Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Green Valley Healthcare and Rehabilitation Center,
(CCN: 67-6161),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-19

Decision No. CR4998

Date: December 21, 2017

DECISION

In this case, we consider whether nursing staff must adhere to a long-term care facility's policy regarding "Do Not Resuscitate" orders.

Petitioner, Green Valley Healthcare and Rehabilitation Center, is a long-term care facility, located in Fort Worth, Texas, that participates in the Medicare program. Based on a survey completed July 14, 2015, the Centers for Medicare & Medicaid Services (CMS) determined that the facility was not in substantial compliance with Medicare requirements, and that its deficiencies posed immediate jeopardy to resident health and safety. Most significantly, CMS found that staff disregarded the facility's requirements for valid "do not resuscitate" orders and refused to administer cardio-pulmonary resuscitation (CPR) to a resident whom the facility policy designated as "full code." CMS has imposed a per-instance civil money penalty (CMP) of $10,000.

The parties have filed cross-motions for summary judgment. For the reasons set forth below, I grant CMS's motion and deny Petitioner's. I find that the facility was not in substantial compliance with Medicare program requirements, and that the penalty imposed is reasonable. I have no authority to review the immediate jeopardy determination.

Background

The Social Security Act (Act) sets forth requirements for skilled nursing facilities to participate in the Medicare program and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act § 1819. The Secretary's regulations are found at 42 C.F.R. Part 483.[1] To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to survey skilled nursing facilities in order to determine whether they are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. Each facility must be surveyed annually, with no more than fifteen months elapsing between surveys, and must be surveyed more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a); 488.308. The state agency must also investigate all complaints. Act § 1819(g)(4).

In this case, on July 14, 2015, surveyors from the Texas Department of Aging and Disability Services (state agency) completed the facility's annual recertification survey. Based on their findings, CMS determined that the facility did not comply substantially with the following program requirements:

- 42 C.F.R. § 483.13(c) (Tag F224 – staff treatment of residents: policies and procedures to prohibit mistreatment, neglect, and abuse) at scope and severity level K (pattern of noncompliance that poses immediate jeopardy to resident health and safety);

- 42 C.F.R. § 483.13(c) (Tag F226 – policies to prohibit abuse and neglect) at scope and severity level K;

- 42 C.F.R. § 483.25 (Tag F309 – quality of care) at scope and severity level K; and

[1] In this decision, I cite to the regulations in effect at the time of the survey.

- 42 C.F.R. § 483.65 (Tag F441 – infection control) at scope and severity level E (pattern of noncompliance that causes no actual harm with the potential for more than minimal harm).

CMS Exhibit (Ex.) 1 at 1; CMS Ex. 4.[2]

CMS subsequently determined that the facility returned to substantial compliance on August 6, 2015. CMS Ex. 1 at 6. CMS imposed against the facility a $10,000 per instance CMP for the deficiencies cited under section 483.25. CMS Ex. 1 at 2, 6. CMS imposed no penalties for the remaining deficiencies.

Initially, it seems, Petitioner waived its appeal rights, and CMS reduced the penalty by 35% (to $6,500), which Petitioner paid. CMS Ex. 1 at 9, 12. Thereafter, however, Petitioner rescinded its waiver and requested a hearing. CMS Ex. 1 at 12. CMS has not objected.

The parties have filed cross-motions for summary judgment. With its motion/pre-hearing brief (CMS Br.), CMS submits 13 exhibits (CMS Exs. 1-13). With its response and cross-motion (P. Br.), Petitioner submits two exhibits (P. Exs. 1 and 2).

Issues

As a threshold matter, I consider whether summary judgment is appropriate.

On the merits, only one issue is before me: was the facility in substantial compliance with 42 C.F.R. § 483.25.

Except to argue that the facility was in substantial compliance, so no remedy should be imposed, Petitioner has not challenged the amount of the CMP. P. Br. at 19.

I have no authority to review CMS's immediate jeopardy determination. I may review CMS's scope and severity findings (which include immediate jeopardy) if: 1) a successful challenge would affect the range of the CMP; or 2) CMS has made a finding

[2] State surveyors also conducted a life safety code survey and, based on their findings, CMS concluded that the facility was not in substantial compliance with two standards at scope and severity levels D (isolated instance of substantial noncompliance that causes no actual harm with the potential for more than minimal harm) and F (widespread substantial noncompliance that causes no actual harm with the potential for more than minimal harm). This put the facility out of substantial compliance with 42 C.F.R. § 483.70(a). CMS Ex. 1 at 1. However, CMS imposed no penalties, and the life safety code deficiencies are therefore not reviewable. *See Lutheran Home – Caledonia*, DAB No. 1753 (2000); *Schowalter Villa*, DAB No. 1688 (1999).

of substandard quality of care that results in the loss of approval of a facility's nurse aide training program. 42 C.F.R. §§ 498.3(b)(14), 498.3(d)(10); *Cedar Lake Nursing Home*, DAB No. 2344 at 9 (2010); *Evergreen Commons*, DAB No. 2175 (2008); *Aase Haugen Homes, Inc.*, DAB No. 2013 (2006). For a per-instance penalty, the regulations provide only one range ($1,000 to $10,000), so the level of noncompliance here does not affect the range of the CMP. 42 C.F.R. § 488.438(a)(2). If I approve a penalty of at least $5,000 or more, CMS's scope and severity finding will not affect approval of the facility's nurse aide training program. Under the statute and regulations, the state agency cannot approve the program if CMS imposes a penalty of $5,000 or more. The facility thus loses its approval without regard to the immediate jeopardy finding. Act § 1819(f)(2)(B); 42 C.F.R. § 483.151(b)(2)(iv).

Discussion

Summary judgment. Summary judgment is appropriate if a case presents no genuine issue of material fact, and the moving party is entitled to judgment as a matter of law. *Bartley Healthcare Nursing & Rehab.*, DAB No. 2539 at 3 (2013), *citing Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986); *Ill. Knights Templar Home*, DAB No. 2274 at 3-4 (2009), and cases cited therein.

The moving party may show the absence of a genuine factual dispute by presenting evidence so one-sided that it must prevail as a matter of law or by showing that the non-moving party has presented no evidence "sufficient to establish the existence of an element essential to [that party's] case, and on which [that party] will bear the burden of proof at trial." *Livingston Care Ctr. v. Dep't of Health & Human Servs.*, 388 F.3d 168, 173 (6th Cir. 2004), *quoting Celotex Corp. v. Catrett*, 477 U.S. 317, 323-24 (1986). To avoid summary judgment, the non-moving party must then act affirmatively by tendering evidence of specific facts showing that a dispute exists. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 n.11 (1986); s*ee also Vandalia Park*, DAB No. 1939 (2004); *Lebanon Nursing & Rehab. Ctr.*, DAB No. 1918 (2004). The non-moving party may not simply rely on denials, but must furnish admissible evidence of a dispute concerning a material fact. *Ill. Knights Templar*, DAB No. 2274 at 4; *Livingston Care Ctr.*, DAB No. 1871 at 5 (2003).

In examining the evidence for purposes of determining the appropriateness of summary judgment, I must draw all reasonable inferences in the light most favorable to the non-moving party. *Brightview Care Ctr.*, DAB No. 2132 at 2, 9 (2007); *Livingston Care Ctr.*, 388 F.3d at 172; *Guardian Health Care Ctr.*, DAB No. 1943 at 8 (2004); *but see Brightview*, DAB No. 2132 at 10 (entry of summary judgment upheld where inferences and views of non-moving party are not reasonable). However, drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions. *Cf. Guardian Health Care Ctr.*, DAB No. 1943 at 11 ("A dispute over the conclusion to be drawn from applying relevant legal criteria to

undisputed facts does not preclude summary judgment if the record is sufficiently developed and there is only one reasonable conclusion that can be drawn from those facts.").

1. CMS is entitled to summary judgment because the undisputed facts establish that, disregarding the facility's written policy, one of its nurses declined to administer CPR to a resident who, according to the policy, was "full code." This puts the facility out of substantial compliance with 42 C.F.R. § 483.25.[3]

Program requirements. Under the statute and the "quality of care" regulation, each resident must receive, and the facility must provide, the necessary care and services to allow a resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. Act § 1819(b); 42 C.F.R. § 483.25. The regulation imposes on facilities an affirmative duty designed to achieve favorable outcomes "to the highest practicable degree." *Windsor Health Care Ctr.*, DAB No. 1902 at 16-17 (2003), *aff'd*, *Windsor Health Care Ctr. v. Leavitt*, 127 F. App'x 843 (6th Cir. 2005); *Woodstock Care Ctr.*, DAB No. 1726 at 25-30 (2000), *aff'd*, *Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 (6th Cir. 2003).

Facility policies. The facility had in place written policies for determining a resident's "Do Not Resuscitate" (DNR) status. The policy provides that DNR orders "*must* be signed by the resident's [a]ttending [p]hysician on the physician's order sheet maintained in the resident's medical record." CMS Ex. 7 at 28 (emphasis added). The DNR order *must* be completed and signed by the attending physician and resident (or the resident's legal surrogate) and placed in the front of the resident's medical record. The policy directs staff to use state-approved forms only, or, if the state has none, facility-approved forms. CMS Ex. 7 at 28; *see* CMS Ex. 7 at 30.

Staff failure to follow the facility's DNR policy. Resident 19 (R19) was an 85-year-old man, admitted to the facility on June 9, 2015. He was undeniably seriously ill, having suffered a subdural hemorrhage. He had asphasia and dementia. CMS Ex. 6 at 1, 17. His family member signed a DNR order shortly after R19's admission. CMS Ex. 6 at 10. However, as everyone agrees, R19's physician did not sign the required DNR order. CMS Ex. 6 at 10.

R19 spent the evening of June 11 with his family. Staff described him as doing well; he was "smiling" and "cooperative" until about 9:00 p.m., when his bed alarm went off. The record does not indicate whether he fell or rose without falling. Staff put him back in bed. CMS Ex. 6 at 24, 28. At 10:00 p.m., his alarm went off again, and staff found him

[3] I make this one finding of fact/conclusion of law.

sitting on the floor. They returned him to bed and told him it was time to sleep. CMS Ex. 6 at 21, 26.[4] He was apparently up again later, so staff put him in a wheelchair and took him to the TV room. At about midnight they returned him to his bed. CMS Ex. 6 at 17, 31.

At 2:00 a.m. on June 12, a nurse aide changed R19's brief and he "seemed fine." CMS Ex. 6 at 18, 31.

At 3:30 a.m. on June 12, 2015, the same nurse aide checked on R19; she wrote that he "did not look well." CMS Ex. 6 at 29. She reported this to the LVN on duty. CMS Ex. 6 at 18. The LVN later documented that R19 was not breathing, had no pulse, and was cold to the touch. She called the facility administrator, the director of nursing, and others, but she did not administer CPR. CMS Ex. 6 at 18, 23, 31.

The facility's assistant director of nursing (ADON), who is a registered nurse, reported that she was at home when, at 3:53 a.m., staff (presumably, the LVN) called, asking her to come in to pronounce a resident dead. According to the ADON, she asked the resident's status code and staff told her that he was full code. She instructed staff to initiate CPR and call the physician immediately. CMS Ex. 6 at 30. She arrived at the facility at 4:30 a.m. and pronounced the resident dead at 4:45 a.m. CMS Ex. 6 at 18, 30.

The LVN challenged the ADON's report, complaining that the ADON *did not* tell her to begin CPR or to call 911. According to the LVN, the ADON told her to wait until she arrived, and, when the ADON arrived, she told the LVN to call R19's family. CMS Ex. 6 at 9, 23.

Thus, even though R19 was full code, the LVN on duty declined to administer CPR, and she did not document why. As reflected in a disciplinary action record, the facility subsequently determined that she failed to follow code protocol because she did not initiate CPR nor call 911 when she came upon a full-code resident with no vital signs. The facility suspended and, ultimately, fired her. CMS Ex. 5 at 10-11; CMS Ex. 6 at 13, 16. The facility also determined that the ADON was derelict; it suspended and reprimanded her for failing to follow code status. CMS Ex. 6 at 13, 16.

The facility self-reported the incident, admitting that, by facility standards, the resident was full-code and staff should have administered CPR when they found R19 unresponsive. CMS Ex. 6 at 13, 15, 20.

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[4] It is deeply troubling that R19 suffered at least this one fall, and likely multiple falls, but staff did not fill out incident reports "because he was continuously doing this." CMS Ex. 6 at 26; *see* CMS Ex. 6 at 21, 24, 28.

Petitioner thus concedes that, under its policies and American Heart Association guidelines (which it follows), a nurse has no discretion; she must perform CPR on a full code resident who presents with no vital signs. P. Br. at 9; *see* CMS Ex. 6 at 13 ("[B]y facility standards, resident was still full code . . .); CMS Ex. 7 at 3, 28, 30. Petitioner, nevertheless, points out that R19 *should* have had a valid DNR order and, alluding to the proposition that a resident has the right to refuse treatment, argues that the facility was not authorized to perform CPR because the resident did not affirmatively agree to it. Petitioner also claims that any attempt to resuscitate R19 would have been futile. According to Petitioner, nursing homes are not equipped to respond effectively with CPR, and performing it on virtually any nursing home resident is ineffective.

The Departmental Appeals Board has rejected such arguments, which, in the Board's view, "impl[y] that members of the nursing staff could, in an emergency, choose to disregard an advance directive if they determined, on-the-spot, that CPR would not likely save the resident," a position that has no support in the regulations or standards of care. The Board recognized a "bright-line rule" with respect to treating residents in distress: a resident without a do-not-resuscitate order *must* be administered CPR unless that resident is irreversibly dead. *Woodland Oaks Healthcare Facility*, DAB No. 2355 at 16 (2010). With respect to the futility argument, the Board pointed out that one of CPR's goals is to reverse clinical death, "even though that outcome is achieved in only a minority of cases." *Id., quoting John J. Kane Reg'l Ctr.*, DAB No. 2068 at 17 (2007).

Petitioner also suggests that the LVN declined to administer CPR because she determined that "rigor had set in," which would demonstrate irreversible death and justify her failing to act. P. Ex. 1 at 2 (McNabb Decl. ¶6).[5] This is, of course, contrary to all of the record evidence. First, the LVN did not make such a claim in her (relatively) contemporaneous statement or her subsequent statement responding to the ADON's remarks. CMS Ex. 6 at 9, 31; *see also* CMS Ex. 6 at 18. *See Sheridan Health Care Ctr.*, DAB No. 2178 at 33 (2008) (holding that professional standards of quality require nurses to record their clinical observations); *Oxford Manor*, DAB No. 2167 at 5 (2008) (holding that a nurse who disregards facility policy must document and justify her actions). Second, after its

[5] I note that Petitioner submitted no written declaration from the LVN herself, which would have subjected her to cross-examination. In my initial order, I require the parties to submit complete written testimony and to make the witness available for cross-examination. Acknowledgment and Initial Pre-hearing Order at 3-4 (¶¶ 4, 6) (October 21, 2015). Because Petitioner did not do so, but instead presented the evidence as a hearsay statement embedded in the written declaration of another, I could consider the evidence of that statement inadmissible. It is not consistent with my order and, although hearsay *may* be admissible, I am not bound to admit patently unreliable hearsay (which I consider this statement). 42 C.F.R. § 498.61. For purposes of summary judgment, Petitioner must submit *admissible* evidence showing that a dispute exists. *Ill. Knights Templar*, DAB No. 2274 at 4.

own investigation, the facility found that the LVN was *required* to administer CPR. *See* CMS Ex. 5; CMS Ex. 6 at 13, 30. Finally, we know that no more than an hour and a half passed between the nurse aide's describing R19 as "fine" at 2:00 a.m. and her finding that he "did not look well" at 3:30 a.m. Petitioner submitted no evidence about how long it takes for rigor mortis and other clinical signs of irreversible death to develop. *See Woodland Oaks Healthcare Facility*, DAB No. 2355 at 9 (2010).

But, even accepting, for purposes of summary judgment, that the LVN thought rigor mortis had set in, she was unqualified to make that call. Under standards of nursing practice and Texas State law, an LVN *reports* her observations regarding conclusive signs of death but she does not determine that irreversible death has occurred. Tex. Health and Safety Code Ann. § 671.001 (providing that a physician assistant or an RN may determine death, but, death must be pronounced before artificial means of supporting a person's respiratory and circulatory functions are terminated); CMS Ex. 7 at 8; *see* Texas Board of Nursing Position Statement § 15.2 (http://www.bon.texas.gov.) (emphasizing the importance of initiating CPR in cases where no clear DNR orders exist and noting that LVNs do not have the legal authority to determine death).

Thus, the facility was not in substantial compliance with 42 C.F.R. § 483.25 because its staff declined to provide one of its residents with the care and services he needed.

Conclusion

For the reasons discussed above, I find that the facility was not in substantial compliance with 42 C.F.R. § 483.25. Petitioner has not challenged the amount of the penalty imposed and I have no authority to review the immediate jeopardy determination.

/s/
Carolyn Cozad Hughes
Administrative Law Judge