel not to perform CPR if the resident had suffered cardiac arrest or had stopped breathing.

P Br. at 2. Petitioner additionally asserted that "Resident 188 had two DNR orders in his medical record, both of which had been signed by his physician." P. Br. at 7. In arguing that it had complied with its own policies, Petitioner explained the following:

> Brightwater has two policies regarding advanced directives and the provision of CPR. The stated purpose of both is "to insure patients' wishes . . . are followed." (CMS Ex. 8 p. 1; Ex. 7, p. 4.). Accordingly, both policies instruct staff not to perform CPR if a resident has a DNR order. (CMS Ex. 8, p. 3 ("If there is a DNR Order. . . . Do not initiate CPR/AED"); CMS Ex. 9, p. 5 ("Verify and check the patient's code status. If s/he has a DNR, do NOT resuscitate.")) Brightwater also instructs its staff to look to a resident's advanced directives, rather than notations in the file, to determine the resident's code status. (York Decl. ¶ 13.)[14]

P. Br. at 4. The excerpts above demonstrate that Petitioner and three of its senior staff members, even to this day, failed to ensure that Resident # 188's resuscitation status was made known to its personnel in the event of the need for resuscitative measures. Neither Petitioner, in its brief, nor its individual staff members, in their written direct testimony, correctly stated the resuscitative measures that were requested in Resident # 188's MOST form. Resident # 188 unambiguously, and under his own signature and that of his physician, requested the "full scope of treatment," to include mechanical ventilation and cardioversion, in the event that he was *either* not breathing or had no pulse; Resident # 188, in that document, only asked to not be resuscitated if he *both* was not breathing and had no pulse. CMS Ex. 7 at 3. Petitioner, in its brief, incorrectly asserts that Petitioner instructed "medical personnel not to perform CPR if the [he] had suffered cardiac arrest *or* had stopped breathing." P. Br. at 2 (emphasis added). In his brief, Petitioner further errs by contending that Resident # 188 had DNR orders and therefore hospital policy dictated that he should not be resuscitated. P. Br. at 4. All three staff members who submitted written direct testimony, to include the Executive

[14] This appears in J.Y.'s declaration but is not in the facility's policy. (P. Ex. at 6).

Director/Administrator, Director of Nursing, and a nurse-in-charge, indicated that the resident directed in the MOST form that he not be resuscitated if he was *not breathing*. P. Ex. 5, 6, and 7. This is simply untrue, and evidences a lack of understanding of one of the two documents Petitioner and its staff relied upon in assessing Resident # 188's DNR status.

The inconsistency in the forms, which is compounded by Petitioner's misunderstanding of the directives contained in the MOST form, supports the surveyors' and CMS's concerns that the conflicting directives required reconciliation. The facility made no attempt to reconcile Dr. C.B.'s full code status order, the interim care plan, the portable DNR order, and the advance directive. Three of these four documents show that Petitioner should not have been treated as having DNR status according to the facility's DNR policy, in that three of the orders directed full resuscitation in the event that Resident # 188 stopped breathing *or* was without a pulse. The July 7, 2014 order from Dr. C.B. and the interim care plan direct that Resident # 188 was a full code, and the MOST form indicates that the full scope of treatment should be provided if Resident # 188 "has a pulse *and/or* is breathing," to include intubation, mechanical ventilation, and cardioversion as indicated. CMS Ex. 7 at 3 (emphasis added). Only the portable DNR order, that was signed only by Resident # 188's then-physician and may potentially pre-date Resident # 188's signature on the MOST form, indicates that cardiopulmonary resuscitation should not be initiated "[i]n the event of cardiac and/*or* pulmonary arrest." CMS Ex. 7 at 2 (emphasis added). While the facility argues that Resident # 188 had DNR status based on *both* the portable DNR order and MOST form and it properly disregarded Dr. C.B.'s full code order and Resident # 188's care plan, it fails to appreciate that the conflict in these documents required reconciliation. It further fails to acknowledge that the attending physician, in consultation with the resident and/or his representative, would have been the appropriate person to direct the necessary end-of-life treatment, as is required by Facility Policy 1.3, which requires the facility to notify the physician if an advance directive is received and also requires a physician to meet with the resident or health care decision maker to complete or review the resident's health care instructions. CMS Ex. 9 at 5. The facility's failure to comply with Policy 1.3 is compounded by the fact that Policy 6.6, Cardiac and/or Respiratory Arrest, considers a DNR order to apply to a resident who is in cardiac *or* respiratory arrest. CMS Ex 8 at 1-2. Pursuant to Policy 6.6, the portable DNR order document indicates that Resident # 188 had DNR status pursuant to that policy, whereas the MOST form indicates that a much higher level of treatment was necessary, to include advanced life support, than would have been provided to a DNR resident under Policy 6.6.

While one interpretation of the evidence could suggest that Resident #188 may have desired the natural, and apparently peaceful, death that ultimately occurred at the facility, the evidence is not conclusive. No one from the facility has indicated that he or she recognized that the MOST form did not bear an effective date or that Resident # 188 sought the full scope of treatment if he had no pulse but was breathing, or was breathing

but had no detectable pulse. Rather, the facility contends the MOST form is valid and supports that Petitioner did not want to be resuscitated if he was not breathing. I had the opportunity to spend a considerable amount of time reviewing those documents, but a facility nurse who discovers a resident who has "coded" does not have the time for detailed chart review and thoughtful deliberation. Rather, such a professional has only fleeting moments to correctly determine whether a resident is a "full code" or has DNR status. While the two health care professionals who tended to Resident # 188 during the evening shift on July 19, 2014 reviewed the chart and decided not to initiate resuscitation because the portable DNR and MOST form both indicated that Resident # 188 had a DNR order, it is entirely possible that another nursing staff member would have looked to Dr. C.B.'s admitting orders or Resident # 188's interim care plan, which both remained in effect on that date. A nurse may have logically looked to the most recent order, which was Dr. C.B.'s July 7, 2014 admitting order. Furthermore, Dr. C.B.'s order was simple and did not require any interpretation, and the nursing staff is supposed to, after all, follow doctors' orders. *See Alexandria Place* at 7-8*, supra.* Furthermore, Facility Policy 1.3 directed that a physician's order would be in the file regarding resuscitation status. A physician's order is clear and concise guidance, and it is more expeditious to review a physician's order than to review two separate portable DNR and MOST forms, especially when every second spent reviewing a chart potentially delays the initiation of treatment and the prospect for successful resuscitation. The Director of Nursing, J.Y., provided written direct testimony that she "would review the physician's order to determine whether a resident should be treated as a 'full code' or 'DNR,' which is how Brightwater trains its nurses and staff to assess a patient's code status." P. Ex. 6 at 3. Instead of looking to the attending physician's more recent July 19, 2014 order, the nursing professionals treating Resident # 188 reviewed the contradictory portable DNR and MOST forms. Most notably, it is clear that three separate facility employees who reviewed the DNR and advance directive, in a non-code situation and many months after Resident # 188's death, misunderstood Resident # 188's MOST form. Resident # 188's chart contains conflicting and unresolved orders, and if Resident # 188's wishes were ultimately followed, it was only through a fortuitous mistake by his caregivers in his favor. The facility failed to adhere to its own policies and failed to follow the full-code status order of Resident # 188's attending physician.

It is important to not lose sight of the fact than an error in deciding whether or not to resuscitate a resident has dire implications: either someone who had a desire to live faces death without any chance for survival, or a person who desired a natural death is forced to undergo significant interventions, such as chest compressions and defibrillation, in an attempt to extend a life that he or she did not want to be unnaturally extended. While the evidence is inconclusive regarding whether Resident # 188's wishes were ultimately followed, it is clear that the facility did not carry out its duty to ensure that it provided the highest quality of care. The facility had the opportunity to reconcile the conflicting documents well before Resident # 188 was pulseless and not breathing. The facility likewise had the obligation, pursuant to its own policy, to notify Dr. C.B. of the portable

DNR and MOST form, but apparently did not do so. Dr. C.B. could have met with Resident # 188 or his decision maker to discuss these issues, as its policy required, but this did not occur, either. The facility's nurses on duty on July 19, 2014 could have followed Dr. C.B.'s full code order, but they did not do so. The facility was obligated to ensure that the highest quality of care was provided to Resident # 188, and it failed to comply with its obligations. With life and death in the balance, the facility violated its own policies and chose to err on the side of death.

Thus, the facility was not in substantial compliance with 42 C.F.R. § 483.25. The facility did not follow its own policies when it determined that Resident # 188 had DNR status and should not receive resuscitation or advanced life support if he was found in cardiac *or* pulmonary arrest. Furthermore, the conflicting evidence regarding the scope of intervention that Resident # 188 sought was not resolved during his lifetime, and is not resolved even now. The facility failed to resolve conflicting orders while Resident # 188 was alive, and failed to maintain her highest practicable physical well-being, in accordance with his comprehensive assessment and plan of care. While I recognize that Resident # 188 was elderly, had numerous health problems, and may have ultimately desired a natural death, the facility did not ensure that its nursing staff had clear guidance regarding his care.

Finally, the facility was not in substantial compliance with 42 C.F.R. § 483.75. A finding of substantial noncompliance in the facility's administration may derive from findings of substantial noncompliance in other areas.

> [W]here a facility has been shown to be so out of compliance with program requirements that is residents have been placed in immediate jeopardy, the facility was not administered in a manner that used its resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of each resident.

Asbury Ctr. at Johnson City, DAB No. 1815 at 11 (2002); *Odd Fellow and Rebekah Health Care Facility*, DAB No. 1839 at 7 (2002).

Moreover, the failings here are attributable to the failings of a number of people in the facility. This is evident in the written direct testimony of the Executive Director/Administrator, Director of Nursing, and a nurse-in charge, as all patently misunderstood Resident # 188's wishes as they were conveyed on the MOST form that bore his signature. The social worker and administration failed to notify the facility's attending physician that a DNR order and advance directive had been received. The facility's attending physician's conflicting orders were allowed to stand, and no effort was made by the facility's administration to reconcile the conflicting directives. The

facility was not administered in a manner that used its resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of its residents.

I now turn to my discussion of why the facility's deficiencies posed immediate jeopardy to resident health and safety, which lends further justification for my finding that the facility was not in substantial compliance with 42 C.F.R. § 483.75.

B. CMS's determination that the facility's deficiencies posed immediate jeopardy to resident health and safety is not clearly erroneous.

Immediate jeopardy exists if a facility's noncompliance 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 as to the level of a facility's noncompliance (which would include an immediate jeopardy finding) must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1962 at 11; *Florence Park Care Ctr.*, DAB No. 1931 at 27-28 (2004) (*citing Koester Pavilion*, DAB No. 1750 (2000); *Daughters of Miriam Ctr.*, DAB No. 2067 at 7, 9 (2007)).

Here, the facility failed to follow its own policies to make sure that Resident # 188's end-of-life wishes were clearly made known to its staff. Rather than notifying the attending physician that advance directive paperwork had been received and ensuring that the doctor had the opportunity to review the advance directive and DNR form, the facility simply filed it in the chart and expected its staff members to interpret these documents during a stressful and time-sensitive life-or-death situation. The facility violated the attending physician's orders by not providing resuscitation. The facility also violated Resident # 188's care plan, in that the care plan instructed that he should be resuscitated. Furthermore, even taking into account the facility's stated reliance on both the portable DNR order and MOST form, the guidance in those documents conflicts and indicates that Resident # 188 desired resuscitation in some circumstances and was not necessarily a DNR under the facility's policies. For instance, had Resident # 188 stopped breathing but still had a pulse, a hypothetical situation that is addressed in each of Petitioner's three witness declarations, the facility's witnesses each incorrectly asserted that the MOST form indicated that he should not have been resuscitated. As discussed previously, these individuals have each understood Petitioner's stated wishes in a manner that expressly contradicts the desired care requested in a document bearing Resident # 188's signature. The attending physician's orders directed that Resident # 188 had full code status, and the failure to resuscitate a full-code resident who has stopped breathing all but assures that resident's death and, thus, poses immediate jeopardy to resident health and safety. The

facility indicated that its staff is trained to follow physicians' orders (P. Ex. 6 at 3), yet also indicated that its staff relied upon the portable DNR order and MOST form, and not the attending physician's order. P. Ex. 7 at 3. If staff members are required to reconcile conflicting orders involving the question of resuscitation during a medical emergency, the resulting inconsistent action is likely to cause serious harm, injury, impairment, or death. 42 C.F.R. § 488.301.

C. CMS's determinations as to the duration of the periods of noncompliance and immediate jeopardy are consistent with statutory and regulatory requirements.

Substantial compliance means not only that the facility corrected the specific cited instances of substantial noncompliance but also that it implemented a plan of correction designed to assure that no additional incidents would occur in the future. Once a facility is found to be out of substantial compliance, it remains so until it affirmatively demonstrates that it has achieved substantial compliance once again. *Premier Living and Rehab. Ctr.*, DAB No. 2146 at 23 (2008); *Lake City Extended Care*, DAB No. 1658 at 12-15 (1998). The burden is on the facility to prove that it is compliant with program requirements, and not on CMS to prove that deficiencies continued to exist after they were discovered. *Asbury Ctr. at Johnson City*, DAB No. 1815 at 19-20 (2002). A facility's return to substantial compliance usually must be established through a resurvey. 42 C.F.R. § 488.454(a). To be found in substantial compliance earlier than the date of the resurvey, the facility must supply documentation "acceptable to CMS" showing that it "was in substantial compliance and *was capable of remaining in substantial compliance*" on an earlier date. 42 C.F.R. § 488.456(e) (emphasis added); *Hermina Traeye Mem'l Nursing Home*, DAB No. 1810 at 12 (2002) (*citing* 42 C.F.R. §488.456(a), (e); *Cross Creek Care Ctr.*, DAB No. 1665 (1998).

Here, Petitioner raises no arguments regarding the duration of the periods of substantial noncompliance and immediate jeopardy. Immediate jeopardy was removed on September 12, 2014, after the facility had provided in-service training to nurses on duty regarding "verifying code status." CMS Ex. 14 at 1; CMS Ex. 1 at 2-3. Prior to the removal of immediate jeopardy, the facility had audited all current resident charts on September 11, 2014 to "identify any discrepancies between code status and supporting documentation," and stated that "[a]ppropriate signatures for DNR order and DNR forms will be obtained by the Social Worker." CMS Ex. 14 at 1. I point out that the surveyors determined that noncompliance began July 19, 2014, the date of Resident # 188's death. Although I cannot disturb this determination, I observe that the surveyors exercised leniency in that they could have determined that the period of substantial noncompliance began as early as the admission date of July 7, 2014; J.J.'s written direct testimony indicates that Resident # 188's portable DNR and MOST forms were received at the time of admission, and Dr. C.B.'s full code order and the interim care plan were implemented on the same date. P. Ex. 5 at 2.

Because Petitioner has not established that an effective plan of correction was implemented any earlier than September 12, 2014, I sustain CMS's determinations as to the duration of the periods of substantial noncompliance and immediate jeopardy.[15]

D. Petitioner substantially complied with 42 C.F.R. 483.10(b).

The subsection of the regulation concerning Notification of Rights and Services, 42 C.F.R. § 483.10(b)(11), requires the following:

> *Notification of changes.* (i) A facility must immediately inform the resident; consult with the resident's physician; and, if known, notify the resident's legal representative or an interested family member when there is -
>
> (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
>
> (B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
>
> (C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment);
>
> (D) A decision to transfer or discharge the resident from the facility as specified in § 483.12(a).

The surveyors found substantial noncompliance with 42 C.F.R. § 483.10(b), a D level deficiency of isolated scope with the potential for more than minimal harm, and determined that Resident # 163's physician orders directed that the facility notify the physician if the resident lost more than five pounds. CMS Ex. 1 at 8-9. The SOD explained that Resident # 163 had been admitted with diagnoses of diabetes mellitus and dyslipidemia, and that Dr. C.B. had ordered that he should be notified if Resident # 163 lost more than five pounds in one week. CMS Ex. 1 at 8-9; *see* CMS Ex. 6 at 1. The surveyors determined "[t]here was no documentation to indicate the physician was notified" of a five-pound weight loss that occurred between May 22 and 24, 2014 and that the facility did not comply with the requirements set forth at 42 C.F.R. § 483.10(b)(11). CMS Ex. 1 at 9.

CMS argues in its brief that "[a]lthough the resident's medical record documented a 'significant weight change' there was no documentation to indicate the nursing home

[15] As discussed earlier, Petitioner concedes five other deficiencies at the non-immediate jeopardy level.

reported the weight loss in accord with the physician's order." CMS Br. at 8. CMS adds that "obviously, without being told of the weight loss, the physician would not be in a position to assess the cause, confer with other disciplines, and issue new orders to address the problem." CMS Br. at 8.

Petitioner contends that Resident # 163's attending physician, Dr. C.B., was notified in a timely manner of the weight loss, and that contrary to CMS's assertion, Dr. C.B. issued an order to address the weight loss. First, the facility points to a May 23, 2014 order from Dr. C.B. prescribing Med Pass 2.0.[16] P. Ex. 4 at 4; *see also* CMS Ex. 6 at 17. The facility also submitted the written direct testimony of Dr. C.B., and CMS has not objected to that testimony or requested the opportunity to cross-examine Dr. C.B. P. Ex. 8. Dr. C.B. states the following in his unrefuted testimony:

> In accordance with my directions, Brightwater's nursing staff informed me on May 23, 2014, that Resident 163 had lost more than five pounds in a week, and, as a result, I ordered that Resident 164 be provided Med Pass 2.0 nutritional supplements. True and correct copies of the telephone orders and entries in Resident 163's file reflecting these steps are located at CMS Ex. 6, pp. 17-18 and Pet'r Ex. 1.

P. Ex. 8 at 1. As Dr. C.B. has declared under penalty of perjury that he was notified of the weight loss on May 23, 2014 and prescribed Med Pass 2.0 as a result of that notification, I find that Petitioner substantially complied with 42 C.F.R 483.10(b).[17]

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[16] The manufacturer of Med Pass 2.0 explains the following on its website: "Fortified Nutritional Shakes provide a convenient way to supplement calories and protein . . . MED PASS 2.0 Fortified Nutritional Shakes deliver more nutrition than water, juice or milk and are nectar thick. This additional intake can mean weight maintenance or weight gain." *See* *http://www.hormelhealthlabs.com/2colTemplate_product.aspx?page=CO_MedPass&cond_id=141&cat_id=147* (last visited February 26, 2016).

[17] CMS, in its brief, points out that the record does not show that the facility obtained daily weights of Resident # 163. CMS Br. at 8. I agree that the record does not show a recorded weight for each date. However, the SOD does not allege a quality of care deficiency regarding the facility's failure to obtain daily weights. Rather, the SOD alleges noncompliance pursuant to 42 C.F.R. § 483.10(b) based on the facility's failure to notify the doctor of the weight loss that occurred between May 22 and May 24, 2014. CMS Ex. 1 at 7-9.

E. The penalty imposed is reasonable.

I examine whether the amount of a CMP is reasonable by applying the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of noncompliance; 2) the facility's financial condition; 3) the factors specified in 42 C.F.R. § 488.404; and 4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort, or safety. The absence of culpability is not a mitigating factor. The factors listed in 42 C.F.R. § 488.404 include: 1) the scope and severity of the deficiency; 2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and 3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

The regulations specify that a CMP that is imposed against a facility on a per-day basis will fall into one of two ranges. 42 C.F.R. §§ 488.408; 488.438. The upper range of a CMP, $3,050 per day to $10,000 per day, is reserved for deficiencies that pose immediate jeopardy to a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i); 488.438(d)(2). The lower range of CMP, $50 to $3,000 per day, is reserved for deficiencies that do not pose immediate jeopardy, but either cause actual harm to residents, or cause no actual harm but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). In assessing the reasonableness of a CMP amount, an ALJ looks at the per-day amount, rather than the total accrued CMP. *See Kenton Healthcare, LLC,* DAB No. 2186 at 28 (2008). The regulations leave the decision regarding the choice of remedy to CMS, and the amount of the remedy to CMS and the ALJ, requiring only that the regulatory factors at 42 C.F.R. §§ 488.438(f) and 488.404 be considered when determining the amount of a CMP within a particular range. 42 C.F.R. §§ 488.408; 488.408(g)(2); 498.3(d)(11); *see also* 42 C.F.R. § 488.438(e)(2) and (3); *Alexandria Place,* DAB No. 2245 at 27; *Kenton Healthcare, LLC,* DAB No. 2186 at 28-29.

Unless a facility contends that a particular regulatory factor does not support the CMP amount that CMS imposed, the ALJ must sustain it. *Coquina Ctr.*, DAB No. 1860 at 32 (2002). CMS decided to impose a per-day CMP in this case, and I found that the immediate jeopardy level of noncompliance was not clearly erroneous. Thus, the minimum CMP I am required to sustain is $3,050 per day. CMS imposed a penalty of $3,700 per day from July 19 through September 11, 2014, which is at the low end of the penalty range for immediate jeopardy situations. 42 C.F.R. § 488.438(a)(1)(i). CMS also imposed a penalty of $200 per day from September 12, 2014, through October 11, 2014, which encompasses the five uncontested non-immediate jeopardy level violations; again, this CMP is at the very low end of the penalty range. 42 C.F.R. § 488.438(a)(1)(ii). Petitioner had more than one immediate jeopardy level deficiency, and failed to adhere to an attending physician's orders in a situation involving a resident who was pulseless and not breathing. The per-day penalty for this violation was very close to the minimum permissible under CMS's regulations, and Petitioner has not pointed to any factors that

show the CMP was unreasonable. Likewise, I have considered all of the facility's deficiencies. In addition to those discussed above, the facility was not in substantial compliance with 42 C.F.R. §§ 483.10(b)(4) and 483.25(m)(2) at a D level of scope and severity, and it was not in substantial compliance with 42 C.F.R. §§ 483.25(h) and 483.75(b) at an E level of scope and severity. The facility was also not in substantial compliance with 42 C.F.R. § 483.35(i) at an F level of scope and severity. Any one of these deficiencies, by itself, would have justified a penalty of at least $50 (and potentially up to $3,000) per day, and I therefore conclude that the $200 per-day CMP is reasonable. 42 C.F.R. § 488.438(a)(1)(ii).

CMS contended in its brief that "[t]he nursing home had a history of noncompliance prior to the survey at issue," yet I see no such support in the document it referenced in support of that assertion. CMS Br. at 10, citing CMS Ex. 13 (AEM Nursing Home Enforcement Case Profile). Nonetheless, the facility had a total of nine deficiencies cited at the September 2014 survey, eight of which I have upheld and three of which constituted immediate jeopardy.

The facility does not allege difficulties with its financial situation, but it does allege a lack of culpability. A lack of culpability is not a mitigating factor, and in this case, the facility's staff is culpable because they did not fulfill their responsibilities to Resident # 188. Even months after Resident # 188's death, the facility still fails to recognize its errors. I reiterate that the per-day CMPs are at the very low end of the wide range allowed by regulation, and the CMPs are reasonable.

Based on all of these significant deficiencies, I do not find the $209,500 CMP was unreasonable.

IV. Conclusion

For the reasons discussed above, I find that the facility was not in substantial compliance with the Medicare requirements, its deficiencies posed immediate jeopardy to resident health and safety from July 19, 2014 through September 11, 2014, and the $209,500 penalty imposed was reasonable. However, I reverse CMS's determination that the facility was not in substantial compliance with 42 C.F.R. § 483.10(b).

/s/
Leslie C. Rogall
Administrative Law Judge