Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Epsom Healthcare Center,	)	
(CCN: 30-5080),	)	Date: March 13, 2008
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-07-326
	)	Decision No. CR1749
Centers for Medicare & Medicaid	)	
Services.	)	
	)	

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose remedies against Petitioner, Epsom Healthcare Center, consisting of: civil money penalties in daily amounts of $5000 for each day of a period that ran from February 1 through February 4, 2007; and a denial of payment for new admissions for each day of a period that ran from February 13 through April 29, 2007.[1]

[1] In its final brief, CMS asserts that the denial of payment for new admissions was effective February 1, 2007. However, in its notice letter to Petitioner, CMS stated that the denial of payment for new admissions would be effective February 3, 2007. And, in its final notice letter to Petitioner dated June 18, 2007, CMS stated that the denial of payment for new admissions was effective February 13, 2007. I conclude that the effective date of the denial of payment for new admissions is February 13, 2007. CMS exhibits (CMS Ex.) 4, 5; CMS final brief at 1.

I. Background

Petitioner is a skilled nursing facility doing business in New Hampshire. It participates in the Medicare program and its participation is subject to requirements stated in sections 1819 and 1866 of the Social Security Act (Act) and in implementing regulations at 42 C.F.R. Parts 483 and 488.

A Medicare compliance survey of Petitioner's facility was completed on February 1, 2007 (February 1 survey). The surveyors, and subsequently CMS, determined that Petitioner was not complying substantially with several Medicare participation requirements. Petitioner's alleged noncompliance included two deficiencies that were determined to be so egregious as to comprise immediate jeopardy for Petitioner's residents. Immediate jeopardy exists where a facility's noncompliance causes or is likely to cause serious injury, harm, impairment, or death to one or more residents. 42 C.F.R. § 488.301. CMS determined to impose the civil money penalties that I describe in the opening paragraph of this decision in order to remedy Petitioner's alleged immediate jeopardy level noncompliance. It determined also that Petitioner abated its immediate jeopardy by February 5, 2007. However, CMS found that Petitioner continued to remain noncompliant, albeit at a level of seriousness that was less than immediate jeopardy, through April 29, 2007.[2]

Petitioner requested a hearing to challenge CMS's findings of immediate jeopardy level deficiencies and the case was assigned to me for a hearing and a decision. I held a hearing in Boston, Massachusetts, on December 13, 2007. At the hearing I received into evidence exhibits from CMS which are identified as CMS Ex. 1-CMS Ex. 16, and CMS Ex. 18-CMS Ex. 20. I received into evidence exhibits from Petitioner which are identified as P. Ex. 1-P. Ex. 19. Each party submitted a post-hearing brief (final brief).

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[2] CMS's determination to impose a denial of payment for new admissions through April 29, 2007 is based on findings of continued non-immediate jeopardy level noncompliance through that date. At the February 1 survey the surveyors found that Petitioner manifested 12 non-immediate jeopardy level deficiencies in addition to the two immediate jeopardy level deficiencies that I address in this decision. Petitioner has challenged neither the presence nor the duration of these non-immediate jeopardy level deficiencies and, so, CMS's determinations of their presence and to impose denial of payment for new admissions to remedy them are administratively final.

II. Issues, findings of fact and conclusions of law

A. Issues

The issues in this case are whether:

1. Petitioner failed to comply with Medicare participation requirements;

2. CMS's determination of immediate jeopardy is clearly erroneous; and

3. CMS's civil money penalty determinations are reasonable.

B. Findings of fact and conclusions of law

I make findings of fact and conclusions of law (Findings) to support my decision in this case. I set forth each Finding below as a separate heading. I discuss each Finding in detail.

1. Petitioner failed to comply with Medicare participation requirements.

At issue here are two of the findings of noncompliance that were made at the February 1 survey. First, CMS asserts that Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.13(c). CMS Ex. 1, at 3-9. This regulation mandates a participating facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. Second, CMS argues that Petitioner contravened 42 C.F.R. § 483.25, which requires that each resident of a facility must receive the necessary care and services to attain or maintain that resident's highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. *Id.* at 16-20.

a. Petitioner failed to comply with the requirements of 42 C.F.R. § 483.13(c).

CMS's allegations of noncompliance center on the care that Petitioner's staff gave to two of its residents who are identified in the February 1 survey report as Residents #s 13 and 7.

Resident # 13 was admitted to Petitioner's facility on October 13, 2006. He expired eight days after his admission. CMS Ex. 6, at 1, 20-21, 22, 26. He was gravely ill at the time of his admission suffering from illnesses which included multiple myeloma and sepsis. CMS Ex. 6, at 1. On October 14, 2006 the resident executed a form in which he told Petitioner's staff that they should attempt to resuscitate him in the event that he were found to be not breathing, without a pulse, or in a status where he would be unlikely to survive without advanced life support. CMS Ex. 6, at 32.[3]

Resident # 13 was observed by Petitioner's staff at about 4:45 a.m. on October 21, 2006 to be alive and responsive. However, at about 5:10 on that same morning, a nursing assistant entered the resident's room and found him to be lying sideways across his bed, unresponsive to verbal and physical stimuli, and with his eyes wide open and bulging. CMS Ex. 6, at 25-26; P. Ex. 15, at 2. The nursing assistant was trained in administration of cardiopulmonary resuscitation (CPR). CMS Ex. 13, at 3. She did not attempt to perform CPR on the resident. Rather, she became distraught and left the resident's room. The nursing assistant reported to a registered nurse on duty telling the registered nurse that she thought that Resident # 13 had expired. CMS Ex. 6, at 26; P. Ex. 15, at 2.

The registered nurse then went to the resident's room in the company of a second nursing assistant. In her notes of that encounter the nurse observed that the resident was positioned sideways across the bed, with his eyes wide open, and with his oxygen cannula detached from his nasal passageway. CMS Ex. 6, at 25-26. The nurse recorded that the resident was unresponsive to verbal stimulus and had no pulse, respiration, or blood pressure. *Id.*

The registered nurse, like the nursing assistant who first discovered Resident # 13 in an unresponsive state, was trained in administration of CPR. She made no attempt to provide CPR to the resident nor did she or any other member of Petitioner's staff attempt to call for emergency services for Resident # 13. After observing the resident the nurse pronounced him dead at 5:20 on the morning of October 21, 2006.

Resident # 7 is an individual who, as of the February 1 survey, was aged 85 years. She had resided at Petitioner's facility since 2003 and her diagnoses included Alzheimer's disease, dementia, and osteoporosis. CMS Ex. 14, at 1, 6; CMS Ex. 18, at 1. The resident had severely limited functional capacity and was totally dependent on

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[3] The document indicating the resident's wishes was signed and dated by Petitioner's medical director on October 24, 2006, three days after the resident's death. CMS Ex. 6, at 32. Neither CMS nor Petitioner argue that the postdated form is in any respect contrary to the wishes expressed by the resident on October 14.

Petitioner's staff for care and support. The resident had a history of sustaining falls. Her care plan included instructions that two staff members assist her with transfers to and from a wheelchair and a nursing summary notes that one staff member was to assist her with bathing. CMS Ex. 14, at 35, 59.

On December 22, 2006 the resident had an accident while she was being bathed, causing her to sustain severe facial trauma. CMS Ex. 14, at 8-13, 61; CMS Ex. 15, at 1, 5. The resident fell from a lift chair while she was being raised from a whirlpool tub. After conducting an investigation into the circumstances of the accident Petitioner terminated the employment of the nursing assistant who was assisting Resident # 7 when the accident occurred. CMS Ex. 15, at 6.

i. Petitioner neglected the needs of Resident # 13.

In alleging that Petitioner neglected the needs of Resident # 13 CMS asserts that Petitioner's staff had a duty to make a reasoned assessment of his condition after the staff discovered the resident lying unresponsive and to determine whether to initiate CPR. CMS argues that Petitioner's staff failed to make that assessment. Rather, the staff simply assumed the resident to be dead and took no action to aid him. According to CMS the appropriate action that the staff should have taken – absent signs of irreversible death such as rigor mortis, dependent lividity, decapitation or decomposition – would have been to implement CPR and to call for emergency assistance. CMS Ex. 12, at 8; CMS Ex. 20, at 8.

Moreover, according to CMS, Petitioner had no policy in place governing the appropriate circumstances under which to administer CPR to a non-responsive resident. Petitioner's only policies relative to CPR governed the obtaining of consent for DNR (do not resuscitate) orders and for administration of CPR. CMS Ex. 8, at 3; CMS Ex. 9; CMS Ex. 20, at 5-7; Tr. at 97-98. Thus, CMS contends that Petitioner's staff were left to exercise their own judgment about when to administer CPR without a governing policy from Petitioner.

CMS argues also that the absence of guidance from Petitioner resulted in its staff coming to individual and, at times, contradictory conclusions about the appropriate circumstances under which to administer CPR to a resident. For example, the nurse who attended Resident # 13 on the date of the resident's death testified that she received no guidance from Petitioner about the appropriate circumstances for administering CPR but, instead, relied on her training to decide when CPR would be appropriate. Tr. at 98. Petitioner's director and assistant director of nursing, by contrast, stated that it would be appropriate for a staff member to administer CPR only when he or she witnessed a resident experiencing cardiac or respiratory arrest. CMS Ex. 8, at 1, 3; CMS Ex. 20, at 5-7. And,

Petitioner's medical director, a physician, averred that a resident with advanced disease might not benefit from CPR. He suggested that it might be more humane in some circumstances not to administer CPR to a patient who was likely to emerge from CPR in a vegetative state. CMS Ex. 20, at 5.

CMS avers, finally, that there is no evidence showing that Petitioner or its staff undertook measures to assure that residents' wishes concerning resuscitation were immediately available to Petitioner's staff during an emergency situation. There were no bedside labels at the facility indicating whether a resident desired to be resuscitated nor did residents wear identification showing that they desired to be or not to be resuscitated in the event of an emergency. In the case of Resident # 13, it was necessary to research the resident's treatment file at Petitioner's nurses' station in order to determine what his wishes were concerning administration of CPR.

The evidence presented by CMS is prima facie proof that Petitioner neglected the needs of Resident # 13 in contravention of 42 C.F.R. § 483.13(c). I find that the regulation imposes on a facility the duty to develop coherent policies governing resuscitation of residents who experience cardiopulmonary arrest. The evidence offered by CMS shows that Petitioner failed to do so. The consequence was that, on the morning of October 21, 2006, Petitioner's staff was without guidance when Resident # 13 went into cardiopulmonary arrest.

Neither the Act nor implementing regulations leave the decision as to when to attempt to resuscitate solely in the hands of a facility's staff. A resident has an absolute right to decide whether a facility should attempt resuscitation in the event of cardiopulmonary arrest. The whole point of having a resident express his or her wishes in advance is to make certain that the facility is aware of the resident's intent and does everything reasonable to carry it out.

The resident's right to expect that the staff will attempt to resuscitate him or her if that is what he or she wants imposes on the facility the duty to develop policies that clearly educate the staff as to the circumstances when resuscitation is appropriate. It imposes the additional duty on the facility to make sure that the resident's intent is known or immediately accessible when an event possibly requiring resuscitation occurs.

The evidence offered by CMS establishes that Petitioner failed to discharge these obligations. It supports a conclusion that Petitioner had no policy governing when resuscitation should be attempted. Effectively, it left that determination up to its nursing staff, to be made on an ad hoc basis. The evidence also supports a finding that Petitioner essentially depended on its individual nurses' personal training and experience without assuring that its staff was trained systematically in the circumstances where resuscitation

should be attempted. Furthermore, the evidence offered by CMS shows that Petitioner failed to have a coherent system in place designed to assure that the staff was aware of the intent of its individual residents. Time is of the essence when an individual goes into cardiopulmonary arrest. Such precious time can be wasted – and lives, potentially, lost – where a staff is not instantly aware of a resident's expressed wish to be resuscitated. However, in this case, there was nothing in Resident # 13's room or on his person to tell the staff what his intent was.

It is impossible to decide from the evidence offered by CMS whether Resident # 13 would have benefitted from CPR or emergency services. However, it is apparent from the evidence that, on the morning of October 21, 2006, Petitioner's staff not only had no facility guidelines for determining whether to attempt to resuscitate the resident, but that they failed also to comply with prevailing standards of care governing when resuscitation should be attempted. The American Heart Association (AHA) guidelines governing administration of CPR specify that all patients in cardiac arrest should receive resuscitation unless:

> • The patient has a valid Do Not Attempt Resuscitation (DNAR) order
>
> • The patient has signs of irreversible death (eg, rigor mortis, decapitation, decomposition, or dependent lividity)
>
> • No physiological benefit can be expected because vital functions have deteriorated despite maximal therapy (eg, progressive septic or cardiogenic shock)

CMS Ex. 12, at 3. The evidence offered by CMS establishes that the resident wanted to be resuscitated and that, on the morning of October 21, when he was first discovered unresponsive, he manifested none of the signs of irreversible death. The nurse's notes made on that date do not record that the resident displayed rigor mortis, was decapitated, had decomposed, or manifested dependent lividity.

In responding to CMS's case Petitioner argues, first, that there is no explicit requirement in the regulations that facilities have in place policies or procedures governing the decision on when to attempt resuscitation. Petitioner's final brief at 2. This lack of specificity, according to Petitioner, means that it was obligated to comply only with professionally recognized standards of quality. It asserts that there is no dispute that the AHA guidelines, which I discuss above, established the criteria for determining whether Petitioner's staff should have attempted to resuscitate Resident # 13. *Id.* at 3. According

to Petitioner, these guidelines are precisely what its staff adhered to in deciding that CPR should not be given to the resident. *Id.* at 3-5. Finally, Petitioner contends that, in fact, it had policies in place which prevented residents such as Resident # 13 from being neglected. *Id.* at 5-6.

I do not find these arguments to be persuasive. The unrebutted evidence of this case establishes that Petitioner had nothing in place that told its staff how to assess and respond to an episode of cardiopulmonary arrest. It is true, as Petitioner contends, that nothing in the regulations says explicitly that a facility must develop policies instructing its staff as to when to attempt or to withhold resuscitation. But, a resident's right to express his wishes concerning resuscitation would be hollow if a facility had no policy in place directing its staff as to how those wishes must be implemented. In confronting an issue of life or death, such as the question of whether to attempt resuscitation, a resident should not be subject to the whim of individual staff members of a facility. If nothing else, a facility should instruct its staff to follow professionally recognized standards of care, such as the AHA guidelines, in the event of a resident going into cardiopulmonary arrest.

Second, I do not find that Petitioner proved that its staff complied with AHA guidelines in deciding whether to attempt to resuscitate Resident # 13. To support its contention that the staff followed AHA guidelines in deciding not to attempt to resuscitate the resident Petitioner relies on the following testimony given by the registered nurse who was called into Resident # 13's room on the morning of October 21:

> [w]hen I walked in and I saw that his color changed and I saw his eyes – you know, his eyes were bulging, and . . . his tongue was thrust up in the back of his throat, his head was hang – you know, everything was hanging there, and I went to grab him and help him up . . . [A nursing assistant] was in the room and tried to grab his feet, and we tried to turn him around. And like I said, his eyes never moved, and, you know, they were bulged severely out of his head when he was laying back.
>
> And when we got him on the bed, his eyes did change a little bit to go back in his head, but they did not move sideways, blink or anything. And when I called his name, did his vital signs, he was dead. He was dead.

Tr. at 92-93. Assuming this testimony to be accurate, it describes nothing that comports with the AHA guidelines' criteria for withholding resuscitation. The testimony does not describe decapitation, dependent lividity, rigor mortis, or decomposition.

Petitioner seems to suggest that the contemporaneous nurse's notes recording Resident # 13's condition on October 21st might be incomplete and that they omit details and observations that support the nurse's conclusion that Resident # 13 was not a candidate for resuscitation. In her declaration and at the hearing the nurse who was summoned to the resident's room averred that the resident's skin tone had changed from a "black" color to "grayish," thereby convincing her, along with other facts, that the resident was dead. P. Ex. 14, at 4; Tr. at 88, 91.[4] I do not accept as credible this observation of the resident's appearance made many months after the resident's death and not contained in the nurse's contemporaneous nursing notes. But, even if it is accurate, it does not provide proof that AHA guidelines for resuscitation were followed by Petitioner's staff. There simply is no evidence in this case establishing that the change in the resident's appearance constituted "lividity" as is defined by the guidelines or met any of the other criteria established in the guidelines as grounds for withholding resuscitation.[5]

The weight of the evidence, therefore, does not prove that Petitioner's staff followed AHA guidelines. But, even had they followed those guidelines to the letter, that would not excuse Petitioner's failure to develop a policy concerning resuscitation. It is simply not sufficient that a facility rely on an individual nurse or other staff member's acumen or training to know when to apply the AHA guidelines in a case of cardiopulmonary arrest. Absent an overall facility policy that makes certain that *all* of its staff are aware of and trained in the applicable guidelines, there is no guarantee that a resident's expression of intent concerning resuscitation will be implemented consistent with professionally recognized standards of nursing care.

To support its assertion that it had policies in place that protected residents against neglect Petitioner cites its internal policy governing pronouncement of death. P. Ex. 6; Petitioner's final brief at 5-6. Petitioner contends that its staff complied with this policy.

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[4] Resident # 13 was an African American.

[5] Petitioner offered a statement from a physician declaring that the resident had "obvious clinical signs of irreversible death." P. Ex. 18, at 6. But this physician is not an expert in resuscitation and, moreover, he did not aver explicitly that the resident's appearance conformed with the AHA guidelines. Moreover, the physician's conclusion clearly was based more on the nurse's current statements than on her contemporaneous notes.

The policy in question permits a registered nurse to pronounce death when a resident is found "without palpable pulse and without audible respirations . . . ." P. Ex. 6. Petitioner reasons that its staff did all that they were required to do for Resident # 13 because, when they discovered him on the morning of October 21, 2006, he was without pulse or respiration. Petitioner's final brief at 5.

I find this argument to be unpersuasive. If Petitioner in fact intended its policy on pronouncement of death to define the circumstances when resuscitation should be withheld that policy was manifestly contrary to professionally recognized standards of nursing care.

Clearly, one of the criteria for death is absence of pulse or respiration. But, it is also evident that individuals may cease breathing and their hearts may stop and, nevertheless, they may be resuscitated. The point of the AHA guidelines is that there are some cases where individuals in cardiopulmonary arrest may be resuscitated. And, for that reason, cessation of pulse and respiration in and of itself is *not* a basis for withholding resuscitation. Consequently, Petitioner's policy on pronouncement of death did not substitute for a policy consistent with professionally recognized standards of nursing care governing when to attempt to resuscitate.[6]

ii. Petitioner neglected the needs of Resident # 7.

CMS contends that a nursing facility has an obligation to provide its residents with safe personal care. It asserts that Petitioner failed to discharge this duty with respect to Resident # 7 in that it allowed the resident to be cared for by a recently hired employee whose competency was not assured.

I agree with CMS's analysis of a facility's duty under the regulations. The regulations implicitly require that all care provided to residents in a skilled nursing facility be given by competent, well-trained care givers. Failure systematically to provide adequate training and supervision of new hires or to establish a mechanism to monitor new employees' performance is a failure to assure that these individuals are competent and adequately trained and that failure constitutes neglect of residents' needs.

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[6] Petitioner also argues that the nurse's decision to pronounce death was consistent with provisions of New Hampshire law. I find that argument to be irrelevant. The issue here is not whether the facility staff violated State law but whether it complied with federal regulations and applicable standards of nursing care. I do not find any inconsistency between State law and Medicare participation requirements but, if one existed, the federal requirements would be controlling.

The nursing assistant providing care to Resident # 7 when the resident sustained her fall from a lift chair was a newly hired employee still within her 90-day introductory period of employment. The probable cause of the resident's fall was that the nursing assistant failed adequately to assure that the resident's seat belt was fastened when she was in the chair. The resident evidently rocked the chair back and forth and fell as she was being lifted. I find it unnecessary to decide whether staff negligence or inadequate supervision and training caused the accident. What is important, and what is supported by CMS's prima facie case, is that there were not systems in place at Petitioner's facility to assure that recently hired employees, such as the nursing assistant in question, received adequate training, supervision, and evaluation.

The evidence offered by CMS amply supports a finding that Petitioner's management did not assure that newly hired nursing assistants received adequate training, supervision and evaluation. Petitioner's policy was that newly hired employees would serve in a probationary status for the first 90 days of their employment. CMS Ex. 19, at 4.[7] During that period the employee's performance would be assessed for suitability to work in a non-probationary status. *Id.* Petitioner's personnel policies did not define "suitability." Nor did they provide specific benchmarks for evaluating the training and performance of newly hired employees. Rather, those policies provided for informal periodic progress reports of newly hired employees' performance and for informal on-the-job feedback between supervisors and newly hired employees. *Id.* The policies did not, however, describe the elements of a typical progress report. Nor did they contain any formal requirements for evaluating the competency of newly hired employees. *Id.*

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[7] CMS's evidence concerning the training, supervision, and evaluation of newly hired employees consists of a surveyor's affidavit. CMS Ex. 19. In her affidavit the surveyor cites to facility policies that she avers are contained in a document entitled "Human Resources Policies and Procedures for Performance Expectations and Appraisals; Promotions and Transfer." *Id.* at 4. CMS does not cite directly to this document. CMS appears to have identified the document originally as CMS Ex. 17, but then did not offer that exhibit into evidence at the hearing (in a letter dated January 9, 2008, I explain how the exhibits that I received were identified and numbered). Normally, I am reluctant to rely on a surveyor's characterization of a document when the document itself is not in evidence. However, in this case Petitioner did not challenge the surveyor's description of Petitioner's policies as inaccurate. Rather, it argued that it trained, supervised and evaluated its employees adequately based on evidence not discussed in the surveyor's affidavit. Given that, I accept the affidavit as an accurate description of the document's contents.

Evidence offered by CMS shows also that the supervision received by the nursing assistant consisted of a preceptorship under the guidance of another nursing assistant. CMS Ex. 19, at 5. But, Petitioner generated no documentation showing that the preceptor nursing assistants were supervised in order to assure that they provided newly hired nursing assistants with adequate training. Nor was there evidence that Petitioner's supervisory employees ever actually worked closely with newly hired nursing assistants to assure that they were trained adequately, performing effectively, and carrying out facility policies. *Id.*

The obvious problem with Petitioner's policies – as described in evidence offered by CMS – is that Petitioner was not actively supervising and training its newly hired nursing assistants. I take notice that in nursing facilities, including Petitioner's facility, much of the day-to-day patient care is provided by nursing assistants. These are the individuals who feed, dress, and bathe incapacitated residents such as Resident # 7. Nursing assistants, unlike nurses, do not receive professional educations outside of the facilities which employ them. The Medicare program assumes that the facilities will train nursing assistants and assure that they are performing their duties competently.

Here, the evidence shows that Petitioner had in place only the vaguest of precatory language governing the training, supervision, and evaluation of its newly hired nursing assistants. CMS's evidence shows that Petitioner had no measurable standards in place to assure that these employees actually received the training and guidance that they needed in order to perform their duties. Furthermore, the evidence offered by CMS shows that Petitioner's professional nursing staff did not even directly supervise its newly hired nursing assistants. Such supervision as occurred was left to other nursing assistants – individuals who were not, in fact, part of Petitioner's management structure and who had no real supervisory training.[8]

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[8] A textbook for nursing assistants provides "role limits" for nursing assistants and states:

> ***Never supervise other nursing assistants or assistive personnel.*** This is a nurse's responsibility. You will not be trained to supervise others. Supervising others can have serious legal consequences.

CMS Ex. 16, at 3 (emphasis in original).

Petitioner argues that, in fact, it provided adequate training, supervision, and evaluation of its nursing assistants. I find these arguments to be unpersuasive. First, Petitioner contends that CMS is asserting that noncompliance consisted of an "employee's failure to follow established policies in one specific instance." Petitioner's final brief at 7. I disagree with this characterization of CMS's contentions. What is at issue here is not the performance of the nursing assistant or whether she caused Resident # 7 to sustain an accident. Rather, it is the overall failure of Petitioner to train, supervise, and evaluate its newly and/or recently hired nursing assistants adequately.

Petitioner argues also that it carefully checked the employment history of the nursing assistant whose job performance underlies CMS's findings before hiring her. Petitioner's final brief at 7. I accept as true this representation. But, Petitioner's hiring practices are not an issue in this case. The issue is what happened at Petitioner's facility after it hired its nursing assistants.

Petitioner contends that the nursing assistant who was involved with Resident # 7 went through an initial orientation where she was provided with information on safety in the workplace, including proper use of equipment, and that Petitioner had a policy in place governing proper use of lift chairs. Petitioner's final brief at 7. I accept these assertions as true but they beg the question of whether Petitioner took steps to assure that the information that its staff imparted to its nursing assistants was adequately assimilated and employed by them. Finally, Petitioner contends that its staff adequately supervised newly hired nursing assistants because an experienced nursing assistant is assigned to shadow each newly hired nursing assistant. *Id.* But, "shadowing" and preceptorships do not constitute supervision. It is simply inadequate for a facility to place in the hands of a non-supervisory employee the responsibility for assuring that another non-supervisory employee is adequately trained and competent to perform the tasks that are assigned to him or her.

b. Petitioner failed to comply with the requirements of 42 C.F.R. § 483.25.

CMS relies on the evidence that I discuss at Part a.i. of this Finding addressing the care that Petitioner's staff gave to Resident # 13 as support for its contention that Petitioner failed to provide its residents with the necessary care and services for each resident to attain his or her highest practicable physical, mental, and psychosocial well-being in accordance with that resident's comprehensive assessment and plan of care.

I find that this evidence is ample support for CMS's contention. A resident in a skilled nursing facility has a right to expect that his or her instructions concerning resuscitation will be carried out scrupulously, in compliance with professionally recognized standards of care, in the event that he or she experiences a cardiopulmonary arrest. The evidence offered by CMS strongly supports the conclusion that Petitioner was unable to provide assurances to its residents that their wishes would be carried out. Petitioner had no comprehensive policy governing resuscitation nor did it provide uniform training and guidance to its staff as to when resuscitation should be attempted.

Petitioner's arguments against being found deficient in providing care pursuant to 42 C.F.R. § 483.25 are identical to those which it makes in opposition to CMS's allegations of failure to comply with 42 C.F.R. § 483.13(c). I find these arguments to be unpersuasive even as I find them to be an unpersuasive defense to the allegations concerning Petitioner's compliance with the other regulation. It is not sufficient for Petitioner to argue, as it has in this case, that providing CPR to Resident # 13 would have been futile, that the nurse who cared for Resident # 13 was well-trained, or that she pronounced death in accordance with Petitioner's policies or even with State law. All of these arguments fail to address the requirement that Petitioner have in place policies that clearly advise staff about the appropriate circumstances when resuscitation should or should not be attempted and to communicate those policies to the staff.

2. Petitioner did not prove to be clearly erroneous CMS's determination of immediate jeopardy.

Where CMS makes a finding of immediate jeopardy the burden falls on the facility to prove that determination to be clearly erroneous. Here, CMS's determination of immediate jeopardy level violations of two regulations is amply supported and Petitioner did not prove that determination to be clearly erroneous.

The likelihood of harm to residents is substantial where, as in this case, a facility fails to develop a policy governing an issue as vital as when to attempt resuscitation and fails to communicate whatever policy it may have to its staff. The obvious risk is that a resident may not have his or her wishes carried out in the event of a cardiopulmonary arrest. Similarly, there is a palpable likelihood of harm to residents where a facility fails to implement adequate systems to train, supervise, and evaluate newly hired employees. Nursing assistants may not be highly skilled or educated individuals but the care that they provide to residents is vital and there are great risks associated with that care. Learning how to provide care for a debilitated resident and providing that care competently are critical functions. Residents are at great risk where even the lowest level care givers are not adequately trained, supervised, or evaluated.

In asserting that CMS's determination of immediate jeopardy was clearly erroneous Petitioner focuses on proving that, in the case of Resident # 13, his death was inevitable and could not have been prevented by attempting to resuscitate him. But, the inevitability of the resident's death really begs the question of Petitioner's compliance and the likelihood of harm resulting from its noncompliance. As I state above, it is impossible to say that resuscitation would have benefitted this resident. But, it is clear also that the episode involving Resident # 13 revealed a glaring flaw in Petitioner's network of care. The absence of any policy governing the appropriate circumstances regarding when to attempt to resuscitate put *all* of Petitioner's residents at risk of misjudgment and potentially fatal staff errors.

As to Resident # 7, Petitioner contends that the accident involving her was an isolated event cured by Petitioner's termination of employment of the nursing assistant who was providing care when the accident occurred. But this argument also begs the question of Petitioner's compliance and the likelihood of harm. Petitioner's failure to have in place a system for training, supervising, and evaluating its nursing assistants put, potentially, *all* of Petitioner's newly hired nursing assistant staff at a deficit. And that redounded to the disadvantage of *all* of Petitioner's residents and not just Resident # 7.

3. CMS's civil money penalty determination is reasonable.

Regulations governing the amounts of civil money penalties provide that, where there is immediate jeopardy level noncompliance, penalties may range in amounts from $3050 to $10,000 per day. 42 C.F.R. § 488.438(a)(i)(1). The regulations prescribe the factors that may be used to decide where within this range an immediate jeopardy level penalty amount should fall. These factors may include: the seriousness of a facility's noncompliance; the facility's culpability; its compliance history; and its financial condition. 42 C.F.R. §§ 488.438(f)(1)-(4); 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)).

A threshold question that I must resolve in deciding what penalties should be imposed against Petitioner is the duration of its immediate jeopardy level noncompliance. A facility may challenge CMS's determination of duration. If it does it bears the burden of proving that the noncompliance ended earlier than that which is determined by CMS.

Here, CMS determined that Petitioner's immediate jeopardy level noncompliance lasted from February 1 through 4, 2007. Although Petitioner disputes whether noncompliance existed in this case it has not offered compelling proof that it corrected its deficiencies at a date that is earlier than was determined by CMS. For that reason I sustain CMS's determination as to duration.

I also sustain CMS's determination of penalty amounts, $5000 per day for each day of the four day period of Petitioner's immediate jeopardy level noncompliance. CMS offered no argument in its final brief on the issue of penalty amount. However, it is evident that the seriousness of Petitioner's noncompliance justifies penalties of $5000 per day. The risks posed to Petitioner's residents by its noncompliance were very high. There was a high likelihood of injury or even death to residents resulting from Petitioner's failure to communicate to its staff any policy concerning the appropriate circumstances to attempt resuscitation and its failure to train, supervise, and evaluate newly hired nursing assistants.

Petitioner argues that there is no evidence that it has a compliance history or a level of culpability that would justify the penalty amounts in this case. I agree with Petitioner that CMS offered no evidence addressing these criteria. But seriousness of noncompliance in and of itself may justify a penalty amount. And, in this case I find that Petitioner's noncompliance was sufficiently egregious to justify the penalties without regard to any of the other regulatory factors that govern penalty amounts.[9]

/s/
Steven T. Kessel
Administrative Law Judge

[9] Petitioner did not offer evidence or argument showing that its financial condition justified reducing the civil money penalty amounts.