Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Green Valley Healthcare and Rehabilitation Center
Docket No. A-18-35
Decision No. 2947
May 24, 2019

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Green Valley Healthcare and Rehabilitation Center (Petitioner), a Texas skilled nursing facility (SNF), has appealed the December 21, 2017 decision by the administrative law judge (ALJ) upholding a $10,000 per-instance civil money penalty (CMP) imposed by the Centers for Medicare & Medicaid Service (CMS) for alleged noncompliance with a Medicare participation requirement. Granting summary judgment to CMS, the ALJ held that Petitioner was not in substantial compliance with the basic quality-of-care requirement in 42 C.F.R. § 483.25 because one of its nurses failed to administer cardiopulmonary resuscitation (CPR) to a resident who was found without vital signs. *Green Valley Healthcare and Rehab. Ctr.*, DAB CR4998 (2017) (ALJ Decision). Petitioner challenges that holding, but we find no error by the ALJ. Accordingly, we affirm the grant of summary judgment to CMS.

Legal Background

To participate in the Medicare program, a SNF must be in "substantial compliance" with the participation requirements in 42 C.F.R. Part 483, subpart B (sections 483.1-.75).[1] 42 C.F.R. §§ 483.1, 488.400. Compliance with Medicare participation requirements is verified through onsite surveys performed by state health agencies. *Id.* §§ 488.10(a), 488.11.

[1] On October 4, 2016, CMS issued a final rule that amended the Medicare participation requirements for long-term care facilities published in 42 C.F.R. Part 483. Final Rule, *Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities*, 81 Fed. Reg. 68,688 (Oct. 4, 2016). Our analysis and decision are based on the version of the participation requirements that was in effect during July 2015, when the compliance survey supporting CMS's enforcement action was performed. *Carmel Convalescent Hosp.*, DAB No. 1584, at 2 n.2 (1996) (applying the regulations in effect on the date of the survey and resurvey).

A SNF is not in substantial compliance when it has a "deficiency" – that is, a failure to meet a Medicare participation requirement – that creates at least the potential for more than minimal harm to one or more residents. *Id.* § 488.301 (defining "substantial compliance"). The term "noncompliance," as used in the applicable regulations, is synonymous with lack of substantial compliance. *Id.* § 488.301 (defining "noncompliance").

CMS may impose enforcement "remedies" on a SNF that is found to be not in substantial compliance. *Id.* §§ 488.400, 488.402(b)-(c), 488.406. Those remedies may include a CMP of between $1,000 and $10,000 for each "instance of noncompliance." *Id.* §§ 488.408(d)(1)(iv), 488.408(e)(1)(iv), 488.438(a)(2).[2]

When CMS elects to impose a CMP, it sets the CMP amount based on, among other factors, the "seriousness" of the SNF's noncompliance. *Id.* §§ 488.404(a)-(b), 488.438(f)(3). Seriousness is a function of the noncompliance's scope (whether it is "isolated," constitutes a "pattern," or is "widespread") and severity (whether it has created a "potential for" harm, resulted in "[a]ctual harm," or placed residents in "immediate jeopardy"). *Id.* § 488.404(b). The most serious noncompliance is that which puts one or more residents in "immediate jeopardy." *Id.* § 488.438(a) (authorizing the highest CMPs for immediate-jeopardy-level noncompliance); *Woodland Oaks Healthcare Facility*, DAB No. 2355, at 2 (2010) (citing authorities).

A SNF may appeal a determination of noncompliance that has resulted in the imposition of a CMP or other enforcement remedy. 42 C.F.R. §§ 488.408(g)(1), 498.3(b)(13), 498.5(b). During a hearing in such an appeal, a SNF may challenge the reasonableness of the amount of any CMP imposed. *Lutheran Home at Trinity Oaks*, DAB No. 2111, at 21 (2007).

Case Background

During a compliance survey that began on July 8 and ended on July 14, 2015, the Texas Department of Aging and Disability Services (state survey agency) found that one of Petitioner's licensed vocational nurses, "LVN A," had failed to administer CPR to an 85 year-old male resident, Resident 19, after discovering him on June 12, 2015 "with no pulse or heartbeat" and "cold to touch." CMS Ex. 4, at 2, 12-13, 23-24. The survey also revealed that Petitioner fired LVN A for not performing CPR on Resident 19 or calling 911 in accordance with its resident care policies. *Id.* at 25-26, 27-28. One of those policies, the "CPR Policy," stated: "in the event of cardiopulmonary arrest of a resident/patient without a DNR [do-not-resuscitate] status, life support measures will be

[2] After the penalties in this case were assessed, the minimum and maximum per-instance penalty amounts specified in 42 C.F.R. § 488.438(a)(2) became subject to annual adjustments, as provided in 45 C.F.R. Part 102.

initiated according to either the American Heart Association/American Red Cross guidelines or per State Guidelines." *Id.* at 29 (internal quotation marks omitted); *see also* CMS Ex. 7, at 3. A second policy, relating to Do-Not-Resuscitate (DNR) orders, stated that Petitioner's staff "will not use cardiopulmonary resuscitation and related emergency measures to maintain life functions on a resident when there is a Do Not Resuscitate Order in effect," and further stated that DNR orders "must be signed by the resident's Attending Physician on the physician's order sheet maintained in the resident's medical record." CMS Ex. 4, at 28-29 (internal quotation marks omitted); *see also* CMS Ex. 7, at 28. The state survey agency found that Petitioner's staff did not consider Resident 19 to have "DNR status" on June 12, 2015 because, although his records included an out-of-hospital DNR order form signed by his wife, the form had not yet been signed by his attending physician. CMS Ex. 4, at 25, 27, 28. (The record shows that the physician did not sign the DNR order until June 15, 2015, three days after Resident 19's death. CMS Ex. 6, at 10.)

Based on its findings regarding Resident 19, the state survey agency cited Petitioner for noncompliance with 42 C.F.R. § 483.25, which directs a SNF to provide each resident with "necessary care and services" to enable the resident to "attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care."[3] CMS Ex. 4, at 23-24. The state survey agency further determined that Petitioner's violation of section 483.25 was at the immediate-jeopardy-level of severity, and that the deficiency also constituted "past noncompliance" in that Petitioner had taken adequate corrective action prior to the survey to return to substantial compliance with that requirement. *Id.* at 24. CMS concurred with the state survey agency's deficiency citation and imposed a $10,000 CMP for the "instance" of noncompliance relating to Resident 19. CMS Ex. 1, at 1-2.

Petitioner requested a hearing before the ALJ to challenge the noncompliance determination and resulting CMP. CMS responded with a motion for summary judgment, supported by, among other material: records of Petitioner's investigation of LVN A's conduct on June 12, 2015; copies of Petitioner's CPR and DNR Order policies; and a declaration by Gordon Foster, R.N., a state agency surveyor who participated in the July survey and authored the deficiency citation at issue in this case. In a brief supporting its summary judgment motion, CMS asserted that Petitioner's care of Resident 19 was not in substantial compliance with section 483.25 because when LVN A found

[3] The state survey agency cited Petitioner for other deficiencies during the July 2015 survey, but those other citations were not appealable because they did not result in the imposition of an enforcement remedy specified in 42 C.F.R. § 488.406. *See* 42 C.F.R. §§ 498.3(a)(1), 498.3(b)(13) (identifying, as an appealable "initial determination," a "finding of noncompliance leading to the imposition of enforcement actions specified in §488.406" and elsewhere); *San Fernando Post Acute Hosp.*, DAB No. 2492, at 2, 6-8 (2012) (discussing the appeal rights of long-term care facilities that receive a determination of noncompliance with Medicare participation requirements).

him without vital signs during the early morning hours of June 12, 2015, she failed to initiate or perform CPR, even though Petitioner considered the resident to be "full code" – that is, a person "without DNR status" for whom the staff was expected to provide CPR in the event his heart or breathing stopped – under its DNR Order and CPR policies. CMS Prehearing Brief and Motion for Summary Judgment at 1, 5-10. In his declaration, Surveyor Foster stated that Petitioner's administrator, Krystal McNabb, told him on July 8, 2015 that, although administering CPR was contrary to the wishes of Resident 19's family, Petitioner's nursing staff considered Resident 19 to have full-code status on June 12, 2015 because his physician had not yet signed the out-of-hospital DNR order. CMS Ex. 9, at 4.

Petitioner filed a response to CMS's motion and a cross-motion for summary judgment, supported by the declarations of Karl E. Steinberg, M.D. (P. Ex. 2) and Administrator McNabb (P. Ex. 1). Petitioner did not dispute that LVN A had failed to perform CPR on Resident 19 when she found him without vital signs on June 12, 2015. Nor did Petitioner dispute the survey's findings about Resident 19's code status and LVN A's discharge. However, Petitioner contended that it did not fail to provide "necessary" services required by section 483.25 in part because Resident 19 did not (according to Petitioner) want to be resuscitated, a desire evidenced by physician notes and his wife's execution of an out-of-hospital DNR order on June 11, 2015, two days after his admission to Petitioner's facility. Pet.'s Cross-Motion for Summary Judgment at 12-13. Petitioner further contended that it did not violate section 483.25 because there is no reason to think that Resident 19 would have survived had LVN A performed CPR. *Id.* at 11, 13, 15-16, 18-19 (stating that CPR would not have restored "normal cardiorespiratory status" and that "[r]ecovery from CPR was not the Resident's . . . . highest practicable physical well-being"). In support of that contention, Petitioner alleged that Resident 19 had "signs of irreversible death" when he was found without vital signs on June 12, 2015. *Id.* at 15-16. Petitioner also pointed to a May 26, 2015 physician's note stating that Resident 19's "comorbid conditions," including dementia and a recent subdural hematoma, "preclude[d] any expected benefit from aggressive cardiac procedures/life sustaining devices." *Id.* at 13, 18 (internal quotation marks omitted, quoting P. Ex. 1, at 7). In addition, Petitioner cited the following opinion expressed by Dr. Steinberg:

> Resident No. 19 would not have benefited from even perfect and immediate CPR – even if he had suffered a *witnessed* arrest, which he did not. In other words, there is essentially no likelihood that the Resident's unwitnessed arrest could have been reversed by CPR even if the CPR had been procedurally flawless and immediate.

Id. at 17 (quoting P. Ex. 2 ¶ 11 (italics in original)).

Petitioner further asserted, more generally, that published medical literature suggests that the "survival rate" of nursing home residents who experience cardiac arrest and undergo CPR in the nursing home "is nearly zero"; that nursing home "patients and their families may suffer greatly as a result of attempted CPR"; that "[n]ursing homes as currently structured and staffed lack the equipment, nurses, and physicians to properly monitor for unexpected cardiac arrest and respond promptly and effectively with CPR"; and that many clinicians consider the low survival rate among nursing home residents who receive CPR to be indicative of that procedure's "medical futility (or, as it is now preferentially referred to, 'medically non-beneficial' or 'medically ineffective' treatment)." *Id.* at 13-15. Finally, Petitioner pointed to a statement from CMS Survey and Certification Letter (S&C Letter) 14-01-NH that "[r]esearch generally shows that CPR is ineffective in the elderly nursing home population" and that a 2006 study "described post-CPR survival rates among nursing home residents ranged from 2 to 11 percent."[4] *Id.* at 17. (CMS issued S&C Letter 14-01-NH, titled "Cardiopulmonary Resuscitation (CPR) in Nursing Homes," in order to provide "guidance" to surveyors concerning a SNF's obligation under 42 C.F.R. Part 483 to furnish CPR to residents.)

The ALJ granted summary judgment to CMS and denied Petitioner's cross-motion for summary judgment. ALJ Decision at 2. She concluded that Petitioner was not in substantial compliance with section 483.25 because LVN A failed to administer CPR to Resident 19 in accordance with its written DNR Order policy (or "code protocol") and American Heart Association guidelines, which, the ALJ said, obligated staff to initiate CPR and call 911 for any "full-code resident who present[ed] with no vital signs." *Id.* at 5, 7. The ALJ further held that Petitioner's evidence of CPR's ineffectiveness in the long-term care population did not preclude a finding of noncompliance, stating that the Board has previously "recognized a 'bright-line rule'" that CPR must be administered to a full-code resident in cardiac arrest unless the resident has clinical signs of irreversible death. *Id.* at 7 (citing *Woodland Oaks* at 16). The ALJ also rejected Petitioner's suggestion that LVN A refrained from administering CPR because Resident 19 had rigor mortis, a clinical sign of irreversible death, calling the suggestion "contrary to all of the record evidence." *Id.* at 8. Even if LVN A believed that irreversible signs of death were present, said the ALJ, that fact would be immaterial because LVN A was "unqualified to make that call" under Texas law. *Id.*

[4] Neither party submitted a copy of S&C Letter 14-01-NH. The letter, last revised on January 23, 2015, is available to the public on CMS's website at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-14-01.pdf.

Analysis

We review the ALJ's grant of summary judgment de novo. *Southpark Meadows Nursing & Rehab. Ctr.*, DAB No. 2703, at 5 (2016). "Summary judgment is appropriate when the record shows there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law." *Id.* A dispute of fact is "material" if its resolution might affect the case's outcome under the governing law. *Id.* (citing *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986)). In evaluating a party's motion for summary judgment, we view the record in the light most favorable to the non-moving party. *Id*.

We affirm the ALJ's grant of summary judgment that Petitioner was not in substantial compliance with the basic quality-of-care requirement in 42 C.F.R. § 483.25 because one of its nurses failed to administer CPR to a resident who was found without vital signs. As noted, section 483.25 requires a SNF to provide each resident with "necessary care and services" to enable the resident to "attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." The Board has held that section 483.25 "implicitly imposes on [a SNF] a duty to provide care and services that, at a minimum, meet accepted professional standards of quality," *Golden Living Ctr. – Foley*, DAB No. 2510, at 23 (2013), and that such standards include CPR decision-making guidelines published by the AHA, *John J. Kane Regional Ctr. – Glen Hazel*, DAB No. 2068, at 11-12 (2007). The Board has also held that the "necessary care and services" required by section 483.25 include care and services called for by an established resident care policy. *Life Care Ctr. of Tullahoma*, DAB No. 2304, at 34 (2010), *aff'd, Life Care Ctr. Tullahoma v. Sec'y of U.S. Dept. of Health & Human Servs.*, 453 F. App'x 610 (6th Cir. 2011); *see also Good Shepherd Home for the Aged, Inc.*, DAB No. 2858, at 12 (2018) (stating that section 483.25 obligates a SNF to follow its own resident care policies); *The Laurels at Forest Glenn*, DAB No. 2182, at 6, 12, 18 (2008) (finding a SNF's failure to follow facility protocol for notification of low blood sugar levels was a failure to provide necessary care and services). CMS "may reasonably rely on a facility's policy relating to the care and treatment of its residents as evidencing the facility's understanding of what must be done to attain or maintain residents' highest practicable physical, mental, and psychosocial well-being, as required by section 483.25." *The Laurels at Forest Glenn* at 18; *see also Hanover Hill Health Care Ctr.*, DAB No. 2507, at 6 (2013) (observing that "the Board has long held that a facility's own policy may be sufficient evidence . . . of what the facility has determined is needed to meet the quality of care requirements in section 483.25").

It is undisputed that, on June 12, 2015, Petitioner had in place two pertinent resident care policies: the CPR policy, and the DNR Order policy. Collectively these policies called upon Petitioner's nursing staff to administer CPR, consistent with American Heart Association (AHA) practice guidelines, to any full-code resident – that is, to any resident without a valid DNR order (or an advance directive instructing health care providers to provide or withhold emergency care) – in cardiac arrest. *See* CMS Ex. 4, at 28-29; CMS Ex. 7, at 3-4; CMS Ex. 9, at 2, 5. The CPR policy stated that under the AHA's "Basic Life Support" guidelines, the "standard of care" for any resident "without DNR status" who experiences cardiac arrest is "prompt initiation of CPR" unless "rigor mortis, lividity, tissue decomposition or obvious fatal trauma are present." CMS Ex. 7, at 3.

It is also undisputed – indeed Petitioner's own investigation revealed – that Petitioner regarded Resident 19 as having full-code status on June 12, 2015; that LVN A, the nurse who first noticed Resident 19 without vital signs on that date, did not initiate CPR or call 911; and that Petitioner discharged LVN A after determining that she had violated its resident care policies by failing to take those steps. CMS Ex. 6, at 13, 15, 20, 31-32; RR at 5-6 (stating only that Resident 19 was seeking to change his status from full-code to DNR on June 12, 2015) and 11 (noting that Petitioner "did terminate and report [to state authorities] the . . . nurse who failed to start CPR pursuant to [its] policy").

As it did before the ALJ, Petitioner suggests, without supporting analysis, that LVN A's inaction did not violate the relevant resident care policies or standard of care because Resident 19 had signs of rigor mortis when she first discovered him without vital signs. RR at 9 (asserting that Resident 19 "was found . . . with signs of rigor mortis"). The only evidence of that alleged clinical finding is a one-page handwritten summary of a June 12, 2015 (4:15 p.m.) telephone interview of LVN A, conducted by an individual whose role with Petitioner is not specified. CMS Ex. 6, at 23; P. Ex. 1 (Attachment I). According to that document, LVN A told the interviewer that, during her June 12, 2015 3:53 a.m. telephone call with the assistant director of nursing about Resident 19, she told the assistant director of nursing that "rigor had set in." *Id.* The interview summary provides no other pertinent details: it does not indicate how, if at all, LVN A assessed the resident or specify the clinical observations or findings which (allegedly) made her think that the resident had rigor mortis. Apart from the interview summary, the record is silent about whether Resident 19 had signs of irreversible death when LVN A first discovered him. There is no evidence that LVN A told surveyors that she thought that Resident 19 had rigor mortis at that point, and her own signed (but unsworn) handwritten statement does not mention or allude to that condition. CMS Ex. 4; CMS Ex. 5, at 2-3; CMS Ex. 6, at 31-32. Nor does that statement indicate what, if any, clinical findings she reported to the assistant director of nursing during the early morning of June 12, 2015. *Id.* None of the individuals identified in the June 12, 2015 interview summary – neither LVN A, nor the interviewer, nor the assistant director of nursing – submitted a declaration, and Petitioner did not ask the ALJ to subpoena their testimony. Petitioner also failed to submit evidence about what rigor mortis is, when it typically sets in, or how its presence is determined.

Finally, Petitioner's appeal brief does not cite the interview summary or claim that it has any probative value. No reasonable factfinder could conclude on this record that Resident 19 had – or that LVN A reasonably thought him to have – signs of irreversible death when she first discovered him without vital signs. In other words, the June 12, 2015 interview summary's mention of rigor mortis does not create a genuine dispute of material fact concerning the nursing staff's obligation to administer CPR to Resident 19 on June 12, 2015.[5] *Cf. Anderson v. Liberty Lobby, Inc.*, 477 U.S. at 248 (holding that a "genuine" dispute exists if "the evidence is such that a reasonable jury could return a verdict for the nonmoving party"); *Johnson v. Perez*, 823 F.3d 701, 705 (D.C. Cir. 2016) (noting that genuine factual dispute does not exist "when a putatively disputed body of evidentiary material could not, even assuming a sympathetic factfinder, reasonably support a finding crucial to the nonmoving party's legal position").

We therefore conclude, as Petitioner's own internal investigation evidently did, that Petitioner's resident care policies and the applicable standard of care called on LVN A to administer CPR to Resident 19 (a full-code resident) when she discovered him without vital signs on June 12, 2015. Because LVN A failed to provide CPR in those circumstances, we also conclude that Petitioner did not meet the basic quality-of-care obligation in section 483.25. *Avalon Place Kirbyville*, DAB No. 2569, at 13 (2014) (holding that the "necessary care and services" required by section 483.25 included the "emergency care services set forth in its emergency response policy adopted for full code residents").

[5] The ALJ characterized the June 12, 2015 interview summary as "patently unreliable hearsay" that she was "not bound to admit (ALJ Decision at 7 n.5, citing 42 C.F.R. § 498.61) and stated that "[f]or purposes of summary judgment, Petitioner must submit *admissible* evidence showing that a dispute exists" (*id.*, citing *Illinois Knights Templar Home*, DAB No. 2274, at 4 (2009)). Petitioner contends that the ALJ's characterization of the interview summary amounted to improper weighing of evidence at the summary judgment stage. RR at 5. We need not discuss this aspect of the ALJ's decision further because our review of the summary judgment is *de novo*, *Lakeridge Villa Healthcare Ctr.*, DAB No. 2396, at 5 n.2 (2011), and because we conclude that the interview summary, even if admissible, does not create a genuine dispute of material fact for the reasons outlined in the text. In any event, the ALJ committed no apparent error: she did not improperly weigh conflicting evidence but merely assessed whether the interview summary was – given its hearsay character and other circumstances bearing upon its reliability – inadmissible. The admissibility of a document and its sufficiency to defeat summary judgment are separate issues. *Cf. Monks v. General Elec. Co.*, 919 F.2d 1189, 1192-93 (6th Cir. 1990) (stating that the "admissibility of an expert's affidavit is distinct from the issue of whether the affidavit is sufficient to withstand a summary judgment motion"); *Crestview Parke Care Ctr.*, DAB No. 1836, at 6 (2002) (noting that, in attempting to defeat a summary judgment motion, "a party may not rely on the denials of its pleadings, but is required to tender evidence of specific facts in the form of affidavits, and/or *admissible* discovery material, in support of its contention that a dispute exists" (italics added)), *remanded on other grounds*, *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743 (6th Cir. 2004).

Petitioner submits that the facts do not make out a "prima facie case" of noncompliance with section 483.25. RR at 11. In support of that proposition, Petitioner makes three interrelated points. First, says Petitioner, given the condition in which its nursing staff found Resident 19 early on June 12, 2015 ("pulseless, apneic (not breathing), cold to the touch"), there was no substantial possibility that CPR would have revived and restored him to "normal cardiovascular status," and thus CPR was not "necessary" to enable the resident to achieve his "highest practicable" well-being. RR at 7, 9, 14 (further stating that CPR was "not likely to be more than futile," "[r]ecovery from CPR" was not Resident 19's "highest practicable physical wellbeing," and that a level of well-being "that cannot be achieved cannot rationally be 'practicable'"). According to Petitioner, Resident 19's "highest practicable level was death," and the administration of CPR would not have changed that.[6] RR at 5. Second, Petitioner contends that because CPR would not have enabled Resident 19 to attain any level of well-being, the claimed violation of section 483.25 did not harm or have the potential to harm him, and thus did not constitute lack of substantial compliance. RR at 9-10, 12-13, 15 (stating that Resident 19 "could not [have been] neglected or harmed further by the lack of CPR" because he "did not have any higher practicable condition aside from death"). Third, Petitioner contends that, in light of CMS's recognition of CPR's limited effectiveness in the long-term care setting, the burden was on CMS to show that Resident 19 would have survived the procedure had it been timely started and performed by LVN A on June 12, 2015. RR at 13, 16 (asserting that a prima facie showing of noncompliance should require "credible evidence" of the "survivable medical condition of the resident"). Whether or not Resident 19 would have survived in that hypothetical circumstance is a "contested" issue that precludes summary judgment, according to Petitioner. *See* RR at 16 (asserting that the resident's probability of survival, or "avoidance of biological death," is an issue that involves "contested facts").

The Board has rejected these, and other similar, arguments in prior decisions, most recently in *North Las Vegas Care Center,* DAB No. 2946 (2019). *North Las Vegas* involved a SNF that failed, as Petitioner did, to administer CPR to a full-code resident in violation of a resident care policy and professional standards of quality (those standards being the AHA's CPR guidelines). The SNF argued, as Petitioner does, that because of CPR's limited effectiveness in the long-term care setting, CPR was not a "necessary" service under section 483.25, and that even if it was, the failure to perform it did not

[6] In support of that contention, Petitioner relies on opinion testimony and other evidence (mentioned in the background narrative) concerning CPR's expected or likely efficacy. That evidence includes the judgment of a treating physician that Resident 19's age and "comorbid conditions" precluded "any expected benefit" from "aggressive cardiac procedures"; Dr. Steinberg's declaration that CPR would not have succeeded in reviving Resident 19 even if that procedure been timely initiated and expertly performed; and CMS's acknowledgment (in program guidance) that CPR has limited effectiveness in the elderly nursing home population. *See* RR at 5-15.

cause or have the potential to cause more than minimal harm to the affected resident. The Board held, however, that CPR, as a lifesaving procedure, is an inherently "necessary" service and thus "an unwarranted failure to perform CPR has the potential for more than minimal harm – that being the evisceration of any possibility of survival and recovery." DAB No. 2946, at 7. The Board further held, citing its long-established precedent, that it was unnecessary for CMS to establish that the violation of section 483.25 had actually or potentially harmed a specific resident, stating that "[a] deficiency is severe enough to warrant a noncompliance finding if it involves acts or omissions that, if repeated, have the potential to cause more than minimal harm to *any* of the SNF's residents, even if surveyors did not observe or identify a particular resident who was actually threatened with harm during the survey." *Id.* at 9 (internal quotation marks omitted).

The Board in *North Las Vegas* also rejected the argument that CMS needed to prove that the resident for whom CPR was not provided would have survived had the procedure been timely and competently performed. The Board reasoned that requiring proof of survivability (1) would be incompatible with CMS's mandate to enforce a SNF's obligation under section 483.25 to meet accepted professional standards of quality and (2) would effectively obligate CMS to prove that the SNF's deficiency caused actual harm, even though the applicable enforcement regulations permit CMS to find noncompliance based solely on a deficiency's "potential" to cause harm. DAB No. 2946, at 8-9. That reasoning applies equally to the present case and suffices to reject Petitioner's contention that it was in substantial compliance because CPR would not have saved Resident 19. As the ALJ noted, the Board has consistently rejected arguments based on CPR's alleged futility in cases in which the SNF has failed to administer CPR in accordance with its own resident care policies and professional standards of quality. *Woodland Oaks* at 14 (emphasizing that "accepted professional standards of quality obligated the nursing staff to carry out the advance directive for [the full-code resident] unless she exhibited clinical signs of irreversible death"); *Lakeridge Villa Healthcare Ctr.*, DAB No. 2396, at 9 (2011) (upholding the ALJ's rejection of the SNF's claim that its staff's "inaction was justified because CPR was a medically futile exercise given [the affected resident's] age, fragile medical condition, and short life expectancy"). Because the undisputed facts establish that this is such a case, we conclude that CMS is entitled to summary judgment on its claim that Petitioner was not in substantial compliance with section 483.25.

Petitioner's remaining contentions are meritless and warrant minimal discussion. Petitioner asserts that the ALJ failed to draw "reasonable inferences" from the record. RR at 4. However, it fails to specify any factual inference, material or otherwise, that the ALJ could reasonably have drawn in its favor but failed to draw.

Petitioner also reiterates that "[n]ursing homes as currently structured and staffed lack the equipment, nurses, and physicians to properly monitor for unexpected cardiac arrest and respond promptly and effectively with CPR." RR at 8. That fact, even if true, is legally irrelevant. A SNF's obligation to provide "necessary care and services" is not contingent on the SNF's staffing level or other resources. In fact, the governing participation requirements explicitly require a SNF to be staffed, structured, and operated to ensure that each resident receive the quality of care mandated by section 483.25. *See* 42 C.F.R. §§ 483.30 (stating that a SNF "must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident"), 483.70 (requiring the SNF to be "designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public"), and 483.75 (requiring the SNF to 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").

Petitioner submits that the $10,000 per-instance CMP imposed by CMS was "punitive." RR at 4. We disagree. Under the governing survey-and-enforcement regulations, a validly imposed CMP is not punishment for a regulatory transgression but instead a remedial tool intended to encourage SNFs to correct deficiencies promptly and maintain compliance with Medicare participation requirements. *Deltona Health Care*, DAB No. 2511, at 5 (2013).

Finally, Petitioner contends that the CMP amount was "unreasonable." RR at 4. In determining the daily or per-instance penalty amount, CMS considers the factors specified in 42 C.F.R. § 488.438(f). 42 C.F.R. § 488.438(e)(3). A penalty amount imposed within the applicable range is presumed to be reasonable based on the regulatory factors unless the SNF demonstrates that the factors warrant a lesser amount. *Crawford Healthcare & Rehab.*, DAB No. 2738, at 19 (2016). In this case Petitioner does not contend that the regulatory factors justify a reduction in the per-instance penalty amount. We therefore decline to find the CMP unreasonable. *Bivins Memorial Nursing Home*, DAB No. 2771, at 13 (2017) (affirming a CMP imposed on a SNF that failed to present an argument based on the regulatory factors).

Conclusion

We conclude that: (1) there are no genuine disputes of material fact; (2) undisputed facts establish that Petitioner's response to Resident 19's cardiac arrest revealed a lack of substantial compliance with 42 C.F.R. § 483.25; and (3) Petitioner alleged no permissible grounds to reduce the per-instance CMP imposed by CMS. Based on these conclusions, we affirm the ALJ's grant of summary judgment to CMS.

/s/
Christopher S. Randolph

/s/
Constance B. Tobias

/s/
Susan S. Yim
Presiding Board Member