Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Legacy Health and Rehabilitation Center
(CCN: 04-5267),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-09-560

Decision No. CR2415

Date: August 17, 2011

DECISION

Petitioner, Legacy Health and Rehabilitation Center, was not in substantial compliance with program participation requirements from April 24, 2009 to July 16, 2009, due to a violation of 42 C.F.R. § 483.25.[1] There is a basis for the imposition of an enforcement remedy. A per instance civil money penalty (PICMP) of $6,000 is reasonable.

I. Background

Petitioner is located in Fort Smith, Arkansas, and participates in Medicare as a skilled nursing facility (SNF) and the state Medicaid program as a nursing facility (NF). On April 24, 2009, Petitioner was surveyed by the Arkansas Department of Human Services, Office of Long Term Care (state agency), and found not in compliance with program participation requirements due to violations of 42 C.F.R. §§ 483.25 (Tag F309) and 483.75(l)(1) (Tag F514). The Centers for Medicare and Medicaid Services (CMS) notified Petitioner by letter, dated May 8, 2009, that it was imposing the following

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[1] Citations are to the version of the Code of Federal Regulations (C.F.R.) in effect at the time of the survey, unless otherwise indicated.

enforcement remedies: a PICMP of $6,000 for the violation of 42 C.F.R. § 483.25 (Tag F309); a denial of payment for new admissions (DPNA) beginning on May 23, 2009, and continuing until Petitioner returned to substantial compliance; and termination of Petitioner's provider agreement on July 24, 2009, if Petitioner did not return to substantial compliance before that date. CMS also advised Petitioner that it would not be eligible to conduct a Nurse Aide Training and Competency Evaluation Program (NATCEP) for two years. CMS Exhibit (Ex.) 1, at 1-3. CMS notified Petitioner by letter dated July 16, 2009, that Petitioner had returned to substantial compliance, and the DPNA and termination remedies were rescinded. CMS Ex. 1, at 4-5.

Petitioner requested a hearing before an Administrative Law Judge (ALJ) by letter dated July 2, 2009. The case was assigned to ALJ Alfonso J. Montaño for hearing and decision on July 13, 2009, and an Acknowledgement and Prehearing Order was issued at his direction. On March 2 and 3, 2010, Judge Montaño conducted a hearing in Fort Smith, Arkansas. On June 1, 2010, Judge Montaño completed the hearing by telephone. A transcript (Tr.) of the proceedings was prepared. Judge Montaño admitted CMS exhibits (Exs.) 1 through 16 at hearing. Tr. at 10-11, 19, 305-06, 309, 360-61. On June 1, 2010, CMS offered the curriculum vitae (CV) for Gary Gerstenblith, M.D., who was called to testify on June 1, 2010. The CV for Dr. Gerstenblith was incorrectly marked as CMS Ex. 17, as CMS had previously offered a document marked CMS Ex. 17 with its April 1, 2010 brief regarding alleged witness perjury.[2] I have remarked the CV for Dr Gerstenblith as CMS Ex. 27, the next CMS exhibit in sequence. No objection has been made to my consideration of CMS Ex. 27, and it is admitted. Judge Montaño admitted Petitioner's exhibits (P. Ex.) 1 through 14, at hearing. Tr. at 12, 118, 361. He admitted

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[2] Each party alleged that the testimony of one of the opposing party's witnesses was false and, possibly, rose to the level of perjury. Judge Montaño permitted supplemental briefing on the matter. Tr. at 354. On April 1, 2010, CMS submitted its brief and CMS Exhibits 17 through 26. On April 14, 2010, Petitioner submitted its supplemental briefing with P. Exs. 16 through 19. During the hearing on June 1, 2010, Judge Montaño informed the parties that he would address the issue of credibility of the witnesses' testimony in the decision, if necessary. Tr. at 450. My review reveals no evidence that either witness testified to any material matter that they believed not to be true. 18 U.S.C. § 1621. Accordingly, I conclude that the allegation of perjury is unsupported. I find it unnecessary to rely upon the testimony of the surveyor related to any material fact in dispute, and her credibility is not in issue. I note that the surveyor did not draft the allegations in the Statement of Deficiencies (SOD) or review the records of the resident involved in the deficiency under consideration. Tr. at 27, 55-56, 130. I do consider the testimony of Petitioner's witness related to the incident that is the basis for the deficiency citation under consideration. I do not find Petitioner's witness's credibility negatively impacted by the perjury allegation, as that allegation is unfounded. The exhibits offered by the parties on this issue, CMS Exs. 17 through 26 and P. Ex. 16 through 19, are not admitted, as they are not relevant to matters properly at issue before me.

P. Ex. 15 by Order dated March 10, 2010. CMS called the following witnesses: Surveyor Ava Applegate, RN (Registered Nurse); Surveyor Kaye Lawrence, RN; and Gary Gerstenblith, M.D. Petitioner called the following witnesses: Kristy Unkel, RN; Brandy Pierce, CNA (Certified Nursing Assistant); Jennifer Garner, RN, Chrystal Lindenau, LPN (Licensed Practical Nurse); Randy McChristian, Petitioner's Administrator; and Phillip Bobo, M.D. The parties filed post-hearing briefs (CMS Br. and P. Br.) and post-hearing reply briefs (CMS Reply and P. Reply).

Judge Montaño left the Departmental Appeals Board in August 2010, and this matter was subsequently reassigned to me. I have reviewed the transcript of the hearing, the documentary evidence, and the pleadings of the parties. I conclude that a supplemental hearing or additional briefing is not necessary.

II. Discussion

A. Issues

Whether there is a basis for the imposition of an enforcement remedy; and

Whether the enforcement remedy proposed is reasonable.

B. Applicable Law

The statutory and regulatory requirements for participation of a SNF in Medicare are found at section 1819 of the Social Security Act (Act) and at 42 C.F.R. Part 483. Section 1819(h)(2) of the Act authorizes the Secretary of Health and Human Services (Secretary) to impose enforcement remedies against a SNF for failure to comply substantially with the federal participation requirements established by sections 1819(b), (c), and (d) of the Act.[3] The Act requires that the Secretary terminate the Medicare participation of any SNF that does not return to substantial compliance with participation requirements within six months of being found not to be in substantial compliance. Act § 1819(h)(2)(C). The Act also requires that the Secretary deny payment of Medicare benefits for any beneficiary admitted to a SNF, if the SNF fails to return to substantial compliance with program participation requirements within three months of being found not to be in substantial compliance – commonly referred to as the mandatory or statutory DPNA. Act § 1819(h)(2)(D). The Act grants the Secretary discretionary authority to terminate a

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[3] Participation of a NF in Medicaid is governed by section 1919 of the Act. Section 1919(h)(2) of the Act gives enforcement authority to the states to ensure that NFs comply with their participation requirements established by sections 1919(b), (c), and (d) of the Act.

noncompliant SNF's participation in Medicare, even if, there has been less than six months of noncompliance. The Act also grants the Secretary authority to impose other enforcement remedies, including a discretionary DPNA, civil money penalties (CMP), appointment of temporary management, and other remedies such as a directed plan of correction. Act § 1819(h)(2)(B).

The Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility that is not in substantial compliance with federal participation requirements. A facility is in "substantial compliance" so long as no identified deficiency poses a greater risk to resident health or safety than the potential for causing minimal harm. 42 C.F.R. § 488.301. "Noncompliance" is any deficiency that causes a facility to not be in substantial compliance. 42 C.F.R. § 488.301. A deficiency is a violation of a participation requirement established by sections 1819(b), (c), and (d) of the Act or the Secretary's regulations at 42 C.F.R. Part 483, subpart B. 42 C.F.R. § 488.301. State survey agencies survey facilities that participate in Medicare on behalf of CMS to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-.28, 488.300-.335. The regulations specify the enforcement remedies that CMS may impose if a facility is not in substantial compliance with Medicare requirements. 42 C.F.R. § 488.406.

A CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 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), (d)(2). "Immediate jeopardy means 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. The lower range of a CMP, $50 per day to $3,000 per day, is reserved for deficiencies that do not constitute 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). CMS is authorized to impose a PICMP from $1,000 to $10,000, and that range is not affected by whether or not immediate jeopardy is identified. 42 C.F.R. § 488.438(a)(2).

Petitioner was notified in this case that any prior approval to conduct a NATCEP was withdrawn and that Petitioner was ineligible to conduct such a program for two years. Pursuant to sections 1819(b)(5) and 1919(b)(5) of the Act, SNFs and NFs may only use nurse aides who have completed a training and competency evaluation program. Sections 1819(e) and 1919(e) of the Act impose upon the states the requirement to specify what NATCEPs they will approve that meet the requirements that the Secretary established and a process for reviewing and re-approving those programs using criteria the Secretary set. Pursuant to sections 1819(f)(2) and 1919(f)(2) of the Act, the Secretary was tasked to develop requirements for approval of NATCEPs and the process for review of those programs. The Secretary promulgated regulations at 42 C.F.R. Part 483, subpart D. Pursuant to 42 C.F.R. § 483.151(b)(2) and (e)(1), a state may not approve, and must

withdraw any prior approval of a NATCEP offered by a SNF or NF that has been: (1) subject to an extended or partial extended survey under sections 1819(g)(2)(B)(i) or 1919(g)(2)(B)(i) of the Act; (2) assessed a CMP of not less than $5,000; or (3) subject to termination of its participation agreement, a DPNA, or the appointment of temporary management. Extended and partial extended surveys are triggered by a finding of "substandard quality of care" during a standard or abbreviated standard survey and involve evaluating additional participation requirements. "Substandard quality of care" is identified by the situation where surveyors identify one or more deficiencies related to participation requirements established by 42 C.F.R. § 483.13 (Resident Behavior and Facility Practices), § 483.15 (Quality of Life), or § 483.25 (Quality of Care) that are found to constitute either immediate jeopardy, a pattern of or widespread actual harm that does not amount to immediate jeopardy, or a widespread potential for more than minimal harm that does not amount to immediate jeopardy and there is no actual harm. 42 C.F.R. § 488.301.

The Act and regulations make a hearing before an ALJ available to a long-term care facility against which CMS has determined to impose an enforcement remedy. Act §§ 1128A(c)(2), 1866(h); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *Residence at Salem Woods*, DAB No. 2052 (2006); *Cal Turner Extended Care*, DAB No. 2030 (2006); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Anesthesiologists Affiliated*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. §§ 488.408(g)(1), 488.330(e), 498.3. However, the choice of remedies and the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance determined by CMS, if a successful challenge would affect the range of the CMP that may be imposed or impact the facility's authority to conduct a NATCEP. 42 C.F.R. § 498.3(b)(14), (d)(10)(i). The CMS determination as to the level of noncompliance, including the finding of immediate jeopardy, "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2); *Woodstock Care Ctr.*, DAB No. 1726, at 9, 38 (2000), *aff'd*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g., Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). ALJ Review of a CMP is subject to 42 C.F.R. § 488.438(e).

The standard of proof, or quantum of evidence required, is a preponderance of the evidence. CMS has the burden of coming forward with the evidence and making a *prima facie* showing of a basis for imposition of an enforcement remedy. Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense. *Batavia Nursing & Convalescent Inn*, DAB No. 1911 (2004); *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v.*

Thompson, 129 F. App'x 181 (6th Cir. 2005); *Emerald Oaks*, DAB No. 1800; *Cross Creek Health Care Ctr.*, DAB No. 1665 (1998); *see Hillman Rehab. Ctr.*, DAB No. 1611 (1997), *aff'd, Hillman Rehab. Ctr. v. U.S.*, No. 98-3789 (GEB), 1999 WL 34813783 (D.N.J. May 13, 1999).

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold text followed by my findings of fact and analysis. CMS alleges, based on the survey that ended April 24, 2009, that Petitioner was not in substantial compliance with program participation requirements due to a violation of 42 C.F.R. § 483.25 (Tag F309) that allegedly posed immediate jeopardy to Petitioner's residents. CMS proposes to impose a $6,000 PICMP for the deficiency. The surveyors also alleged a violation of 42 C.F.R. § 483.75(l)(1) (Tag F514), but that deficiency is not subject to my review as it is not cited as a basis for an enforcement remedy. 42 C.F.R. §§ 488.408(g), 498.3(b)(13). Both the DPNA and termination remedies were rescinded because Petitioner returned to substantial compliance. CMS Ex. 1, at 4-5. Petitioner became ineligible to conduct a NATCEP because the amount of the PICMP is $5,000 or more. CMS Ex. 1.

I have carefully considered all the evidence and the arguments of both parties, though not all may be specifically discussed in this decision. I discuss in this decision the credible evidence given the greatest weight in my decision-making.[4] The fact that evidence is not specifically discussed should not be considered sufficient to rebut the presumption that I considered all the evidence and assigned such weight or probative value to the credible evidence that I determined appropriate within my discretion as an ALJ. There is no requirement for me to discuss the weight given every piece of evidence considered in this case, nor would it be consistent with notions of judicial economy to do so.

1. Petitioner violated 42 C.F.R. § 483.25 (Tag F309).

2. The violation of 42 C.F.R. § 483.25 (Tag F309) posed a risk for more than minimal harm.

Petitioner is obligated as a program participant to ensure that each resident receives the "necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." 42 C.F.R. § 483.25. The surveyors allege in the SOD that Petitioner failed to provide the necessary care and services for Resident 6 when he was found not

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[4] "Credible evidence" is evidence that is worthy of belief. *Black's Law Dictionary* 596 (18th ed. 2004). The "weight of evidence" is the persuasiveness of some evidence compared to other evidence. *Id*. at 1625.

breathing, without a pulse, and with dilated pupils, and staff failed to immediately begin cardiopulmonary resuscitation (CPR). The surveyors allege that Petitioner's failure to provide necessary care and services for Resident 6 posed immediate jeopardy. CMS Ex. 2, at 1-10. Surveyor Kaye Lawrence testified that the deficiency was cited because: the surveyors could not find a Do Not Resuscitate (DNR) order for Resident 6; CPR was not provided to Resident 6; and the surveyors concluded that Petitioner's staff did not provide CPR because they believed that Resident 6 had a DNR order. Tr. at 127-28, 145. She testified that immediate jeopardy was declared because CPR was not initiated, and Petitioner failed to protect its other residents from a similar incident. Tr. at 140-41. I conclude that Petitioner violated the regulation, and the deficiency posed a risk for more than minimal harm.

a. Facts

Resident 6 was admitted to Petitioner on April 1, 2009, and he was 55 years old. Resident 6 died on April 16, 2009, fifteen days after his admission. CMS Ex. 7, at 11-12; P. Ex. 1, at 1, 44. Resident 6 was admitted to Petitioner following his hospitalization on March 29 and 30, 2009, for end-stage liver disease and recurrent hepatic encephalopathy. A paracentesis was performed, which involved the removal of ten liters of accumulated fluid (ascites) from his abdomen. CMS Ex. 6.[5] According to a history and physical dated March 29, 2009, Resident 6 had a long history of end-stage liver disease associated with hepatitis C and drinking, with multiple hospitalizations. The history and physical states that Resident 6 was evaluated and determined to be a candidate for a liver transplant. CMS Ex. 6, at 8; CMS Ex. 7, at 64.

Resident 6's diagnoses on admission to Petitioner included: end-stage cirrhosis of the liver and ascites; hepatic encephalopathy; hepatitis C; a history of alcoholism; and insomnia. CMS Ex. 6, at 2, 8-9; CMS Ex. 7, at 33; P. Ex. 2, at 5; P. Ex. 4, at 1. Petitioner's records for Resident 6 include a document from the prior hospitalization titled "Do Not Resuscitate Orders," dated March 29, 2009, with a check-mark by the line that specified no intubation. P. Ex. 8, at 1; CMS Ex. 6, at 11. But, Petitioner's records for Resident 6 also included a form titled "Advance Directive Acknowledgment," dated April 1, 2009, and signed by the resident's responsible party, which indicates that there were no advance directives in existence. P. Ex. 1, at 29; CMS Ex. 7, at 34. The evidence does not show whether Petitioner clarified with either Resident 6 or his responsible party whether the form completed on admission to Petitioner was intended to supersede or rescind the prior hospital form. His admission nursing assessment indicated that he did not have a DNR order, advanced directive, or other treatment restrictions, which may indicate the other form was not known to the admitting nurse; alternatively, it may

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[5] Surveyor Kaye Lawrence identified CMS Ex. 6 as hospital records obtained by the surveyors during the survey. Tr. at 110.

indicate that the prior advance directive was rescinded. P. Ex. 4, at 5; CMS Ex. 7, at 9. Resident 6's admission Minimum Data Set (MDS), with an assessment reference date of April 14, 2009, indicates, however, that he did not have a DNR advance directive, but he did have other treatment restrictions, the nature of which are not indicated on the MDS. The MDS indicates that Resident 6 was independent for daily decision-making. He could make himself understood, and he usually understood others. P. Ex. 2, at 3; CMS Ex. 7, at 13. The MDS shows he required extensive assistance or was totally dependent for all activities of daily living (ADLs) except eating, for which he required supervision. P. Ex. 2, at 4-5; CMS Ex. 7, at 14-15. His condition was assessed as being unstable. He was receiving medicine intravenously and oxygen therapy. P. Ex. 2, at 6-7; CMS Ex. 7, at 16-17. A RAP (Resident Assessment Protocol) Worksheet indicates that Resident 6 would be totally alert and oriented and then become confused and disoriented due to an increase in his ammonia level. The form states the resident's confusion indicated that his ammonia level was high, and he needed medical treatment as soon as possible. P. Ex. 2, at 11, 13; CMS Ex. 7, at 21, 23.

The deficiency citation at issue arises from the events surrounding Resident 6's death on April 16, 2009. A "Departmental Notes" entry, dated April 16, 2009 at 3:40 a.m., indicates that the charge nurse checked on Resident 6, his temperature was normal, he had no signs or symptoms of ascites, and he denied any needs. P. Ex. 4, at 10; CMS Ex. 7, at 54. A "Nursing Notes" entry at 10:30 a.m. on April 16, 2009 indicates that the resident had been showered and returned to bed. The note states that he was so sleepy he could not keep his eyes open, and his friend was concerned. The note indicates that: the RN was paged to assess the resident; she directed that oxygen be started; and she contacted the physician. A note at 2:00 p.m. indicates that: the resident's pulse was up; he took his medication by mouth without difficulty; and the RN was aware of his condition. P. Ex. 4, at 11; CMS Ex. 7, at 53. There are no "Nursing Notes" or "Departmental Notes" entries between 2:00 p.m. and 4:46 p.m. on April 16. Tr. at 167-68; P. Ex. 4, at 10-11; CMS Ex. 7, at 53-54. The next record is a "Departmental Notes" entry on April 16, 2009 at 4:46 p.m., by Jennifer Garner, RN, the MDS coordinator, which states she was called to the resident's room, he had no respiration, his skin was cool to the touch, he had no palpable or audible heart beat, and he was presumed to have died at 4:40 p.m. The note contains no explanation for the presumed time of death. P. Ex. 4, at 10; CMS Ex. 7, at 54.

RN Garner signed a witness statement on April 20, 2009, and she signed the same statement again on April 24, 2009, after it was typed. RN Garner states that she was called to Resident 6's room at 4:20 p.m., and, while the date is not specifically stated, I infer from the content of the statement that the date was April 16, 2009. She observed that his breathing was slow and labored, he was not responsive to verbal and physical stimuli, and his pupils were fixed and dilated. RN Garner directed the CNAs present to take the resident's vital signs and get him ready for transport to the emergency room. She met Resident 6's family in the hall, advised them the resident was not doing well, and obtained their agreement that he should be sent to the emergency room. RN Garner indicates in her statement that she called Dr. Ross, the resident's physician, and he

consented to the resident's transfer to the emergency room. RN Garner then called for emergency transport to the hospital. She states that, at about 4:35 p.m., she was called back to the resident's room, where she observed that the resident was cold to the touch and with no vital signs. She states that she cancelled the emergency transport at the direction of Petitioner's Administrator, Olivia Heller, because Resident 6 was already dead. RN Garner then called Dr. Ross and the responsible parties and advised them that the resident was dead. P. Ex. 9, at 1-3.

In this case, Petitioner presented the testimony of three witnesses who were actually present in, or near, Resident 6's room at the time of his cardiac arrest. The testimony is significantly inconsistent in recounting what happened with Resident 6 between 4:00 p.m. and 5:00 p.m. on April 16, 2009.

CNA Brandy Pierce was called to testify by Petitioner. CNA Pierce testified that, at just after 4:00 p.m. on April 16, 2009, CNA Shirley McCain asked that she look at Resident 6, as he did not seem right. CNA Pierce agreed that Resident 6 did not look good, his skin looked moist or sweaty and was mottled, but he was breathing. She testified that she went and found RN Garner, she reported her observation to RN Garner, and the nurse returned to Resident 6's room with her. She testified that RN Garner listened to Resident 6's heart and then departed giving no instructions, but saying she was going to call the emergency services. Resident 6 was breathing at that time. CNA Pierce and CNA Amanda remained in the room when RN Garner departed. When RN Garner returned, she instructed the CNAs to clean-up Resident 6 for transport to the emergency room. CNA Pierce testified that all residents were cleaned-up before they were taken out of the facility. CNA Pierce testified that, as she was leaving the room to get clean linen, she saw RN Garner checking Resident 6's heart beat and pulse again. While exiting the walk-in linen closet, CNA Pierce saw RN Garner with Jerry Lee, Social Services Director, and Administrator Heller, go to Resident 6's room. CNA Pierce testified that she followed the three into Resident 6's room and saw RN Garner listen to Resident 6 again. Then, Administrator Heller instructed that emergency services be canceled, and she stated that Resident 6 was not going to make it. Administrator Heller, Jerry Lee, and RN Garner left the room. She did not recall anyone going to cancel the call for emergency medical services. But she did go ahead and clean-up Resident 6 because she thought emergency services were coming, and he had a bowel movement. She testified that he was still breathing with his oxygen in place and his mouth and chest moving. She testified that she finished the clean-up between 4:45 p.m. and 5:00 p.m., at about 4:50 p.m. Tr. at 187-201.

Petitioner presented the testimony of RN Jennifer Garner. Nurse Garner no longer worked at the facility at the time of hearing, having left Petitioner in August 2009. Tr. at 201-03, 266. She testified that, on April 16, 2009, she was the MDS Coordinator for Petitioner. Her version of the events on April 16 that involved Resident 6 was significantly different from the story told by CNA Pierce. RN Garner testified that she was called to Resident 6's room about 4:20 p.m., but she could not recall who called for her first. She found Resident 6 unresponsive, breathing, pupils dilated and fixed, pale

with audible heartbeat and pulse, and she concluded he needed immediate medical attention. She did not perform CPR because he was breathing. She recalled that CNAs were in the room, and she told them to get him cleaned-up for discharge to the hospital. She returned to her office down the hall to call for emergency services to transport and to obtain an order from Dr. Ross. She called Dr. Ross and explained to him the condition of Resident 6, and he gave a verbal order to send Resident 6 to the hospital. She contacted emergency services. She testified that she knew it could take twenty minutes for emergency services to respond, but she believed they responded quickly in this case. She was then interrupted by Carla Carvey, Petitioner's Admissions Director. Ms. Carvey, who admitted Resident 6, insisted that Resident 6 was a DNR. RN Garner testified Resident 6's code status had not occurred to her because, when code status is not known, the resident is to be treated as a full code, meaning that CPR was to be initiated. Ms. Carvey could not find a DNR order in the chart for Resident 6, and Nurse Garner testified that she told Ms. Carvey that, if it is not on the chart, it does not exist. Ms. Carvey continued to insist that the resident had a DNR order. She testified that dealing with Ms. Carvey took time. She did not check the time, when she finished with Ms. Carvey. Tr. at 241-53, 268.

RN Garner testified that she was then called back to the resident's room, which was full of people. She could not recall who called her back to the room, but she believed it might have been the Social Services Director again. There was an LPN named Crystal at the foot of the bed, and she was doing nothing. RN Garner testified that the resident had no heartbeat or respirations, his skin was very cold, and his pupils were fixed and dilated. She concluded that CPR was not necessary because the body would not get to that condition in less than four minutes. She testified that it was up to her to decide whether or not to initiate CPR. The LPN asked if there was anything she could do, and RN Garner sent her back to passing medication. The Admissions Director, Administrator, and several CNAs remained in the room. RN Garner testified that she told the aides to clean-up the body for transport to the funeral home. Tr. at 253-57. She explained that she prepared her electronic nurse's note at 4:46 on April 16 (P. Ex. 4, at 10), and it accurately reflected her recollection of events. She testified that she did not create a note after her first visit to Resident 6's room that afternoon, though she admitted that she should have. She testified that she presumed that the resident died at 4:40 p.m. Tr. at 258-61.

On cross-examination, she testified that, although she could have instructed the CNAs to monitor his vital signs, she doubted that either CNA could have performed CPR for Resident 6. She agreed that she did not have someone qualified in CPR remain with Resident 6, while she went to make telephone calls. She agreed that her nurse's note on April 16 at 4:46 stated that the resident was cool to the touch, but her statement on April 20 was that he was cold to the touch. Tr. at 270-76.

She testified that, in her opinion, there was a break-down in the DNR system, and it was possible that information was not being posted to charts timely. She felt that not everyone, including nurses, were clear on code status. She raised this issue with the

Administrator, Social Services Director, Admissions Director, and her boss, RN Unkel. She recalled that RN Unkel came to the facility to work on corrective action. She testified that procedures for identifying code status did not change. Tr. at 262-64. She testified in response to questions by Judge Montaño that one of the CNAs was Brandy, but she could not recall the name of the other CNA. She testified that at least ten minutes elapsed between her two visits to Resident 6's room. When she returned to the room, the Administrator, Social Services Director, at least three CNAs, and the LPN were present. She admitted that she did not ask the people present what they were doing or when Resident 6 stopped breathing. She admitted that she did not ask the LPN why she had not started CPR. She could not recall how she arrived at the presumed time of death. Tr. at 279-81.

Petitioner called LPN Chrystal Lindenau to testify. LPN Lindenau was still employed by Petitioner at the time of hearing. Tr. at 284. She testified that she was called to Resident 6's room by CNA Brandy Pierce who said the resident had shallow breathing. She entered the room, and the Administrator was already there. LPN Lindenau testified that she immediately started checking the resident's pulses and capillary refill. The Administrator told her that RN Garner was already taking care of the resident and that emergency services had been called. She testified that Resident 6 had no capillary refill, and he was cyanotic, *i.e.*, blue. She checked with a stethoscope and heard no lung sounds or breath sounds. She checked the pupils, and they were not reactive. She testified that she believed it was necessary before starting CPR to determine whether he was a full code or a DNR and that required going to look at his chart. She testified that she did not go to check his chart because the Administrator told her that RN Garner had already turned emergency services away. RN Garner also came into the room about the time LPN Lindenau completed checking pulses. She testified that she concluded Resident 6 was dead, and he was already cool to the touch and very blue around the lips and fingers. However, she admitted that she could not determine how long he had been dead. She asked RN Garner if she needed to chart anything, and RN Garner told her no, and she should go back to the floor. She testified that she did know that Resident 6 was a full code without checking his chart because he was a regular patient, and she had checked his chart because she believed he would not be around much longer. She testified that she was certified to perform CPR. Tr. at 286-300. She testified that her next step would have been to start CPR, if RN Garner had not entered the room. Tr. at 303, 321.

It is not disputed that CPR was not initiated for Resident 6.

The Certificate of Death for Resident 6 shows he died on April 16, 2009, at 4:35 p.m., due to end-stage liver disease and cirrhosis of the liver. P. Ex. 1, at 45; CMS Ex. 7, at 52.

Petitioner's policy, titled "Cardio Pulmonary Resuscitation (CPR)," had an effective date of February 1, 2008 (CPR Policy). The purpose stated in the policy for administering CPR was "[t]o ventilate a resident until adequate circulation to the brain is re-established." P. Ex. 11, at 1 (eff. February 1, 2008); CMS Ex. 8, at 8 (eff. November 1, 2001). The policy states under "Standard" that:

> The licensed nurse makes his/her best judgement (sic), based upon the time passing and the clinical symptoms of the resident, whether to initiate CPR on a resident. CPR is not initiated on residents who have DNR orders.

P. Ex. 11, at 1; CMS Ex. 8, at 8. Under a section titled "Process" the policy provides:

> 1. Begin compressions and assisted ventilation within four minutes immediately after the following symptoms occur:
> · No pulse
> · No respirations
> · No heartbeat
> · Unconsciousness

P. Ex. 11, at 1; CMS Ex. 8, at 8. The policy provides that, once CPR is started, it must be continued, until help arrives or the resident regains consciousness and there are vital signs. P. Ex. 11, at 1. Kristy Unkel, RN, Regional Case Manager with Northport Management, LLC of Arkansas testified that she assisted Petitioner's staff developing and implementing the plan of correction after the survey. She testified that she investigated the incident to determine what happened as part of developing the plan of correction. She testified that whether a resident at Petitioner's facility had a DNR order or was to be provided CPR could be readily determined from the resident's record, including Resident 6's record. Tr. at 152-58. She testified that, under Petitioner's CPR policy, a resident with a DNR order was not to receive CPR, but, if there was no DNR, the nurse had the discretion to withhold CPR, if the four listed symptoms were present and the nurse decided the symptoms were present at least four minutes. She testified that the nurse would make a judgment call as to whether or not four minutes had passed and that, in making that judgment, she would consider body temperature and color. She testified that, if a nurse found a resident with the four signs, the nurse would leave the resident and go check the record to determine whether or not the resident had a DNR order; if not, the nurse would return to the resident and initiate CPR, if four minutes had still not passed. She testified that only licensed nurses, LPN and RN, are required to have CPR certification. Tr. at 161-64, 172.

b. Analysis

The surveyors cited Petitioner for violation of the general quality of care regulation. The regulation requires that each resident receive care and services necessary to attain and maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care and services are to be based upon the resident's comprehensive assessment and plan of care. 42 C.F.R. § 483.25. The Act, the regulations, and the State Operations Manual (SOM) do not specify what treatment is required in the event of cardiac arrest, *i.e.*, cessation of a heartbeat, pulse, and breathing, and loss of consciousness. The Act,

the regulations, and the SOM do not address whether or not CPR may be a necessary care or service.[6] Therefore, it is necessary to consider what the standard of care is for long-term care residents who experience cardiac arrest.

The parties dispute the appropriate standard of care to be applied. CMS advocates that the American Heart Association (AHA) guidelines control. CMS is the proponent for the regulations at 42 C.F.R. Part 483 that establish requirements for long-term care facilities but CMS has never issued a regulation that requires that a long-term care facility comply with the AHA guidelines. CMS points to no policy statement that encourages adherence to the AHA guidelines. The Board has referred to the AHA guidelines in several cases but has never stated that those guidelines establish the standard of care binding upon all long-term care facilities in the case of a resident who suffers cardiac arrest. *Lakeridge Villa Healthcare Ctr*, DAB No. 2396, at 9 (2011); *Woodland Oaks Healthcare Facility*, DAB No. 2355, at 15 (2010); *John J. Kane Reg'l Ctr. – Glen Hazel*, DAB No. 2068, at 10-18 (2007)); *Royal Manor*, DAB No. 1990, at 6 (2005). Petitioner advocates that it had the discretion to adopt a policy; its policy reflects the appropriate standard of care; and its policy controls.

AHA guidelines state that few criteria can accurately predict the futility of administering CPR. Therefore, all persons in cardiac arrest should receive CPR, unless: (1) the person has a valid DNR order; (2) the person has signs of irreversible death such as rigor mortis, decapitation, decomposition, or dependent lividity; or (3) no physiological benefit can be expected because vital functions have deteriorated. CMS Ex. 10, at 3. The AHA states, regarding out-of-hospital resuscitation, that the first lay responder to arrive should begin CPR. Further, healthcare providers are expected to provide CPR and advanced cardiovascular life support (ACLS) as part of their duty to respond. The enumerated exceptions are: (1) the person has obvious signs of irreversible death, such as rigor mortis, decapitation, decomposition, or dependent lividity; (2) an attempt to perform CPR would place the rescuer at risk of physical injury; (3) the person has indicated by an advance directive, such as a DNR order, that resuscitation is not desired. The AHA states

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[6] Effective July 31, 2009, Arkansas provided by statute that CPR may be withheld by a licensed nurse employed by a nursing facility, absent a DNR order, when: (1) the death was unwitnessed; (2) the body shows clear and unmistakable dependent lividity (clear demarcation of pooled blood in the body) or rigor (major joints are unmovable); (3) respirations, carotid pulse, lung sound (using stethoscope) are absent for 30 seconds; and (4) both pupils, if they can be accessed, are nonreactive to light. If CPR is withheld under the conditions described, the facility and licensed nurse are not liable for administrative sanctions, civil damages, or subject to criminal prosecution. Ark. Code Ann. § 20-17-104 (2011). The bill that became this law was pending in the Arkansas legislature at the time of Resident 6's death. Available at http://www.arkleg.state.ar.us/assembly, 87th General Assembly, Act No. 718.

that neither a lay person nor medical professional should withhold CPR based on a judgment about the future quality of life of the victim. The AHA further states that CPR and ACLS should be initiated if clear indication of the victim's wishes is not available; there is a reasonable doubt about the validity of a DNR order or other advance directive; there is reason to believe the patient changed his or her mind; or the best interests of the victim are in question. CMS Ex. 10, at 4-5.

CMS called Gary Gerstenblith, MD, to testify as an expert. He testified, generally, that nursing staff should comply with the AHA guidelines, as they set forth the appropriate standard of care for withholding CPR. Tr. at 391-415. Petitioner called Phillip Bobo, MD, to testify as an expert. Dr. Bobo opined that the AHA guidelines are for the emergency medical services personnel in the field and for lay people, not for medical professionals in the hospital or long-term care facilities. Tr. at 426-28, 442-43. This opinion is not credible based on my reading of the AHA document in evidence, which clearly indicates that the guidelines for withholding CPR apply to both the layman and the licensed nurse or physician, though the decision to terminate CPR clearly resides with the physician. CMS Ex. 10.

Petitioner's policy is not as detailed as the AHA guidelines. According to Petitioner, its policy provides that, absent a DNR order, a nurse should use his or her best judgment to decide whether or not to initiate CPR based upon the passage of time and clinical symptoms. Petitioner argues that its policy sets forth the correct standard of care. The standard of care advocated by Petitioner requires that a nurse initiate CPR within four minutes of the onset of no pulse, no respirations, no heartbeat, and unconsciousness. Petitioner argues that its policy allows a nurse to decide to withhold CPR, if more than four minutes have elapsed during which the victim has no pulse, no respirations, no heartbeat, and the victim is unconsciousness. P. Reply at 2; P. Ex. 11; CMS Ex. 8, at 8.

I conclude that it is unnecessary for me to decide whether the AHA guidelines or Petitioner's policy reflected the correct standard of care for initiating or withholding CPR at the time of Resident 6's death – Petitioner's staff did not comply with either. Petitioner does not argue that its nursing staff satisfied the AHA guidelines when providing care and services to Resident 6 on April 16, 2009, by assessing whether there were signs of irreversible death, such as rigor mortis or dependent lividity. Petitioner does not assert that either nurse attempted to assess whether there could be no expected physiological benefit from administering CPR due to deterioration of the resident's vital functions. Petitioner's staff also failed to meet even the less stringent standards of its own policy by withholding CPR from Resident 6.

There is no disagreement that Resident 6 did not have a DNR order in his clinical record, or chart, on April 16, 2009. P. Br. at 3. Petitioner admits that, under its policy, Resident 6 should have been considered a "full code," *i.e.*, he should be presumed to prefer to receive CPR in the event of cardiac arrest. P. Reply at 2. There is no question raised by either party as to whether or not CPR qualifies as a care or service within the meaning of 42 C.F.R. § 483.25. Petitioner's policy states that the purpose of administering CPR is to

ventilate the resident until adequate circulation to the brain is reestablished, which is consistent with CPR being a necessary care and service for one in cardiac arrest. CMS Ex. 8, at 8; P. Ex. 11. The AHA states that "[t]he goals of emergency cardiovascular care are to preserve life, restore health, relieve suffering, limit disability, and reverse clinical death," which is also consistent with the conclusion that CPR is a necessary care or service. CMS Ex. 10, at 2. I conclude that CPR is, absent a valid DNR order, a necessary care or service under the standard of care within the meaning of 42 C.F.R. § 483.25, for the long-term care facility resident who suffers cardiac arrest. There is no dispute that Petitioner's staff did not initiate CPR for Resident 6 on April 16, 2009, and he died. I conclude that death and failure to resuscitate is more than minimal harm. Accordingly, CMS made a *prima facie* showing of a deficiency under Tag F323.

The burden is upon Petitioner to rebut the CMS *prima facie* showing or to establish an affirmative defense. The quantum of evidence required is a preponderance of the evidence. Petitioner's defense is that, under its policy, there was no requirement for nursing staff to initiate CPR because more than four minutes elapsed with no respiration, heartbeat, or pulse, and the resident was unconscious. Petitioner does not satisfy its burden, as the evidence does not show that more than four minutes elapsed before it was discovered that Resident 6 had no respiration, heartbeat, or pulse, and that he was unconscious.

The facts set forth above show that RN Garner entered an electronic nurse's note at 4:46 p.m. on April 16, 2009. The note indicates she was called to the resident's room where she found him with no respiration, skin that was cool to the touch, with no palpable or audible heartbeat. The note states she presumed he died at 4:40 p.m., but there is no explanation for her conclusion. The note does not record that she saw Resident 6 in his room when he was still alive, or what transpired between her initial visit to Resident 6 about 4:20 p.m. and 4:40 p.m. the time she presumed he died, or 4:35 p.m. the time the coroner certified death. P. Ex. 4, at 10; CMS Ex. 7, at 54. RN Garner testified that she first saw Resident 6 in his room about 4:20 p.m., and he was unresponsive and his pupils were dilated and fixed. Serious neurologic signs existed, but he was still breathing and had a pulse, so she did not initiate CPR. She testified that she knew that he needed immediate medical attention. She does not deny that she left Resident 6 without anyone present who could provide CPR, if necessary, when she went to call the treating physician and the emergency services to take the resident to the hospital. She did not note the time she left Resident 6, she did not note the time she received the order from the physician to transport the resident to the hospital, she did not note when she called emergency medical services. Petitioner did not present any record from the emergency medical services related to the call from RN Garner. RN Garner testified that she had to spend time discussing with the Admissions Director whether or not Resident 6 had a DNR order. However, she testified that she believed he should be treated as not having a DNR order, as one could not be located. Despite having previously concluded that he required immediate medical attention and that he had no DNR, she did not immediately return to Resident 6's room to check his status. Rather, she had to be called back to the room, by whom she was not certain, and she did not note the time. RN Garner testified

that, when she returned to Resident 6's room, she found it full of people, including LPN Lindenau, the Admissions Director who had insisted that the resident had a DNR, the Administrator, and several CNAs. She testified she assessed Resident 6, and he had no heartbeat or respirations and his skin was very cold. She testified that she decided not to do CPR because she believed the body could not get to that condition in less than four minutes. Tr. at 241-57, 268, 270-76. She testified that she believed ten minutes elapsed between her first and second visits to Resident 6's room. She could not explain why she characterized the resident's skin as cool in her contemporaneous nurse's note but later gave a statement and testified that his skin was very cold. She admitted that she did not ask anyone present in the room when Resident 6 stopped breathing, and she did not ask the LPN why she had not initiated CPR. She also admitted she could not recall how she determined the time of death. Tr. at 279-81.

LPN Lindenau testified that she was in Resident 6's room because CNA Pierce requested her assistance due to Resident 6's shallow breathing. LPN Lindenau did not specify how long it took her to go to Resident 6's room. But she testified that when she did arrive she assessed the resident as having no capillary refill, he was cyanotic, he had no audible lung or breath sounds, and his pupils were not reactive. She testified that she knew that the resident did not have a DNR order, but she did not initiate CPR. She testified that the Administrator, who was already present, told her that RN Garner was already taking care of the resident. She testified she thought the resident was dead when she arrived in the room, but she admitted she could not tell how long he had been dead. Tr. at 286-300. However, according to LPN Lindenau's testimony, CNA Pierce told her the resident was still breathing when CNA Pierce started looking for the LPN. Unless it could be determined by LPN Lindenau that the combined time required for CNA Pierce to find LPN Lindenau and for LPN Lindenau to arrive in Resident 6's room exceed four minutes, CPR should not have been withheld under Petitioner's policy. I also note that, under Petitioner's policy, the decision to withhold CPR had to be made by a nurse not the Administrator, who was not a nurse. Tr. at 338; P. Ex. 11, at 1, CMS Ex. 8, at 8. LPN Lindenau also testified that, had RN Garner not reentered the room as she finished her assessment of Resident 6, she would have initiated CPR. Tr. at 303, 321. This testimony is significant, as it strongly suggests that LPN Lindenau: (1) had determined that less than four minutes had passed; or (2) was uncertain about how much time had passed and believed CPR was necessary under Petitioner's policy. Of course, her testimony is also inconsistent with her prior testimony that the Administrator told her that RN Garner was handling the situation.

According to CNA Pierce, it was actually the Administrator who told RN Garner that Resident 6 was not going to make it and instructed that the call to emergency medical services be cancelled. Tr. at 195, 200. CNA Pierce also testified that, after the Administrator and RN Garner left the room, she observed that Resident 6 was still breathing with his oxygen machine at about 4:50 p.m. Tr. at 196-97; 201-02. Petitioner asserts that this was not the CNA's testimony, but that is certainly my reading. Petitioner also asserts it should not be considered fact because it is not corroborated. P. Reply at 4. CNA Pierce was called to testify by Petitioner, she testified under oath, neither party

impeached her, and Petitioner did not rebut her testimony, even though it was adverse to Petitioner. No corroboration is required for me to find CNA Pierce's testimony fully credible. I do not, however, treat CNA Pierce's testimony as conclusively establishing that Resident 6 was still alive at 4:50 p.m. on April 16, 2009. Rather, I accept her testimony as weighty evidence showing that Petitioner failed to show: (1) when Resident 6 experienced cardiac arrest; and (2) that nursing staff determined CPR could be withheld because there was no breathing, pulse, or heartbeat, and the resident was unconscious for four minutes, as the standard of care reflected by Petitioner's policy required.

The Administrator notified the coroner that Resident 6 died at 4:35 p.m. on April 16, 2009. CMS Ex. 7, at 51. The death certificate indicates that Resident 6 died at 4:35 p.m. on April 16, 2009. Apparently, the death certificate was based solely on the Administrator's notice to the coroner, as Petitioner states that there was no onsite investigation or pronouncement by the coroner. P. Br. at 4-5. I note that, if the Administrator correctly determined the time of death as 4:35 p.m. and RN Garner is correct that she returned to the room at 4:40 p.m., arguably, the evidence shows more than four minutes elapsed. However, even if I accepted this evidence as credible, it does not show that LPN Lindenau was not in the room during the critical four minute period. I also do not accept as credible the Administrator's determination that the time of death was 4:35 p.m. The Administrator was not a physician or nurse, and I have no evidence from which to determine how she determined that the resident was dead. Furthermore, there is the conflicting testimony of CNA Pierce that Resident 6 was actually breathing as late as 4:50 p.m.

Petitioner attempts to rely upon the testimony of RN Garner that the resident was cold to the touch and that a body would not be that cold if not dead for more than four minutes. Petitioner's reliance is misplaced. RN Garner described the resident as only cool to the touch in her nursing note made at the time. Subsequently, she described his skin as cold. She never gave a more precise description as to how cold the resident's skin was, and there is no evidence that the resident's temperature was taken. Even Petitioner's expert Doctor Bobo was not willing to testify that the temperature of the resident's skin was good evidence that he had been dead for more than four minutes. He testified that the resident's condition was indicative of him having been in arrest for more than four minutes, but he was clear that the period of time that passed, as reflected by clinical records, was the basis for his opinion. Tr. at 425. On cross-examination and on examination by the judge, he admitted that there was no clear evidence that four minutes had passed. Tr. at 436-38. He subsequently admitted on further inquiry by the judge that it was not known when the resident stopped breathing. Tr. at 441, 443.

Based on my review of all the evidence, I conclude that Petitioner has failed to show that either LPN Lindenau or RN Garner determined that Resident 6 had no respiration, heartbeat, or pulse, and had been unconscious for more than four minutes. Therefore, by withholding CPR, the nurses violated the standard of care to the extent that the standard of care was reflected by Petitioner's policy.

Petitioner also argues that the regulations do not compel a facility to take actions that are futile. P. Br. at 14-15. The gist of Petitioner's argument is that it is permissible for it to have a policy that allows nursing staff to withhold CPR, even absent a DNR, under certain defined circumstances. Petitioner argues that its policy is adequate in this regard. Whether or not Petitioner's policy satisfies some requirements suggested by the Board or ALJ s in prior decisions need not be addressed in this case, as I have determined that Petitioner's staff failed to comply with its policy. To the extent that Petitioner's argument could be construed to be that withholding CPR in violation of the standard of care evidence by its policy should be excused, I do not agree. Dr. Bobo opined in testimony (Tr. at 420) and in his letter of April 24, 2009 (P. Ex. 12, at 2) that initiating CPR would not have affected the outcome for Resident 6. Dr. Ross also opined in his statement, dated April 28, 2009, that CPR would have proven futile. P. Ex. 12, at 1. Neither Petitioner's policy nor the AHA guidelines permit withholding CPR simply because CPR may ultimately prove futile.

3. There is a basis for the imposition of an enforcement remedy.

4. A $6,000 PICMP is reasonable in this case.

I have concluded that Petitioner violated 42 C.F.R. § 483.25 and that the violation posed a risk for more than minimal harm to one or more facility residents. If a facility is not in substantial compliance with program requirements, CMS has the authority to impose one or more of the enforcement remedies listed in 42 C.F.R. § 488.406, including a CMP. CMS may impose a per day CMP for the number of days that the facility is not in compliance, or a PICMP for each instance that a facility is not in substantial compliance, whether or not the deficiencies pose immediate jeopardy. 42 C.F.R. § 488.430(a). The minimum amount for a PICMP is $1,000, the maximum amount is $10,000, and the presence or absence of immediate jeopardy does not affect the range. 42 C.F.R. § 488.438(a)(2). I conclude that there is a basis for the imposition of an enforcement remedy in this case.

If I conclude, as I have in this case, that there is a basis for the imposition of an enforcement remedy and the remedy proposed is a CMP, my authority to review the reasonableness of the CMP is limited by 42 C.F.R. § 488.438(e). The limitations are: (1) I may not set the CMP at zero or reduce it to zero; (2) I may not review the exercise of discretion by CMS in selecting to impose a CMP; and (3) I may only consider the factors specified by 42 C.F.R. § 488.438(f), when determining the reasonableness of the CMP amount. In determining whether the amount of a CMP is reasonable, the following factors specified at 42 C.F.R. § 488.438(f) must be considered: (1) the facility's history of non-compliance, including repeated deficiencies; (2) the facility's financial condition; (3) the seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404(b), the same factors CMS and/or the state were to consider when setting the CMP amount; and (4) the facility's degree of culpability, including, but not limited to, the facilities neglect, indifference, or disregard for resident care, comfort, and safety and the absence of culpability is not a mitigating factor.

The factors that CMS and the state were required to consider when setting the CMP amount and that I am required to consider when assessing the reasonableness of the amount are set forth in 42 C.F.R. § 488.404(b): (1) whether the deficiencies caused no actual harm but had the potential for minimal harm, no actual harm with the potential for more than minimal harm, but not immediate jeopardy, actual harm that is not immediate jeopardy, or immediate jeopardy to resident health and safety; and (2) whether the deficiencies are isolated, constitute a pattern, or are widespread. My review of the reasonableness of the CMP is *de* novo and based upon the evidence in the record before me. I am not bound to defer to the CMS determination of the reasonable amount of the CMP to impose, but my authority is limited by regulation as already explained. I am to determine whether the amount of any CMP proposed is within reasonable bounds, considering the purpose of the Act and regulations. *Emerald Oaks*, DAB No. 1800, at 10; *CarePlex of Silver Spring*, DAB No. 1683, at 14–16 (1999); *Capitol Hill Cmty. Rehab. and Specialty Care Ctr.*, DAB No. 1629 (1997).

Based upon the facts discussed above, I find that the deficiency was serious. There is no evidence that Petitioner had a history of noncompliance. Petitioner has not alleged to me that it cannot pay a PICMP and has presented no evidence of its financial condition. The facts show that Petitioner was culpable by its failure to ensure that Resident 6 received the necessary care. The $6,000 PICMP is in the middle range. Based upon my evaluation of the required regulatory factors, I conclude that the $6,000 PICMP is reasonable.

III. Conclusion

For the foregoing reasons, I conclude that: Petitioner violated 42 C.F.R. § 483.25; the violation posed a risk for more than minimal harm; and a PICMP of $6,000 is reasonable.

/s/
Keith W. Sickendick
Administrative Law Judge