Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Woodland Oaks Healthcare Facility
Docket No. A-10-95
Decision No. 2355
December 30, 2010

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Woodland Oaks Healthcare Facility (Woodland), a Kentucky skilled nursing facility (SNF), appeals the July 7, 2010 decision of Administrative Law Judge (ALJ) Carolyn Cozad Hughes, *Woodland Oaks Healthcare Facility,* DAB CR2175 (2010) (ALJ Decision). At issue before the ALJ was a determination by the Centers for Medicare & Medicaid Services (CMS) that Woodland was not in substantial compliance with several Medicare participation requirements. The most serious allegations of noncompliance arose from a December 24, 2008 incident in which members of Woodland's nursing staff failed to perform cardiopulmonary resuscitation (CPR) on a resident in cardiac arrest.

Based on evidence relating to the December 24 incident and its aftermath, the ALJ concluded that Woodland was not in substantial compliance with four Medicare participation requirements from December 24, 2008 through January 15, 2009. The ALJ also upheld CMS's determination that this noncompliance placed residents in "immediate jeopardy." In addition, the ALJ sustained the $4,550 per-day civil money penalty that CMS had imposed on Woodland for the 23-day period of immediate jeopardy-level noncompliance.

For the reasons below, we affirm the ALJ Decision.

Legal Background

In order to participate in Medicare, a SNF must comply with the participation requirements in 42 C.F.R. §§ 483.1-483.75. Compliance with these requirements is verified by nursing home surveys conducted by state health agencies. 42 C.F.R. Part 488, subpart E. Survey findings are reported in a document called a Statement of Deficiencies (SOD). A "deficiency" is "any failure to meet a participation requirement." 42 C.F.R. § 488.301.

CMS may impose enforcement remedies on a SNF if it determines, on the basis of survey findings, that the facility is not in "substantial compliance" with one or more participation requirements. 42 C.F.R. § 488.402(b). A facility is not in substantial compliance when it has a deficiency that creates the potential for more than minimal harm to one or more residents. 42 C.F.R. § 488.301 (defining "substantial compliance" to mean the "level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm"). Under the regulations, the term "noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." *Id.*

The enforcement remedies that CMS may impose for a SNF's noncompliance include per-day civil money penalties (CMPs). 42 C.F.R. § 488.408(b). When CMS elects to impose a CMP, it sets the CMP amount based on, among other factors, the "seriousness" of the SNF's noncompliance. 42 C.F.R. §§ 488.404(b), 488.438(f). The most serious noncompliance is that which puts one or more residents in "immediate jeopardy." *See* 42 C.F.R. §§ 488.404 (setting out the levels of scope and severity that CMS considers when selecting remedies), 488.438(a) (authorizing the highest CMPs for immediate jeopardy); State Operations Manual (SOM), CMS Pub. 100-07, § 7400.5.1.[1]

A SNF may challenge a finding of noncompliance that has resulted in the imposition of a CMP or other enforcement remedy by requesting a hearing before an administrative law judge. *See* 42 C.F.R. §§ 488.408(g)(1), 498.3(b)(13), 498.5(b). The SNF may also contend in that proceeding that the amount of a CMP imposed by CMS is unreasonable. *Capitol Hill Community Rehabilitation and Specialty Care Center*, DAB No. 1629, at 5 (1997).

Case Background

From January 5 through January 12, 2009, the Kentucky Cabinet for Health Services (state survey agency) performed a compliance survey of Woodland and later issued a SOD containing its survey findings. *See* CMS Ex. 1, at 1; CMS Ex. 10. Among other things, the state survey agency found that: (1) on December 24, 2008, Woodland's nursing staff failed to perform CPR on a resident – known here as Resident 8 – who had an advance directive calling for the administration of CPR in the event she experienced cardiac or respiratory failure; (2) Woodland failed to investigate the December 24 incident as possible resident neglect; and (3) Woodland lacked an "effective system" to ensure that its nursing staff complied with advance directives calling for the administration of CPR. *See* CMS Ex. 1, at 6-12, 16-17, 20-21, 29, 31-32. The state survey agency further determined that these alleged lapses constituted noncompliance with the participation requirements in 42 C.F.R. §§ 483.13(c), 483.20(k)(3)(ii), 483.25, 483.75, and 483.75(o)(1). *Id.* at 5-6, 16-17, 20-21, 29-30, 41-43. In addition, the state survey agency determined that Woodland's noncompliance with each of those five requirements was at the level of immediate jeopardy. *Id.* Finally, based on circumstances largely unrelated to the December 24 incident, the state survey agency

[1] The SOM is available on CMS's website at http://www.cms.hhs.gov/Manuals/IOM/ list.asp.

cited Woodland for less serious noncompliance with 42 C.F.R. §§ 483.10(b)(11), 483.10(k)(2), 483.20(d)(3), 483.10(k)(2), and 483.75(l)(1). *Id.* at 1-2, 12-13, 37-38.

On or about January 26, 2009, Woodland submitted a plan of correction to the state survey agency. *See* CMS Ex. 10, at 14; CMS Ex. 1, at 1. On January 29 and 30, 2009, the state survey agency revisited Woodland and determined that it had come back into substantial compliance with all participation requirements as of January 16, 2009. CMS Ex. 10, at 10.

Concurring with the state survey agency's deficiency findings, and with the finding of immediate jeopardy, CMS imposed a $4,550 per-day CMP for the period from December 24, 2008 through January 15, 2009. Respondent's Post-Hearing Br., Att. A & B. Woodland subsequently requested a hearing before the ALJ to contest the immediate jeopardy-level deficiency citations and the resulting CMP.[2]

The ALJ conducted an evidentiary hearing. Surveyors Gae Vanlandingham, R.N. and Tim Combs, R.N. testified on CMS's behalf. The following facility employees provided testimony on Woodland's behalf: Director of Nursing Tiffany Evans, R.N.; Administrator Kimberly Tice; Licensed Practical Nurse (LPN) Michelle Monroe; and Medical Director John A. Bond, M.D.

The ALJ Decision

As indicated, the disputed deficiency citations at issue arose from the December 24, 2008 incident involving Resident 8. Noting that the contemporaneous documentary evidence of that incident was "sparse," the ALJ found that "the most reliable evidence" established the following facts:

- Resident 8 was an 85 year-old woman with multiple ailments, including chronic obstructive pulmonary disease, cerebral palsy, dementia, and depression. ALJ Decision at 6.

- Prior to December 24, 2008, Resident 8's legal representative signed a "Full Code Consent Form," which directed the nursing staff "to use cardiac massage or artificial ventilation" to resuscitate Resident 8 "in the event of death while at Woodland Oaks."[3] ALJ Decision at 6; *see also* CMS Ex. 5, at 43.

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[2] Woodland stated in its hearing request that it was also contesting a finding by CMS that its noncompliance with two participation requirements constituted "substandard quality of care," as defined in 42 C.F.R. § 488.301. *See* March 19, 2009 Request for Hearing at 1. The ALJ did not discuss this issue in her decision, and Woodland does not raise the issue in its request for review. We therefore decline to address it.

[3] "A resident's 'code status' refers to the resident's decision whether resuscitation efforts should be initiated in the event that the resident's heart fails or he stops breathing. If a resident or her [designated legal representative] wishes to have resuscitation efforts attempted, the resident is a 'full code.' If the resident does not want the life saving measures initiated, he or she is designated as a Do Not Resuscitate or 'DNR.'" P. Ex. 7, at 2 ¶ 6.

- Resident 8's plan of care instructed the nursing staff to honor the full-code advance directive. ALJ Decision at 6.

- Nurses' notes for the night of December 23, 2008 indicate that Resident 8 was alert and oriented, her breathing was unlabored, and she displayed no signs or symptoms of distress. ALJ Decision at 6.

- The nurse assigned to care for Resident 8 during the night of December 23 told Surveyor Combs that a family member, who was also a facility employee, visited Resident 8 at 6:00 a.m. on December 24. ALJ Decision at 6. At that time Resident 8 was "alert and acting normally." *Id.*; *see also* CMS Ex. 13, at 3 ¶ 9; Tr. at 66-67.

- A nursing assistant told Surveyor Combs that while preparing residents for breakfast at 7:00 a.m. on December 24, she found Resident 8 unresponsive and breathing with difficulty. ALJ Decision at 6. The nursing assistant positioned Resident 8 so that she could breathe more easily, then called Nurse Crystal Shamblin, who was assigned to care for Resident 8 that day and who was the only nursing staff member to contemporaneously document the events that unfolded. *Id.* at 6, 8.

- In her December 24 nursing notes, Nurse Shamblin wrote in a 7:15 a.m. entry that when she entered Resident 8's room, Resident 8 had no pulse, and her respiration "seemed shallow." ALJ Decision at 7 (citing CMS Ex. 5, at 31). In addition, Nurse Shamblin reported that she was "unable to obtain [Resident 8's] blood pressure." *Id.*

- After assessing Resident 8, Nurse Shamblin asked another nurse to confirm that Resident 8 had no pulse, respiration, or blood pressure. ALJ Decision at 7; *see also* CMS Ex. 5, at 31. The 7:22 a.m. entry in Nurse Shamblin's December 24 notes states that a "crash cart" was brought to Resident 8's room, another nurse was called to assist, and the director of nursing (DON) was notified of the situation. ALJ Decision at 7 (citing CMS Ex. 5, at 31).

- At 7:31 a.m., Nurse Shamblin called the attending physician, who pronounced Resident 8 dead. ALJ Decision at 7. The funeral home picked up Resident 8's remains at 8:55 a.m. *Id.*

- Emergency Medical Service (EMS) records reflect that Woodland called for paramedics at 7:09 a.m., then called back four minutes later at 7:13 a.m. to cancel its request, advising EMS that Resident 8 "'has been down for approx[imately] 30 min[utes].'" ALJ Decision at 7 (quoting CMS Ex. 5, at 33).

- A Nursing Discharge Summary signed by Nurse Shamblin (and dated December 24, 2008) states that, at the time of Resident 8's transfer to the funeral home,

Resident 8's respiratory status was "absent," and her skin was "cool" and "pale." ALJ Decision at 6, 7 (citing CMS Ex. 5, at 57).

- When surveyors raised concern about the December 24 incident during the January 2009 survey, Woodland obtained unsworn handwritten statements from Nurse Shamblin and three other nurses – Julie Hall, Katie Washburn, and Michelle Monroe – all of whom had assessed Resident 8's clinical status sometime between 7:00 a.m. and 7:31 a.m. on December 24. ALJ Decision at 8. The statements of Nurses Shamblin, Hall, and Washburn are dated January 6, 2009; the statement of Nurse Monroe is dated January 22, 2009. P. Ex. 1, at 22-25.)

- Although Nurse Shamblin's contemporaneous (December 24) nursing notes "likely misstates the exact timing of events," the available contemporaneous documents "are consistent in establishing that mere minutes elapsed between staff's discovery of [Resident 8] in respiratory distress and staff's decision to deny her CPR." ALJ Decision at 7.

- Between December 24, 2008 and the start of the compliance survey on January 5, 2009, "the facility conducted no investigation [of the December 24 incident] at all, and . . . its belated inquiry was simply inadequate." ALJ Decision at 6.

- Administrator Kimberly Tice did not learn of the December 24 incident until the time of the survey. ALJ Decision at 11 (citing Tr. at 93-94).

Based largely on these factual findings, the ALJ concluded that Woodland was, as of December 24, 2008, not in substantial compliance with 42 C.F.R. §§ 483.13(c), 483.20(k)(3)(ii), 483.25, and 483.75 because it: (1) "failed to honor [Resident 8's] advance directive that she be administered CPR"; and (2) failed to investigate the December 24 incident or report it to the appropriate authorities, in violation of its policies that prohibited resident neglect. *See* ALJ Decision at 4, 11-12.

During the ALJ proceeding, Woodland's principal defense to the deficiency citations was that CPR was medically unnecessary. That defense rested largely on the post-December 24 handwritten statements by Nurses Shamblin, Hall, Washburn, and Monroe. Those statements set out the nurses' assessment of Resident 8's appearance and clinical status when the decision was made to withhold CPR. Nurse Shamblin indicated in her statement that she was called to Resident 8's room at 7:00 a.m. P. Ex. 1, at 22. She found Resident 8 "cold to touch" with "yellow skin" and "black colored lips," observations not reported in her December 24 nursing notes. *Id.* Nurse Shamblin also wrote that Resident 8 had no pulse or blood pressure. Her statement omits any reference to Resident 8's respiration. *Id.* Nurse Hall stated that Resident 8 was "very cold to touch," and her joints were "stiff." *Id.* at 23. Nurse Washburn stated that Resident 8 was "cool to touch" and had "stiff joints." *Id.* at 24. Nurse Monroe described Resident 8's skin as pale and cool and further stated that her head and neck were "in a flexed position." *Id.* at 25. Nurses Hall, Washburn, and Monroe all stated that Resident 8 had no respiration, pulse, or heartbeat.

Relying on these unsworn statements, Woodland argued that the nurses' decision to withhold CPR was consistent with accepted professional nursing standards because Resident 8 exhibited "obvious signs of irreversible death." *See* Pet.'s Post-Hearing Br. at 9. As evidence of the applicable standard of nursing care, Woodland pointed to Kentucky Board of Nursing Advisory Opinion Statement (AOS) # 36 (February 2008), which states in relevant part:

> In February 2003, it was the advisory opinion of the Board that a nurse would not start CPR when . . . [o]bvious signs of death are present. The most reliable are: dependent livido [general bluish discoloration of the skin as in pooling of blood in dependent body parts]; rigor mortis [hardening of muscles or rigidity]; algo mortis [cooling of the body following death]; and injuries that are incompatible with life.

P. Ex. 1, at 31. Woodland also pointed to 2005 guidelines published by the American Health Association (AHA), which state in relevant part:

> Scientific evaluation shows that few criteria can accurately predict the futility of CPR . . . . In light of this uncertainty, all patients in cardiac arrest should receive resuscitation unless
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> - The patient has a valid Do Not Attempt Resuscitation (DNAR) order
> - The patient has signs of irreversible death (e.g., rigor mortis, decapitation, decomposition, or dependent lividity)
> - No physiological benefit can be expected because vital functions have deteriorated despite maximal therapy (e.g., progressive septic or cardiogenic shock).

P. Ex. 2, at 3-4.

The ALJ accepted that "nurses should not attempt CPR if the individual is obviously 'irreversibly dead,'" and she further found that "signs of irreversible death include lividity, rigor mortis, and algo mortis." ALJ Decision at 8. However, the ALJ found that Resident 8 displayed none of those signs prior to the pronouncement of death at 7:31 a.m. on December 24 based on the contemporaneous nursing notes. *Id.* She also characterized the "after-the-fact" handwritten statements by Nurses Shamblin, Hall, Washburn, and Monroe as "self-serving and unreliable" evidence that Resident 8 was irreversibly dead when the decision was made to withhold CPR. *Id.*

The ALJ further concluded that CMS's determination that Woodland's noncompliance with sections 483.13(c), 483.20(k)(3)(ii), 483.25, and 483.75 had placed residents in immediate jeopardy was not clearly erroneous. ALJ Decision at 13. In addition, she sustained CMS's determination that Woodland did not abate the immediate jeopardy-level noncompliance until January 16, 2009. *Id.* at 14-15. Finally, the ALJ concluded the amount of the per-day CMP imposed by CMS for Woodland's alleged noncompliance – $4,550 per day – was reasonable. *Id.* at 15-16.

Standard of Review

Our standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. Our standard of review on a disputed finding of fact is whether the ALJ decision is supported by substantial evidence on the record as a whole. *Guidelines - Appellate Review* of *Decisions* of *Administrative Law Judges Affecting* a *Provider's Participation in the Medicare and Medicaid Programs* ("*Board Guidelines*"), http://www.hhs.gov/dab/ divisions/appellate/guidelines/index.html.

Discussion

1. *The ALJ's finding that Resident 8 did not exhibit signs of irreversible death is supported by substantial evidence in the record as a whole.*

Woodland contends that substantial evidence is lacking for the ALJ's finding that Resident 8 did not exhibit signs of irreversible death when its nurses decided to withhold CPR. *See* Request for Review (RR) at 6-12. As it did before the ALJ, Woodland relies heavily on the post-December 24 handwritten statements of Nurses Shamblin, Hall, Washburn, and Monroe. RR at 8-9. Those statements, Woodland maintains, are uncontradicted by other testimony or documentary evidence and clearly refer to signs of irreversible death, including rigor mortis and algo mortis. Reply Br. at 3. Moreover, says Woodland, all four nurses consistently reported that Resident 8 had no vital signs (pulse, respiration, blood pressure) when they examined her. RR at 8-9; Reply Br. at 2-3. In Woodland's view, the nurses' post-December 24 statements "conclusively establish" that Resident 8 was irreversibly dead when the decision was made to withhold CPR. Reply Br. at 3.

This argument is essentially a request to overturn a finding by the ALJ that the nurses' post-December 24 statements lacked "credibility." See ALJ Decision at 9 n.6 (commenting that "I do not find credible the nurses' after-the-fact descriptions of irreversible death"). In general, the Board defers to an administrative law judge's findings on weight and credibility of witness "testimony" unless there are "compelling" reasons not to do so. *Koester Pavilion*, DAB No. 1750, at 15, 21 (2000). We hold that similar deference is warranted for credibility findings concerning unsworn written statements of facility employees who, for whatever reason, do not testify in-person. *Cf. Hollon ex rel. Hollon v. Comm'r of Social Security*, 447 F.3d 477, 488 (6th Cir. 2006) (rejecting suggestion that appellant's failure to appear at hearing "precluded [an administrative law judge] from discounting the 'credibility' of her unsworn statements in the administrative record"); *United States v. McCoy*, 242 F.3d 399, 408 n.15 (D.C. Cir. 2001) (rejecting the proposition that a court cannot resolve credibility dispute without directly observing the witnesses' demeanor).

Here, we see no compelling reason to overturn the ALJ's credibility finding because the ALJ gave sufficient reasons for discounting the post-December 24 statements. The ALJ first noted that none of the nurses testified concerning the December 24 incident, and thus none "has sworn to the accuracy of [their] statements [or] been subject to cross-

examination." ALJ Decision at 9. During the evidentiary hearing, Nurses Monroe, Hall, and Washburn were still employed by Woodland, and the ALJ subpoenaed their testimony. As the ALJ noted, however, the subpoenaed nurses declined, on the advice of their attorney, to testify, invoking their Fifth Amendment privilege against self-incrimination. These circumstances support a reasonable inference that the nurses' post-December 24 statements were, at minimum, unreliable. *Cf. Baxter v. Palmigiano*, 425 U.S. 308, 318-19 (1970), *citing* 8 J. Wigmore, Evidence 439 (McNaughton rev. 1961) ("the prevailing rule [is] that the Fifth Amendment does not forbid adverse inferences against parties to civil actions when they refuse to testify in response to probative evidence offered against them: the Amendment 'does not preclude the inference where the privilege is claimed by a party to a Civil cause.'"; *Nationwide Life Ins. Co. v. Richards,* 541 F.3d 903, 911 (9th Cir. 2008) ("When a party asserts the privilege against self-incrimination in a civil case, the district court has discretion to draw an adverse inference from such assertion."); *Kosinski v. Comm'r of Internal Revenue,* 541 F.3d 671, 678 (6th Cir. 2008) ("The Fifth Amendment's Self-Incrimination Clause bars the prosecution from compelling the defendant's testimony and from advancing an adverse inference from his decision not to testify-a limitation that is generally absent in civil proceedings."); e*Plus Technology, Inc. v. Aboud*, 313 F.3d 166, 179 (4th Cir. 2002) (same).

Second, the ALJ noted that references in the post-December 24 statements to Resident 8's body temperature, skin color, and joint stiffness are not mentioned in Nurse Shamblin's contemporaneous notes of the incident. Compare P. Ex. 1, at 22-25 and CMS Ex. 5, at 31. Nurse Shamblin's January 6, 2009 statement that Resident 8 was "cold to touch" and had "yellow skin" and "black colored lips" is inconsistent with her contemporaneous nursing notes. P. Ex. 1, at 22. In addition, as the ALJ accurately noted, Nurse Shamblin's January 6 statement did not report her assessment of Resident 8's respiration, P. Ex. 1, at 22, whereas her contemporaneous notes reported that Resident 8's breathing seemed "shallow" when she entered Resident 8's room, CMS Ex. 5, at 31. The facility's medical expert, Dr. Bond, testified that if a facility withheld CPR from a full-code resident, he would expect the nursing staff to report clinically significant findings of death (cold skin, rigor, absent corneal reflex) in their contemporaneous notes. Tr. at 166-67. However, Nurse Shamblin's contemporaneous notes did not mention these types of clinical observations. In view of Dr. Bond's testimony that nurses should report clinically significant findings, and because none of the nurses involved in the December 24 incident testified to clear up apparent inconsistencies between their post-December 24 statements and Nurse Shamblin's contemporaneous notes, the ALJ reasonably assigned more weight to the contemporaneous notes in determining whether Resident 8 had clinical signs of irreversible death when the decision was made to withhold CPR from her. *See Jennifer Matthew Nursing & Rehabilitation Center*, DAB No. 2192, at 10-11 (2008) (finding nothing improper about according more weight to "eyewitness contemporaneous statements" in appropriate circumstances).

Third, the ALJ found it "highly unlikely that [Resident 8] had stopped breathing long enough to have exhibited the signs of irreversible death," and that the "more reliable

evidence establishes that [Resident 8] was awake, alert, and talking at 6:00 a.m. on December 24; was "in distress *but breathing* at 7:00 a.m." (italics added); and "still exhibited signs of breathing when [Nurse] Shamblin entered her room, probably just minutes before the 7:09 a.m. call to EMS." ALJ Decision at 9. We find no fault with these findings because Woodland: (1) does not dispute that Resident 8 was "alert and acting normally" at around 6:00 a.m. on December 24; (2) offered no evidence to rebut CMS's evidence that a nursing assistant found Resident 8 unresponsive but "breathing with difficulty" at around 7:00 a.m.; (3) submitted no evidence about how long it takes for rigor mortis and other clinical signs of irreversible death to develop or become manifest; and (4) did not explain how the nursing staff arrived at its judgment that Resident 8 had "been down" for 30 minutes when the facility cancelled its request for EMS services at 7:13 a.m. Moreover, Woodland does not point to any evidence indicating a different and more likely timeline of events than the one found by the ALJ.

Woodland contends that substantial evidence does not support the ALJ's finding that Resident 8 was breathing at 7:00 a.m. on December 24. Reply Br. at 1-3. Woodland asserts that Nurse Shamblin never stated that Resident 8 was breathing at 7:00 a.m. *Id.* at 2. In addition, says Woodland, the three other nurses who assessed Resident 8 all reported (in their post-December 24 statements) that Resident 8 was not breathing. *Id.*

We disagree with this contention. The absence of a statement in Nurse Shamblin's December 24 nursing notes that Resident 8 was not breathing at 7:00 a.m. is consistent with (rather than undercuts) the ALJ's finding that she was in fact breathing. The available evidence indicates that Nurse Shamblin entered Resident 8's room sometime around 7:00 a.m. because the documented call to EMS was made at 7:09 a.m. Regardless of precisely when she entered the room, Nurse Shamblin reported in her notes that Resident 8's breathing seemed shallow *when she entered.* CMS Ex. 3, at 51. There are no other contemporaneous notes contradicting *that* reported observation, and Nurse Shamblin did not disavow it in her post-December 24 statement. Furthermore, the fact that the nurses who entered later detected no respiration does not prove that Resident 8 was not breathing when Nurse Shamblin entered at or shortly after 7:00 a.m.[4] Woodland's objection to the finding that Resident 8 was still breathing at 7:00 a.m. also overlooks the evidence that a nursing assistant reported to surveyors that she had observed Resident 8 breathing with difficulty around 7:00 a.m. *See* ALJ Decision at 6. Woodland contends that the ALJ erroneously relied on this evidence, contending that "it is established, without contradiction in the record, that a SRNA [state registered nurse aide] is not qualified to assess a resident's respiratory status." RR at 9-10. In support of that contention, Woodland points to the testimony of Surveyor Combs and Director of Nursing (DON) Evans. RR at 10 (citing Tr. at 68, 87). In response to a question about whether a nurse aide is "actually qualified to assess a resident's respirations," Surveyor

[4] Woodland complains that the ALJ also disregarded the EMS report, which indicates that Resident 8 was not breathing when the 911 call was placed at 7:09 a.m. RR at 10; P. Ex. 1, at 19. Like the post-incident statements of Nurses Hall, Washburn, and Monroe, the EMS report describes Resident 8's respiratory status some minutes after Nurse Shamblin entered her room. The EMS report does not necessarily prove that Resident 8 was not breathing when Nurse Shamblin first entered the room.

Combs stated that a nurse aide is "not qualified to assess respirations, but she can identify that there's a concern that a nurse needs to come and assess." Tr. at 68. DON Evans also testified that a nurse aide was unqualified to "assess" a resident's "respiratory status," and further indicated that it was "possible" for a nurse aide to mistake a resident's breathing for something else. Tr. at 87.

This testimony has little, if any, probative value. It presumes that the nurse aide attempted to clinically assess Resident 8's respiratory status based on a physical examination. There is no evidence that she did, however. The nurse aide merely reported observing that Resident 8 *appeared* to be having difficulty breathing. Woodland has not explained why a nurse aide (or any lay person) would be incapable of recognizing and observing general breathing difficulty. Although DON Evans indicated that it was "possible" for a nurse aide to "mistake a resident's breathing for something else when in fact the resident is not breathing," no testimony was elicited about what those possibilities were,[5] and, as the ALJ noted at the hearing, Woodland did not interview or obtain testimony from the nurse aide.

Woodland also complains that the ALJ disregarded Dr. Bond's testimony that if a patient were "under stress," "I would think" that her breathing "wouldn't be shallow. It would be rapid and hard." Tr. at 164. For various reasons, this testimony is insufficient to undercut the ALJ's finding that Resident 8 was still breathing at 7:00 a.m. First, Dr. Bond provided no medical explanation for his opinion. Second, he did not indicate that the opinion accounted for all of the relevant clinical circumstances (including Resident 8's Chronic Obstructive Pulmonary Disease). Third, he not testify that shallow breathing would *never* be observed in a patient in the dying process. Fourth, before another question was posed, Dr. Bond seemed to limit the scope or force of his opinion, stating: "But I don't know whether the time frame was that the person had – what the time frame was. I don't have any information on it." Tr. at 164. Finally, Dr. Bond's use of the words "I would think" to preface his opinion supports an inference that it was neither strongly held nor fully informed.

In short, substantial evidence supports the ALJ's finding that Resident 8 was still breathing at 7:00 a.m., a finding that, in turn, supports the ALJ's rejection of the nurses' post-December 24 statements. Woodland has failed to point to any evidence not addressed by the ALJ that fairly detracts from that finding.

The ALJ's final reason for discounting the post-December 24 statements was perceived discrepancies between them and the evidence of post-mortem examinations. *See* ALJ Decision at 10. The SOD reported the following interview statements by the mortician who embalmed Resident 8's body: "[T]he mortician . . . . revealed the resident had no pooling of blood or dark discoloration to the resident's back when he was preparing the body. He further stated there was slight rigor mortis to the large joint, suggesting the

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[5] Woodland's counsel asked DON Evans to "[e]xplain . . . what [the] nurse aide might [have been] seeing." Tr. at 88. The ALJ cut off that line of questioning, finding it speculative. *Id.* Woodland does not object to that evidentiary ruling.

resident had only been dead for a short while." *Id.* at 9. The ALJ found that the post-December 24 nurses' statements "described more significant signs of irreversible death than the mortician found at least two hours later[.]" *Id.* Woodland objects to that finding, asserting that it is not supported by substantial evidence. We agree with Woodland that, based on the vague or imprecise statements provided by the nurses and attributed to the mortician (*see* CMS Ex. 1, at 9), it is difficult to compare the "significance" of any of the reported findings. In any event, the other reasons given by the ALJ for discounting the nurses' statements adequately support her credibility determination.

Woodland generally contends that it was improper to reject the post-December 24 nurses' statements because "there is no dispute that each of these nurses did assess Resident 8. They simply did not record their findings in the nurses' notes, nor were they required to do so." RR at 11. "More importantly," says Woodland, "each of the nurses was interviewed by the state surveyors. Their interviews were consistent with the written statements they later provided, and establish that Resident 8's lips were black, her body temperature was cold, and her joints were stiff . . . ." *Id.*

These contentions do not establish that the ALJ's findings are unsupported by substantial evidence in the record. Although the nurses' interview statements and unsworn written statements are generally consistent (*compare* CMS Ex. 5, at 19-20, 23, 27-29 with P. Ex. 1, at 22-25), that consistency does not alter the fact that the nurses gave both sets of statements only after several days had passed from the December 24th incident and only after the state survey agency identified that incident as a topic concern. More importantly, both sets of statements are, as the ALJ found, inconsistent with Nurse Shamblin's contemporaneous report of the incident. Moreover, we (like the ALJ) regard the failure of Nurses Hall, Washburn, and Monroe to document their findings as significant in the credibility calculus. Even if the nurses were not *legally* required to document the findings supporting the decision to withhold CPR, they were obligated to do so under accepted professional standards, as Dr. Bond implicitly testified (Tr. at 166-67).[6] Therefore, we cannot conclude in this context that the nurses' post-incident "consistency" constitutes conclusive proof of their reliability.

In sum, the ALJ was faced with conflicting or inconsistent evidence about whether Resident 8 exhibited signs of irreversible death. In that circumstance, the ALJ's "role as the finder of fact was to determine which testimony [s]he believed, what weight to give the various items of evidence, and which permissible inferences to draw." *Royal Manor*,

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[6] In *Sheridan Health Care Center*, the Board found the nursing standard of care was the same as the standard to which Dr. Bond implicitly testified:

> Professional standards of quality nursing care require nursing notes to include nurses' clinical observations of patients and to document the care and services furnished to patients. Professional standards of quality also require that notes be timely entered, preferably at the end of the nurse's shift if at all possible, and generally within a 24-hour period.

DAB No. 2178, at 33 (2008) (citations and internal quotations omitted).

DAB No. 1990, at 12 (2005). The ALJ properly exercised that role in this case, giving several valid reasons for assigning no weight to the nurses' post-December 24 statements. For this reason, we conclude that substantial evidence supports the ALJ's finding that Resident 8 did not exhibit signs of irreversible death prior to the pronouncement of her death at 7:31 a.m. on December 31, 2008.

2. *The ALJ's conclusion that Woodland was not in substantial compliance with 42 C.F.R. §§ 483.13(c), 483.20(k)(3)(ii), 483.25, and 483.75 is supported by substantial evidence and is not legally erroneous.* [7]

We next consider Woodland's contention that the ALJ lacked a basis to find it noncompliant with sections 483.13(c), 483.20(k)(3)(ii), 483.25, and 483.75.

(a) 42 C.F.R. § 483.13(c)

Section 483.13(c) states that a SNF "must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property." The term "neglect" is defined in CMS's regulations as a "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 42 C.F.R. § 488.301. The Board has held that multiple or sufficient examples of neglect may support a reasonable inference that a facility has failed to develop or implement policies and procedures that prohibit neglect. *Barn Hill Care Center*, DAB No. 1848, at 10 (2002); *Emerald Oaks*, DAB No. 1800, at 18 (2001).

The ALJ found, and the record shows, that Woodland had a written policy that required any employee having "reasonable cause to believe or even suspect that a resident has suffered . . . neglect" to report the belief or suspicion "immediately" to a supervisor, to the facility's administrator, or to the administrator's designee. ALJ Decision at 5; P. Ex. 1, at 12. The policy further instructed Woodland to notify appropriate state authorities of any incident of possible neglect and to investigate the incident within five working days. *Id.* In addition, Woodland had a separate policy, entitled "Residents Rights," that obligated its staff to "ensure" that all residents were protected from "neglect," which it defined, as the regulations do, as the "failure to provide the services necessary to avoid physical harm, mental anguish or mental illness." P. Ex. 1, at 27. Finally, there is evidence that Woodland obligated its employees to acknowledge, with a signature, their responsibility to report any incident about which the employee "has reasonable cause to

[7] The ALJ concluded that it was unnecessary to address the deficiency citation which alleged noncompliance with section 483.75(o)(1), finding that the other four immediate jeopardy-level deficiency citations – namely, those which alleged noncompliance with sections 483.13(c), 483.20(k)(3)(ii), 483.25, and 483.75 – were sufficient to support the remedies imposed. ALJ Decision at 4 n.2. Woodland states in its request for review that it objects to the ALJ's failure to render a judgment about the merits of the deficiency citation alleging noncompliance with section 483.75(o)(1) but provides no argument to support its objection. *See* RR at 2. For that reason, we decline to address that objection. *See Board Guidelines* (indicating the Board need not consider issues not raised in the request for review).

believe or suspect that a resident has suffered abuse or neglect." *Id.* at 12. During the evidentiary hearing, Woodland's director of nursing agreed that failing to provide CPR to a full-code resident constituted neglect. Tr. at 79.

The ALJ found that "[a]lthough [Woodland] may have had in place acceptable written policies designed to prevent neglect, and to assure that each resident's advance directive would be honored," the facility failed to implement those policies in connection with the December 24 incident involving Resident 8. ALJ Decision at 12. In support of that finding, the ALJ stated that "[f]acility nurses neglected to provide [Resident 8] the services she needed when she stopped breathing on the morning of December 24, 2008." *Id.* The ALJ also found: "Until the time of the survey, the incident was neither reported nor investigated, even though the regulation and the facility's anti-neglect policy required that the incident be reported immediately to the administrator and to the appropriate state agency and that an in-house investigation be completed and its results reported to the administrator (or her designee) and to the state officials within five working days. To this day, the facility has not thoroughly investigated the incident, since it has never questioned some key witnesses." *Id.*

In response to the ALJ's conclusion that it was noncompliant with section 483.13(c), Woodland asserts that "no written policy can possibly contemplate every scenario that might arise with respect to an individual resident's condition." RR at 6. "In such cases," says Woodland, "it is important to permit individual nurses to exercise their own clinical judgment in accordance with professionally recognized standards of care." RR at 6-7. The facility asserts that its written anti-neglect policy "did not contemplate the actions that would be taken if a resident was exhibiting obvious signs of irreversible death" but that, in any event, "the nurses appropriately implemented the facility policy until it became apparent that the policy was no longer applicable to the particular situation." RR at 7. "At that point," says the facility, "the nurses acted in accordance with professionally recognized standards of care with respect to Resident 8 by not initiating CPR." *Id.* Finally, Woodland asserts: "Once a resident displays obvious signs of irreversible death, the facility policy regarding implementation of a resident's advance directives no longer applies. Therefore, the determination that the facility did not follow its policy regarding advance directives is not supported by the record, and the finding of substantial noncompliance under 42 C.F.R. § 483.13(c) is clearly erroneous." RR at 12.

We reject this argument because we find no basis for its factual premise, which is that the nurses acted in compliance with the applicable standard of care. As discussed, the ALJ made a finding that Resident 8 did not display clinical signs of irreversible death at the time that nurses decided to withhold CPR. Because we have affirmed that finding, and because it is undisputed the standard of care required the nursing staff to administer CPR to Resident 8 in the absence of clinical signs of irreversible death, we cannot accept Woodland's assertion that the nurses made a clinical judgment "in accordance with professionally recognized standards of care."

In response to the ALJ's finding that it failed to investigate the December 24 incident, Woodland contends that there were no reasons to suspect neglect and thus no need to

investigate the incident. RR at 13; *see also* RR at 19-20. We disagree. Under Woodland's anti-neglect policies, the obligation to investigate an incident is triggered when there is "reasonable cause to believe or even suspect" that a resident was neglected. In our view, Nurse Shamblin's December 24 nursing notes, the only contemporaneous nursing documentation of the incident, were sufficient to raise a reasonable suspicion of neglect because of information they did *not* contain. The notes contain few clinical findings, do not describe a clear timeline of events, and fail to explain or justify, in clinical terms, the nursing staff's decision to withhold CPR. They also suggest that Resident 8 was still breathing within 10 to 15 minutes before the decision to withhold CPR was made. We agree with the ALJ that it was incumbent on Woodland in these circumstances to investigate the incident to verify that a full-code resident was not improperly denied potentially life-saving medical care.[8]

Woodland contends that "once the survey team voiced their concerns about Resident 8's death, the facility undertook an investigation," and that the "adequacy of that investigation was not the basis for any citation at issue in this case[.]" RR at 19-20. This assertion is immaterial because Woodland was not cited for failing to perform an adequate investigation after the survey began on January 5, 2009. Rather, it was cited for failing to investigate the December 24 incident within five working days, as required by its own anti-neglect policy. See CMS Ex. 1, at 11-12.

These failures – by both supervisory and non-supervisory employees – collectively demonstrate systemic problems relating to staff training and administrative policies that in turn support a conclusion that Woodland had not implemented its policies prohibiting neglect. Woodland has not suggested that its failure to honor Resident 8's advance directive, in accordance with the accepted standard of care, and concomitant failure to investigate support any other reasonable conclusion.

For the foregoing reasons, we affirm the ALJ's conclusion that Woodland was noncompliant with section 483.13(c) as of December 24, 2008.

(b) 42 C.F.R. § 483.20(k)(3)(ii)

Title 42 C.F.R. § 483.20(k)(3)(ii) requires that a SNF's services "[b]e provided by qualified persons in accordance with each resident's written plan of care."

The ALJ held: "Inasmuch as [Resident 8]'s comprehensive care plan instructed the staff to honor [her] full code advance directive, and the nurses failed to do so, they failed to provide care and services "in accordance with" Resident 8's written plan of care, as section 483.20(k)(3)(ii) required. ALJ Decision at 12.

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[8] According to the Statement of Deficiencies, Woodland's Director of Nursing told surveyors that Nurse Shamblin contacted her on December 24 to inform her about Resident 8's death. CMS Ex. 1, at 11. The Director of Nursing also indicated that, at some unspecified point, she reviewed the clinical record of Resident 8's death and found nothing that required investigation. *Id.*

Woodland objects to this conclusion on the ground that the record "conclusively establishes that the care provided to Resident 8 was consistent with her plan of care." RR at 14. To the contrary, the facts (as found by the ALJ and affirmed here) establish that the care provided to Resident 8 on December 24 was inconsistent with her plan of care. Resident 8's plan of care expressly incorporated an advance directive that, in turn, obligated the nursing staff to administer CPR in the event of respiratory or cardiac failure. *See* ALJ Decision at 6; CMS Ex. 5, at 75. Substantial evidence (outlined above) supports the ALJ's finding that Woodland's nurses withheld CPR from Resident 8 in violation of her advance directive and the accepted standard of care.

Because we find no merit in the assertion that the nursing staff complied with Resident 8's plan of care on December 24, 2008, we affirm the ALJ's conclusion that Woodland was not in substantial compliance with section 483.20(k)(3)(ii) as of that date.

(c) 42 C.F.R. § 483.25

Section 483.25 states that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being" of the resident "in accordance with [the resident's] comprehensive assessment and plan of care."

In upholding the deficiency citation alleging noncompliance with section 483.25, the ALJ stated that because the nursing staff failed to provide CPR "during the first critical minutes, as her care plan called for," and because Resident 8 died, "I can only conclude that the facility failed to provide her the care and services she needed to maintain her highest practicable physical well-being, in accordance with her comprehensive assessment and plan of care." ALJ Decision at 11.

Woodland contends that it was in substantial compliance with section 483.25 because "Resident 8 was already showing signs of irreversible death at the time she was found by the nurses," and thus CPR was futile and "unnecessary." RR at 16. We reject that contention because, as we have discussed at length, substantial evidence supports the ALJ's finding that Resident 8 did not have clinical signs of irreversible death when nurses decided to withhold CPR. Asked about whether the nursing staff was obligated to perform CPR in the absence of those clinical signs, Dr. Bond reluctantly acknowledged the merit of CMS's position, stating that it would "probably" have been "not inappropriate" for the nursing staff to begin CPR given the information reported in Nurse Shamblin's December 24 notes. Tr. at 180.

Woodland counters that "there is absolutely no evidence to support a finding CPR would have allowed Resident 8 the chance to survive" in any event. RR at 16. However, CMS was under no obligation to produce such evidence. The plain language of section 483.25 requires that a SNF's services "be in accordance with" the resident's plan of care. *Sheridan Health Care Center* at 15. Furthermore, section 483.25 "implicitly imposes on facilities a duty to provide care and services that, at a minimum, meet accepted professional standards of quality[.]" *Id.* Woodland's services to Resident 8 on December

24, 2008 clearly failed to satisfy those criteria. Her plan of care expressly directed the nursing staff to honor Resident 8's "full code" advance directive. CMS Ex. 1, at 75. Honoring the advance directive meant the provision of CPR to Resident 8 when she experienced cardiac or respiratory arrest. Furthermore, accepted professional standards of quality obligated the nursing staff to carry out the advance directive for Resident 8 unless she exhibited clinical signs of irreversible death.[9] As discussed, the ALJ's findings of fact, which are supported by substantial evidence, establish that Woodland failed to provide that service in accordance with either the plan of care or with accepted professional standards.

By stressing the potential futility of CPR, Woodland implies 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. That position has no support in either the regulations or in the medical standards discussed above. The AHA guidelines caution that "few criteria can accurately predict the futility of CPR." P. Ex. 2, at 3. As a result, those guidelines provide a bright-line rule: a patient without a do-not-resuscitate order must receive CPR unless one of the stated exceptions applies. As the Board indicated in *John J. Kane Regional Center – Glen Hazel*, "[t]he fact that a person may exhibit signs of death does not necessarily obviate the caregiver's duty to provide CPR because one of CPR's goals, according to the AHA Guidelines, is the reversal of clinical death, even though that outcome is achieved in only a minority of cases." DAB No. 2068, at 17 (2007).

For the foregoing reasons, we affirm the ALJ's conclusion that Woodland was not in substantial compliance with section 483.25 as of December 24, 2008.

(d) 42 C.F.R. § 483.75

Section 483.75 states in its prefatory paragraph that a SNF "must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident." The ALJ held that Woodland was not in substantial compliance with this "administration" requirement because it had been shown to be noncompliant at the immediate jeopardy level with other requirements relating to resident health and safety. ALJ Decision at 12 (citing *Asbury Center at Johnson City*, DAB No. 1815, at 11 (2002)). The ALJ also observed that Woodland's noncompliance with other requirements was "not attributable to a single individual":

> Four nurses are immediately implicated in the failure to honor [Resident 8]'s advance directive. Management is implicated, because of the DON's failure to act, to report, or to investigate. The administrator is also implicated for failing to

[9] The AHA guidelines also make an exception for patients for whom "[n]o physiological benefit can be expected because vital functions have deteriorated despite maximal therapy (e.g., progressive septic or cardiogenic shock)." P. Ex. 2, at 4. Woodland's arguments concerning Resident 8 do not invoke this exception.

> investigate adequately, when the incident was finally reported to her. The facility was therefore not administered in a manner that used its resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of its residents.

ALJ Decision at 13.

We find no error with the ALJ's conclusion that Woodland was noncompliant with section 483.75. The Board has held, and Woodland concedes (RR at 19), that a deficiency citation alleging noncompliance with section 483.75 may be derived from findings of noncompliance with other participation requirements. *Stone County Nursing and Rehabilitation Center*, DAB No. 2276, at 15-16 (2009) (citing cases). Woodland contends that it cannot be held noncompliant with section 483.75 because CMS did not demonstrate that it was noncompliant with other requirements. RR at 19. As our prior discussion makes clear, however, substantial evidence supports the ALJ's conclusion that Woodland was noncompliant with sections 483.13(c), 483.20(k)(3)(ii), and 483.25.

For these reasons, we affirm the ALJ's conclusion that Woodland was not in substantial compliance with section 483.75 as of December 24, 2008.

3. *CMS's determination that Woodland's noncompliance placed residents in immediate jeopardy is not clearly erroneous.*

As indicated, CMS determined that Woodland's noncompliance with sections 483.13(c), 483.20(k)(3)(ii), 483.25, and 483.75 posed "immediate jeopardy" to the facility's residents. Immediate jeopardy is defined as "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. A determination by CMS "as to the level of [a SNF's] noncompliance . . . must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). Immediate jeopardy is a "determination as to the level of noncompliance" and is therefore subject to the clearly erroneous standard of review. *Maysville Nursing & Rehabilitation Facility*, DAB No. 2317, at 11 (2010). "Under the clearly erroneous standard, CMS's immediate jeopardy determination is presumed to be correct, and the facility has a heavy burden to overturn it." *Id.*

The ALJ held that CMS's immediate jeopardy determination was not clearly erroneous, stating that "[f]ailing to provide CPR to a full-code resident who has stopped breathing all but guarantees that resident's death and, thus, poses immediate jeopardy to resident health and safety." ALJ Decision at 13. The ALJ also observed that 29 of 104 of the facility's residents were "full code," and that "any one of these individuals was at risk" in the period before the facility "instituted procedures and training to assure that all full-code directives would be honored[.]" *Id.* at 13 n.9.

In response to that holding, Woodland asserts that "overwhelming evidence" demonstrates that it was in substantial compliance with all requirements. RR at 20.

However, we have just affirmed the ALJ's conclusion that Woodland was noncompliant with four Medicare participation requirements based on its handling of the December 24 incident. Consequently, if Woodland seeks to reverse the immediate jeopardy determination, it must demonstrate that this noncompliance did not cause, or was not likely to cause, serious injury, harm, impairment, or death to a resident. Woodland has not attempted to carry that burden in this appeal; it merely contends that there was no noncompliance at any level of seriousness, asserting that the nursing staff "exercised appropriate nursing judgment in determining that CPR was not warranted in the case of Resident 8." RR at 8, 20-21. For that reason, we affirm, without further discussion, the ALJ's conclusion that CMS's immediate jeopardy determination was not clearly erroneous.

4. *The ALJ's conclusion that the period of immediate jeopardy-level noncompliance was not abated until January 16, 2009 is supported by substantial evidence and is not legally erroneous.*

Woodland contests the ALJ's determination that the immediate jeopardy-level noncompliance was not abated until January 16, 2009. RR at 21-23. Woodland asserts that "[i]n the event that this tribunal determines that the ALJ appropriately found that immediate jeopardy level noncompliance did exist as a result of any of the alleged violations, under no circumstances should a finding of noncompliance and/or immediate jeopardy be determined to exist beyond January 6, 2009." RR at 21.

A per-day CMP may begin to accrue "as early as the date that the facility was first out of compliance, as determined by CMS or the State." 42 C.F.R. § 488.440(a)(1). "Alternative remedies," which include any per-day CMP, continue to accrue until "[t]he facility has achieved substantial compliance, as determined by CMS or the State based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit." 42 C.F.R. § 488.454(a).

The Board has said that "a facility's noncompliance is deemed to be corrected or removed only when the incidents of noncompliance have ceased and the facility has implemented appropriate measures to ensure that similar incidents will not recur." *Florence Park Care Center*, DAB No. 1931, at 30 (2004) (emphasis in original). Similarly, immediate jeopardy is deemed to have been removed only when the facility has implemented necessary corrective measures. *See Fairfax Nursing Home, Inc.*, DAB No. 1794 (2001) (finding that the SNF had taken inadequate steps to abate the immediate jeopardy), *aff'd, Fairfax Nursing Home v. Dep't of Health & Human Servs.*, 300 F.3d 835 (7th Cir. 2002), *cert. denied*, 537 U.S. 1111 (2003). "A determination by CMS that a SNF's ongoing compliance remains at the level of immediate jeopardy during a given period . . . is subject to the clearly erroneous standard of review under [42 C.F.R. §] 498.60(c)(2)." *Brian Center Health and Rehabilitation/Goldsboro*, DAB No. 2336, at 7-8 (2010).

According to the SOD, the state survey agency "identified" Woodland's immediate jeopardy-level noncompliance on January 9, 2009 and found that this noncompliance arose on December 24, 2008 and "was ongoing" during the survey. CMS Ex. 1, at 6, 17,

21, 29-30. In its plan of correction, which Woodland did not submit until January 26, 2009, Woodland stated (in relevant part):

> All resident charts have been audited to ensure that code status is reflected on the current physician orders and that residents with orders for "Do Not Resuscitate" have a red dot on the outer spine of the chart, which serves as a visual flag. Any death that occurs in the facility will be reported to the Director of Nursing and/or Quality Assurance Nurse immediately. The Director of Nursing and/or the Quality Assurance Nurse will immediately upon notification review each death that occurs in the facility to ensure all policies and procedures were followed. Once completed, these reviews will be forwarded to the Administrator within two business days of completion of the review by the Director of Nursing/Quality Assurance Nurse to ensure reviews were timely and in compliance with facility policies and procedures. Any deviation in facility policy will be followed up with an inservice by the Director of Nursing or Quality Assurance Nurse to review that policy within twenty-four hours, as well as one on one in-servicing with the person who failed to follow facility policy.

Id. at 6-7 (SOD quoting plan of correction). The plan of correction further stated that "[a]ll licensed staff were in-serviced [i.e., received training] on 01-06-09 . . . regarding code status, identification of code status, and appropriate nursing assessment and initiation of CPR." *Id.* at 8. In addition, the plan of correction specified other corrective measures, including a January 15, 2009 training session in which staff received instruction "regarding updating and implementing the care plan to ensure that it reflects the resident's current code status and wishes" and instruction that "facility policy [was] to provide CPR to all full code residents." *Id.*

In upholding CMS's determination that the immediate jeopardy noncompliance did not cease until January 16, 2009, the ALJ found:

> . . . [B]y itself, one in-service training session [on January 6, 2009] does not establish that the facility has corrected its problems and assured that they will not recur. After all, a serious error occurred here, involving multiple staff members, even though the facility believed that they had been trained adequately. So the facility must not only make sure that its staff is adequately trained, it must thereafter monitor to make sure that the training has resolved the problem.

ALJ Decision at 14. Moreover, said the ALJ:

> [T]he facility's promised corrective actions were not limited to one in-service training session. The facility conducted additional training on January 15, 2009. The facility promised that every death would be 'immediately' reported to the DON and/or quality assurance nurse, who would review and forward her conclusions to the Administrator. Any

> deviation from facility policy would be followed-up with additional training. Medical records would be audited monthly. The facility promised enhanced oversight by the administrator. *The facility repeatedly set January 16, 2009, as the completion date for its corrections.*

Id. (citations omitted; italics added). In short, the ALJ sustained CMS's determination concerning the duration of the noncompliance and immediate jeopardy "[b]ecause [Woodland] has not established that an effective plan of correction was implemented any earlier than that determined by CMS[.]" *Id.* at 15.

In objecting to the ALJ's conclusion, Woodland contends that the in-service training that it conducted for all nurses on January 6, 2009 "was sufficient to ensure that the staff was familiar with the policies regarding code status, identification of code status, and appropriate nursing assessment and initiation of CPR." RR at 22. Woodland also asserts that by January 6, "each of the 108 residents' charts [had been] reviewed to ensure they contained accurate and complete information regarding code status[.]" *Id.* According to Woodland, "the audit of the residents' charts, coupled with the training provided on January 6, 2009 ensured that the staff was familiar with the prevailing standards of practice regarding initiation of CPR and the identification of irreversible signs of death." RR at 22-23. As for "the remaining measures cited by the ALJ, including immediate reporting of resident death to the DON and/or Quality Assurance Coordinator, additional training following any further deviations from facility policy, monthly auditing of medical records and enhanced oversight by the administrator," Woodland characterizes them as "ongoing initiatives" and states that there "were no new measures initiated in between January 6, 2009 and January 15, 2009." RR at 23. In addition, Woodland states that the "additional training provided on January 15, 2009 was further protection against noncompliance, but was not necessary to ensure that resident's health and safety was not in immediate jeopardy." RR at 22.

We conclude that ALJ's resolution of this issue was not erroneous. The Board has held "that abatement of an immediate jeopardy condition (or removal of noncompliance) ordinarily requires the performance of corrective measures that the facility has included in a plan of correction." *Brian Center* at 9 (citing cases). In this case, Woodland concedes that it did not fully implement its plan of correction until January 16, 2009, and thus it cannot now claim that partial implementation of that plan sufficed to remove the immediate jeopardy-level noncompliance. "The Board has long rejected as contrary to the goals of the program" the proposition "that a facility can belatedly claim to have achieved substantial compliance at a date earlier than it even alleged that it had done so" in a corrective action plan. *Cal Turner Extended Care Pavilion*, DAB No. 2030, at 18-19 (2006).

Woodland has not, in any event, met its burden of demonstrating clear error. It is, first of all, difficult to evaluate whether the additional in-service training performed on January 15, 2009 was, as Woodland suggests, unnecessary to abate the immediate jeopardy because it failed to submit detailed documentation or testimony about the content of each in-service training session. There is no evidence that the core deficiency in this case – a

failure to carry out a full-code advance directive – was addressed before the January 15th training, which instructed nurses that it was facility "policy" to provide CPR to all full-code residents. Moreover, Woodland submitted no evidence that it conceived, or instituted procedures and policies to implement, its so-called "ongoing initiatives" by January 6, 2009. Like the ALJ, we are unconvinced that those initiatives were inconsequential or unnecessary to abate the immediate jeopardy. Some of the measures, such as the requirement to immediately report all resident deaths to the director of nursing or quality assurance nurse, appear to be a direct response to Woodland's failure to identify and investigate possible incidents of resident neglect – a failure that was deemed to be at the level of immediate jeopardy.

For the foregoing reasons, we affirm the ALJ's conclusion that CMS's determination concerning the duration of Woodland's immediate jeopardy-level noncompliance was not clearly erroneous.

5. *The ALJ committed no error in concluding that the amount of the per-day CMP imposed by CMS for Woodland's noncompliance was reasonable.*

If CMS imposes a per-day CMP for noncompliance at the immediate jeopardy level, the CMP must be set within the "upper range" of $3,050 to $10,000 per day. 42 C.F.R. §§ 488.408(d)(3)(ii), 488.438(a)(1)(i). Here, CMS imposed a $4,550 per-day CMP for the period of Woodland's immediate jeopardy-level noncompliance. Woodland contends that the amount of the CMP is unreasonable and that the ALJ erred in holding otherwise. RR at 23-25.

In deciding whether the per-day CMP amount is reasonable, an administrative law judge (or the Board) may consider only those factors specified in section 488.438 of CMS's regulations. *See* 42 C.F.R. § 488.438(e), (f); *Senior Rehabilitation and Skilled Nursing Center*, DAB No. 2300, at 19-20 (2010). Those factors are: (1) the SNF's history of noncompliance; (2) the SNF's financial condition; (3) factors specified in 42 C.F.R. § 488.404 (i.e., the severity and scope of the noncompliance, and "the relationship of the one deficiency to other deficiencies resulting in noncompliance"); and (4) the SNF's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. 42 C.F.R. §§ 488.438(f), 488.404. An administrative law judge (or the Board) reviews the reasonableness of the CMP de novo, based on the facts established in the appeal record. *Emerald Oaks*, DAB No. 1800 (2001); *CarePlex of Silver Spring*, DAB No. 1683 (1999).

In finding the $4,550 per-day CMP to be reasonable, the ALJ first noted that the CMP amount chosen by CMS was at the low end of the applicable penalty range, and that CMS had not cited Woodland's compliance history as an aggravating factor. ALJ Decision at 15. The ALJ further noted that Woodland had not argued that its financial condition affected its ability to pay the CMP. *Id.* The ALJ then stated that she had considered all of CMS's deficiency findings in light of the remaining regulatory factors – including the uncontested findings of noncompliance with sections 483.10(b)(11), 483.20(d), 483.10(k)(2), and 483.75(l)(1). The ALJ stated that any one of those uncontested

findings would, by itself, support a per-day penalty of at least $50 (and potentially up to $3,000) and thereby justified increasing the upper range CMP (applicable to immediate jeopardy-level noncompliance) above the regulatory minimum of $3,050 per day. ALJ Decision at 15. The ALJ also found Woodland "culpable" for its noncompliance "because four nurses neglected their direct responsibilities" to Resident 8, and because "when the [Director of Nursing] learned of the situation, she dismissed it as insignificant and failed to investigate." *Id.* at 16. The ALJ further found Woodland culpable because, in her view, it "conducted a half-hearted and wholly inadequate investigation" after its administrator learned (during the survey) of the December 24 incident. *Id.*

We find no material factual or legal error in the ALJ's analysis. Woodland does not contend that it lacks the ability to pay the CMP, nor does it contend that the ALJ was precluded from considering the uncontested deficiency findings in determining whether the CMP amount was reasonable.[10]

Woodland does contend that the ALJ, in finding it culplable for the noncompliance, erroneously relied on her belief about adequacy of the facility's investigation of the December 24 incident. RR at 24-25. According to Woodland, "the adequacy of that investigation was not the basis for any of the alleged noncompliance, nor was it even mentioned by CMS in its argument. Any reliance by the ALJ on the adequacy of the investigation conducted by the Administrator during or after the survey is clearly erroneous." *Id.*

We agree that the adequacy of the investigation performed by Woodland after the survey commenced is not a basis for the deficiencies found by the ALJ and therefore does not support a culpability finding. However, the ALJ articulated sufficient other reasons for her culpability finding, including the failure of four nurses to carry out their "direct responsibilities" to Resident 8. Moreover, Woodland does not dispute that its failure to investigate the December 24 incident *prior to* the survey is evidence of culpability.

Finally, Woodland suggests that the CMP amount is excessive because "each of the alleged deficiencies at the immediate jeopardy level is related to the same issue – the implementation of Resident 8's advanced directives." RR at 24. Although it is true that all of the immediate jeopardy-level findings of noncompliance relate to the December 24 incident, Woodland overlooks the fact that its noncompliance involved not only a failure to honor a resident's advance directive, but a failure to comply with the standard of care for initiating CPR and a subsequent failure by the supervisory staff to investigate the incident to determine whether it involved resident neglect. Moreover, as we said in a recent decision in which we sustained an identical CMP ($4,550 per day) for noncompliance involving a failure to perform CPR, "[w]e cannot find such a penalty amount to be unreasonable when it is imposed for immediate-jeopardy-level noncompliance involving a failure to perform a basic life-saving procedure." *Brian Center* at 13.

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[10] "The regulations permit [an ALJ or the Board] to consider the severity and scope of all deficiencies constituting noncompliance in determining whether a CMP amount is reasonable." *Brian Center* at 14.

For all these reasons, we affirm the ALJ's conclusion that the amount of the CMP imposed by CMS is reasonable.

Conclusion

For the reasons stated above, we affirm the ALJ Decision.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Stephen M. Godek
Presiding Board Member