Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Oceana County Medical Care Facility, (CCN: 23-5002),	)	Date: August 18, 2009
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-08-685
	)	Decision No. CR1993
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

Petitioner, Oceana County Medical Care Facility (Petitioner or facility), is a long-term care facility located in Hart, Michigan, that participates in the Medicare program. The Centers for Medicare & Medicaid Services (CMS) has determined that the facility was not in substantial compliance with Medicare requirements, and that its deficiencies posed immediate jeopardy to resident health and safety because, contrary to a resident's advance directive, facility staff failed to perform cardio-pulmonary resuscitation (CPR) on him when he went into cardiac arrest. The resident died.

Petitioner here challenges CMS's determinations. The parties agree that no material facts are in dispute, and have filed cross-motions for summary judgment.

For the reasons set forth below, I find that, from June 9 through July 7, 2008, the facility was not in substantial compliance with Medicare requirements, and that, on June 9, 2008, its deficiencies posed immediate jeopardy to resident health and safety.

I. Background

The Social Security Act (Act) sets forth requirements for nursing facility participation in the Medicare program, and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act § 1819. The

Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act §1864(a); 42 C.F.R.§ 488.20. The regulations require that each facility be surveyed once every twelve months, and more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a); 488.308.

Here, following a complaint investigation/partial extended survey, completed June 10, 2008, CMS determined that the facility was not in substantial compliance with Medicare participation requirements, including:

- 42 C.F.R. § 483.20 (k)(3)(i) (Tag F281 – comprehensive care plans, professional services);
- 42 C.F.R. § 483.25 (Tag F309 – quality of care);
- 42 C.F.R. § 483.75 (Tag F490 – administration).

CMS also determined that these deficiencies posed immediate jeopardy to resident health and safety, and imposed civil money penalties (CMPs) of $10,000 per day for one day of immediate jeopardy, and $500 per day for the period of substantial noncompliance that was not immediate jeopardy. CMS Exs. 1, 2, 3.[1]

Petitioner timely requested a hearing. After submitting pre-hearing briefs (CMS Br.; P. Br.), the parties agreed that the case could appropriately be decided on summary judgment without the need for an in-person hearing. Pre-Hearing Conference Order (March 9, 2009). They have filed cross-motions for summary judgment, with supporting

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[1] Petitioner limits its appeal to these deficiencies cited at the immediate jeopardy level. P. Br. at 2. Petitioner does not appeal the deficiencies cited under 42 C.F.R. § 483.60(b)(d) and (e) (Tag F431 – pharmacy services) at scope and severity level "E" (a pattern of noncompliance causing no actual harm, with the potential for more than minimal harm). CMS Ex. 3. Those un-appealed deficiencies are therefore sustained, and establish that the facility was not in substantial compliance with program requirements. 42 C.F.R. § 498.20(b).

briefs (CMS MSJ Br.; P. MSJ Br.) and replies (CMS Reply; P. Reply). CMS has submitted 19 exhibits (CMS Exs. 1-19) and Petitioner has submitted 12 exhibits (P. Exs. 1-12).

II. Issues

The issues before me are:

1) whether, from June 9 through July 7, 2008, the facility was in substantial compliance with certain program requirements, specifically, 42 C.F.R. §§ 483.20(k)(3)(i), 483.25, and 483.75;

and

2) if the facility was not in substantial compliance on June 9, 2008, did its deficiencies pose immediate jeopardy to resident health and safety?

Except to argue that it was in substantial compliance so no penalty should be imposed, Petitioner raises no arguments as to the reasonableness of the CMPs. CMS maintains that Petitioner has therefore waived the issue. CMS Br. at 22; CMS MSJ Br. at 29; CMS Reply, at 19. Petitioner has not challenged CMS's repeated assertions of waiver, and I therefore consider that Petitioner has waived the issue.

III. Discussion

A. CMS is entitled to summary judgment because the undisputed facts establish that facility staff failed to honor a resident's advance directive that he be administered CPR; the facility therefore failed to meet professional standards of quality (42 C.F.R. § 483.20(k)(3)(i)), failed to provide necessary care and services (42 C.F.R. § 483.25), and was not administered in a manner enabling it to use its resources effectively and efficiently to attain or maintain for each resident the highest practicable physical, mental, and psychosocial well-being (42 C.F.R. § 483.75).

The parties agree that this case presents no genuine issue of material fact, and that summary judgment is appropriate. Nevertheless, in considering CMS's motion for summary judgment, I draw all reasonable factual inferences in the light most favorable to Petitioner. *Brightview Care Center*, DAB No. 2132, at 2, 9 (2007); *Livingston Care Center*, 388 F.3d at 172 (6th Cir. 2004); *Guardian Health Care Center,* DAB No. 1943, at 8 (2004); *but see Brightview*, DAB No. 2132, at 10 (entry of summary judgment upheld where inferences and views of non-moving party are not reasonable). Of course, drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions. *Cf. Guardian Health Care*

Center, DAB No. 1943, at 11 ("A dispute over the conclusion to be drawn from applying relevant legal criteria to undisputed facts does not preclude summary judgment if the record is sufficiently developed and there is only one reasonable conclusion that can be drawn from those facts.").

CMS argues that it is entitled to summary judgment because the undisputed facts establish the facility's substantial noncompliance with: 1) 42 C.F.R. § 483.20(k)(3)(i) which requires that the facility provide services that meet professional standards of quality; 2) 42 C.F.R. § 483.25, which, echoing statutory language, requires that each resident receive and the facility provide the necessary care and services to allow a resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care (*see also* Act § 1819(b)); and with 3) 42 C.F.R. § 483.75, which requires that the facility 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.

This case centers around the care (or lack of care) facility staff provided to a resident who went into cardiac arrest. Resident 101 (R101) was an 88-year-old man. He was admitted to the facility on March 5, 2008, subsequently hospitalized for several days (March 26-31), and readmitted on March 31, 2008. CMS Ex. 8, at 20, 119. As Petitioner emphasizes, R101 was quite ill, suffering from a multitude of ailments, including congestive heart failure, pneumonia, arteriosclerotic coronary artery disease, peripheral vascular disease and history of coronary artery bypass graft. CMS Ex. 8, at 20, 43, 45-46. Although his cognitive status was moderately impaired, he was nevertheless still able to make his own decisions, his family assisting him as needed. CMS Ex. 8, at 65.[2]

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[2] Petitioner faults CMS for purportedly minimizing R101's medical problems. Citing CMS Ex. 14, at 15, Petitioner claims that R101 suffered from ailments not mentioned by CMS, including chronic obstructive pulmonary disease, cardiomyopathy, noninsulin dependent diabetes, and chronic renal failure. P. MSJ Br. at 4. By disputing the ailments CMS attributes to R101, Petitioner has arguably alleged a dispute of fact. However, this purported "dispute" does not preclude entry of summary judgment for two reasons. First, as even a cursory review of the cited document shows, the resident described in CMS Ex. 14, at 15 is *not* R101. He has a different birth date; he is in a different room; and he is still alive the day after R101's death. Petitioner has therefore not tendered evidence showing that a factual dispute exists since, on its face, the cited document does not support Petitioner's allegations as to R101's ailments. *See Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 n.11 (1986); *Vandalia Park*, DAB No. 1939 (2004); *Lebanon Nursing and Rehabilitation Center*, DAB No. 1918 (2004). Second, any alleged dispute of fact here is not material. As discussed below, the facility was bound to administer CPR regardless of the resident's underlying ailments.

R101 wanted to be resuscitated if he went into cardiac arrest. From the time of his admission, he indicated that he wanted CPR administered, and those instructions were incorporated into his care plan. CMS Ex. 8, at 17, 43. On May 2, 2008, he again signed an advance directive, instructing the facility that, in the event of a cardio-pulmonary arrest, he wanted CPR. The form indicates that CPR would be initiated by a nurse, that an ambulance would be called, and that he would be transferred to the hospital. CMS Ex. 8, at 16, 103.

The facility's written policy governing the administration of CPR provides that,

> if a resident or responsible person has signed a "Code Purple" form (which instructs staff to resuscitate him), C.P.R. will be initiated upon determination that resident has no pulse and no breathing and advanced directives have been noted. C.P.R. must be started on a resident found with no pulse or respiration and has is [sic] a yes to C.P.R. When a resident has been determined to have no pulse and no respiration a staff member is sent immediately to check the chart to see if resident is a yes to C.P.R. A full code will be called, C.P.R. started and EMS initiated.

CMS Ex. 8, at 7, 13; CMS Ex. 14, at 69.

Notwithstanding R101's explicit and repeated instructions, staff did not follow the facility's policy when he went into cardiac arrest. Instead, through a series of errors, miscommunications, and bad judgment, staff made no effort to revive him until well after he was dead.

Specifically, on the morning of May 13, 2008, Certified Nurse Aide (CNA) Letha Hammerly assisted R101 to the bathroom. While still on the toilet, he slumped forward. CNA Hammerly called for assistance and CNA Barbara Sherman, who had been caring for R101's roommate, left the room at 11:31 a.m. and returned with Registered Nurse (RN) Susan Lessard. They found R101 still on the toilet, his complexion pale and his pulse faint. After they put him in his wheelchair, RN Lessard sent CNA Sherman to get the charge nurse, RN Sarah Gray. CNA Sherman went to the nurses' station and told Charge Nurse Gray that she was needed in the room shared by R101 and his roommate, apparently identifying the room by number without naming the resident. CMS Ex. 14, at 14, 94; P. Ex. 6, at 16 *et seq.*; P. Ex. 6, at 33, 78, 96; P. Ex. 12, at 32, 25, 37.

Charge Nurse Gray entered the resident's room, followed by Licensed Practical Nurse (LPN) Sue Graham, and the ward clerk, CNA Pat Hoxie. They brought with them a "crash cart." R101 was then sitting in his wheelchair, not moving, not breathing, his skin pale. He had no pulse. Charge Nurse Gray pronounced him dead at 11:35 a.m. According to Charge Nurse Gray, "[s]ome one then said he was a full code, a yes to

CPR." CMS Ex. 8, at 4; CMS Ex. 14, at 94. But, again in Charge Nurse Gray's words: "I thought the death had not been witnessed so I didn't think we had to initiate CPR." CMS Ex. 8, at 4; CMS Ex. 14, at 94. The ward clerk then wheeled the crash cart out of the room. P. Ex. 6, at 45-47, 49; P. Ex. 12, at 51.

CNA Hamersley testified at a state administrative hearing that Charge Nurse Gray checked the resident's back for lung sounds and announced "if we don't witness it, we do not do anything." Remarkably, CNA Hamersley did not remember whether she then told Charge Nurse Gray that she had been with the resident and witnessed his arrest. P. Ex. 6, at 22-23. However, she remembered telling RN Lessard earlier that she was with the resident when he collapsed. P. Ex. 6, at 23. She could not remember RN Lessard saying anything to the charge nurse about the incident having been witnessed. P. Ex. 6, at 24.[3]

The CNAs returned R101 to his bed and Charge Nurse Gray left the room. She tried to call his family, did not reach them, and left a message. She paged R101's doctor. She called the facility's Director of Nursing (DON), Renee Sutton, telling her that the resident had died and that no one had administered CPR "because we didn't witness his death."[4] DON Sutton told her that they were required to administer CPR because R101 had requested it. So, at 11:43 a.m. – at least 12 minutes after R101 went into cardiac arrest – Charge Nurse Gray and RN Lessard, joined by DON Sutton, took the crash cart back to R101's room, instructing the ward clerk to call 911 and to page a Code Blue over the PA system. When the nurses arrived at R101's room, the CNAs were performing post mortem care. DON Sutton told Charge Nurse Gray to call R101's physician while she and RN Lessard attempted CPR. But the nurses were not even able to put in place the backboard necessary for initiating CPR. The DON determined that too much time had elapsed since the arrest anyway, so she cancelled the code. The paramedics arrived a few minutes later, at 11:49 a.m. CMS Ex. 8, at 4; CMS Ex. 14, at 14, 48, 93, 94; P. Ex. 6, at 16-27, 82-91; P. Ex. 12, at 69-70, 83.[5]

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[3] Of course, even if his arrest had not been witnessed, staff were required to administer CPR. CMS Ex. 8, at 7, 13; CMS Ex. 14, at 69, 70.

[4] RN Lessard testified at the state administrative hearing that she eventually returned to the nurses' station and challenged Charge Nurse Gray's understanding of the facility policy for administering CPR following an unwittnessed event, and that their disagreement precipitated the call to DON Sutton. P. Ex. 6, at 86.

[5] A security video camera outside R101's room door recorded the staff's comings and goings, making it at least theoretically possible to pinpoint times. CMS Ex. 3, at 12-13; P. Ex. 12, at 17-18, 21. The video was not submitted here, but testimony from a state administrative hearing describes its contents. Although the testimony is confusing, the video apparently shows the following timeline:

(continued...)

Several days later, both nurses were disciplined for not performing CPR "during the first critical minutes of arrest." CMS Ex. 8, at 6, 9. It appears that the facility fired them. CMS Ex. 14, at 13.

The record is murky as to how and when staff determined R101's code status. According to CMS, when RN Lessard first approached Charge Nurse Gray, Ward Clerk Hoxie heard the room number, and, by mistake, checked the code status for R101's roommate. When she got to the room and saw that R101 was the resident in distress, she went back to the nurses' station to check R101's chart, and then returned to the room. CMS MSJ Br. at 6 (citing P. Ex. 6, at 25; CMS Ex. 3, at 3, 9; CMS Ex. 4, at 7, 12). Petitioner does not exactly dispute any of this, but characterizes as "speculative" the evidence CMS cites regarding Ward Clerk Hoxie's having initially checked the wrong chart, and argues that the nurses' station was nearby, so Ward Clerk Hoxie's purported running back and forth caused "no undue delay in discovering [R101's] actual code status." P. Reply at 3-4.

The state hearing testimony describing the contents of the video shot outside R101's room does not mention Ward Clerk Hoxie's departure and return to the room at times consistent with CMS's version of events. On the other hand, the evidence as to what the video contains is very confusing, and Petitioner does not argue that the video contradicts CMS's version. Nor does Petitioner offer any alternative. In fact, Petitioner does not even identify the name of the staff person who checked the resident's code status. The investigative report says nothing about the issue, only mentioning that, after Charge Nurse Gray pronounced him dead, she "was told" that he was full code. CMS Ex. 14, at 14.

RN Lessard offered a different (and arguably even more disturbing) version of the events. She testified at the state hearing that she only learned R101's code status after Charge

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[5](...continued)

11:31 a.m.	CNA Sherman leaves room and returns with RN Lessard. P. Ex. 6, at 96; P. Ex. 12, at 26-27.
11:33 a.m.	CNA Sherman leaves room, and returns with Charge Nurse Gray. Both enter the room. P. Ex. 12, at 32, 35, 37, 44-45.
11:34 a.m.	LPN Graham and Ward Clerk Hoxie enter room with crash cart. CNA Sherman leaves room with R101's roommate. P. Ex. 12, at 45-47, 49.
11:35 a.m.	Ward Clerk Hoxie leaves room with crash cart. P. Ex. 12, at 51.
11:38 a.m.	Charge Nurse Gray leaves room. P. Ex. 12, at 59.
11:40 a.m.	RN Lessard leaves room. P. Ex. 12, at 64.
11:43 a.m.	Charge Nurse Gray, RN Lessard, and DON Sutton enter room with crash cart. P. Ex. 12, at 69-70.

Nurse Gray had pronounced the resident dead, departed the room and returned to the nurses' station to call his family. RN Lessard said that she followed Nurse Gray to the nurses' station, where she learned, for the first time, that R101 was full code. Since RN Lessard was in the resident's room throughout the incident, her testimony (if believed) suggests that no one announced R101's code status. P. Ex. 6, at 80-82, 85-86.[6]

I see no evidence that the facility's investigators attempted to resolve these inconsistencies, or, for that matter, that they tried to determine who, when, and how staff ascertained R101's code status. Petitioner's silence on the issue is particularly troubling because it shows that the facility did not fully review the effectiveness of its policies for determining a resident's code status. Given the facility's problematic history in this regard (*see* CMS Ex.16, and discussion below) and the considerable staff errors in their treatment of R101, such review was critical to ensuring that the errors would not be repeated.

Nevertheless, I do not find material these questions regarding how or when staff determined R101's code status. Even assuming, for summary judgment purposes, that the nurses timely determined that R101 was full code, that knowledge was simply irrelevant to their willingness to provide him with CPR. Even accepting the proposition that the nurses knew R101's code status in time to administer CPR, their refusal to honor the resident's wishes, by itself, establishes the facility's substantial noncompliance with Medicare regulations, 42 C.F.R. §§ 483.20(k)(3)(i), 483.25, and 483.75.

1. The facility did not meet professional standards of quality because it failed to provide CPR to a resident whose advance directive called for it.

In CMS's view, by failing to provide CPR to R101, as he had instructed, staff did not meet professional standards of quality, and the facility thus was not in substantial compliance with 42 C.F.R. § 483.20(k)(3)(i).

I agree. The staff's actions were unquestionably inconsistent with the standard of care. For a resident who stops breathing or goes into cardiac arrest, staff *must* initiate CPR and call the emergency medical services unless the resident has in place a valid "do not resuscitate" order. *John J. Kane Regional Center – Glen Hazel*, DAB No. 2068, at 16 (2007). According to the *Fundamentals of Nursing* (Mosby Publishing Company, 6th ed. 2005), which I consider authoritative, CPR "is performed on an appropriate client unless a DNR [Do Not Resuscitate] order is written in the client's chart." CMS Ex. 9, at 2. So, under the standard of care, any ambiguity about the resident's wishes must be resolved in favor of administering CPR.

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[6] Petitioner submits an affidavit from RN Lessard which says nothing about how or when she learned of R101's code status.

But, here, Petitioner cannot even argue ambiguity, since R101 explicitly and affirmatively directed staff to administer CPR. As Judge Kessel noted in *Epsom Healthcare Center*:

> A resident has an absolute right to decide whether a facility should attempt resuscitation in the event of cardiopulmonary arrest. The whole point of having a resident express his or her wishes in advance is to make certain that the facility is aware of the resident's intent and does everything reasonable to carry it out.

DAB CR1749, at 6 (2008).

Petitioner submits an article from the *Journal of Hospital Medicine* that reflects this position. It says that when a patient stops breathing "accurate and timely information about DNR status is critical to respecting the patient's preferences and avoiding a potentially devastating error," i.e., staff must learn the patient's DNR status so they can honor the resident's wishes, and failure to honor those wishes would be a "devastating error." P. Ex. 1, at 3.

As noted above, the facility policy states that CPR "*must* be started on a resident found with no pulse or respiration" who "is a yes to CPR." CMS Ex. 8, at 7 (emphasis added). Just weeks prior to the incident, DON Sutton reminded staff of the policy. In an email to staff, dated March 28, 2008, she wrote, "We can't, as nurses, determine who and when we do CPR on a resident." CMS Ex. 14, at 70. In her affidavit, Petitioner's expert witness, Shari L. Carson, RN, declares that this policy "was appropriate and met the standard of care for a nursing home in the State of Michigan." Carson Decl. at 4, ¶ 4a. CMS may reasonably rely on the provider's policies as "evidence of the standard of care the facility expect[s] its staff to provide" as well as evidence of the professional standards of care. *The Laurels at Forest Glen*, DAB No. 2182, at 18 (2008), quoting *Oxford Manor*, DAB No. 2167, at 5-6 (2008).

Thus, where, as here, a resident's advance directive explicitly calls for CPR, the universally accepted standard of care mandates that facilities honor that instruction. Every authoritative source confirms that facilities must follow a resident's advance directive, and Petitioner cites no evidence or opinion to the contrary.

Petitioner nevertheless denies that the standard of care requires staff to perform CPR in accordance with the resident's wishes. Petitioner points to language from *Fundamentals of Nursing* that refers to performing CPR on "an appropriate client" and argues that staff may justifiably decline to administer CPR, without regard to the resident's wishes, if they determine that the resident is not an "appropriate" candidate for CPR. Petitioner does not define "appropriate" except to suggest that anyone as ill as R101 would not qualify. I

find Petitioner's argument wholly unreasonable. First, the argument is defeated by the facility's written policy, which mandates that a resident's advance directive be followed, without regard to the resident's long-term prospects. Second, immediately before that cited language, the *Fundamentals of Nursing* chapter describes the significant legal hurdles set up to prevent denial of life-sustaining treatment to an incompetent client (courts require "clear and convincing evidence" of the client's choice to decline treatment), a message plainly inconsistent with Petitioner's suggestion that staff are free to make *ad hoc* decisions at a time of crisis without regard to the resident's wishes. Thus, in context, the word "appropriate" refers to a client in need of resuscitation, not to someone meeting some ill-defined standard of health.

The undisputed evidence establishes that staff's failure to provide CPR violated the standard of care, and the facility was therefore not in substantial compliance with 42 C.F.R. § 483.20(k)(3)(i). CMS is entitled to summary judgment on that issue.

2. The facility did not provide R101 the care and services he required to maintain his highest practicable well-being, in accordance with his comprehensive assessment and plan of care.

Obviously, when R101 went into cardiac arrest, his *only* hope for survival rested with staff providing him CPR during the first critical minutes, as his care plan directed. CMS Ex. 8, at 17. Since they failed to do so and he died, I can only conclude that the facility failed to provide him the care and services he needed in order to maintain his highest practicable physical well-being, in accordance with his comprehensive assessment and plan of care. The facility was therefore not in substantial compliance with 42 C.F.R. § 483.25.

Petitioner, however, argues that the "overwhelming medical information" establishes that R101 was simply too ill to have survived. P. MSJ Br. at 38.[7] For summary judgment

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[7] Although, in considering summary judgment, I do not weigh the evidence, I note that Petitioner offers virtually no reliable evidence to support this claim. First, Petitioner points to RN Carson's opinion that R101 would not have survived because he was in "significant and steady decline," was losing weight, and refused a feeding tube. Carson Decl. at 12, ¶ 4(f). But she also bases this opinion on her determination that R101 suffered all of the ailments set forth in CMS Ex. 14, at 15, which include chronic obstructive pulmonary disease, noninsulin dependent diabetes, and chronic renal failure. Carson Decl. at 9-10, ¶ 4(e)(i). The problem is that R101 did not suffer from these ailments. RN Carson is relying on the records of a different resident. *See* n.2. R101 was unquestionably quite ill, but he did not have all of the ailments described by RN Carson. CMS Ex. 8, at 20, 43. I am not bound to accept an opinion that is not supported by the

(continued...)

purposes, I accept that R101 was seriously ill, and not looking forward to a much longer life. However, such post-death rationalizations are simply irrelevant. The facility does not get to decide, after the fact, that the services it promised but failed to provide should not have been provided at all. If efforts at resuscitation are truly futile, that issue should be discussed with the resident and resolved *before* the crisis. The Petitioner in *John J. Kane Regional Center – Glen Hazel* made a similar argument, claiming that administering CPR to a seriously ill resident was not only futile, but cruel. In rejecting that argument, the Departmental Appeals Board acknowledged that CPR's goal of reversing clinical death is "achieved in only a minority of cases." On the other hand, the Board also recognized that no clear criteria accurately predict the futility of CPR. *Kane*, DAB No. 2068, at 17.

Moreover, the problem here was not limited to a couple of nurses deciding not to administer CPR to just one resident. Rather, facility staff – including a charge nurse – considered it within their discretion to disregard *any* resident's advance directive. Accepting Petitioner's argument would render advance directives meaningless, since they could be overridden whenever staff determined that the resident in crisis was not an "appropriate candidate" for resuscitation.

3. Because it did not effectively implement a policy of insuring that its staff honor advance directives, the facility was not administered in a manner that enabled it to use its resources effectively and efficiently to maintain R101's highest practicable physical, mental, and psychosocial well-being.

The facility must be administered in a manner that enables it to use its resources effectively and efficiently to maintain the highest practicable physical, mental and psychosocial well-being of each resident. 42 C.F.R. § 483.75. A finding of substantial

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[7](...continued)
underlying facts. *See Kenton Healthcare LLC*, DAB CR1666, at 23, n.18 (2007), *aff'd*, DAB No. 2186, at 16-17 (2008).

Petitioner's second piece of "medical information" is a short surveyor note of a conversation with Dr. Paul Wagner, D.O., who was apparently the medical examiner. *See* CMS Ex. 8, at 15. The note says "No autopsy – family declined" and "delay in CPR did not [h]ave any effect on the outcome – slow decline. ↓ 20 lbs. wt." CMS Ex. 4, at 25. Dr. Wagner submitted no declaration or other statement, and I would hardly consider this note "overwhelming" evidence of anything.

noncompliance in the facility's administration may derive from findings of substantial noncompliance in other areas.

> [W]here a facility has been shown to be so out of compliance with program requirements that its residents have been placed in immediate jeopardy, the facility was not administered in a manner that used its resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of each resident.

Asbury Center at Johnson City, DAB No. 1815, at 11 (2002); *Odd Fellow and Rebekah Health Care Facility*, DAB No. 1839, at 7 (2002).

I discuss below why I conclude that the facility's deficiencies posed immediate jeopardy to resident health and safety which, itself, justifies the finding that the facility was not in substantial compliance with 42 C.F.R. § 483.75.

CMS cites additional reasons for finding that the facility was not in substantial compliance with the regulation governing administration, characterizing as inadequate the facility's written procedures for determining an impaired resident's code status. In CMS's view, sending a staff member to check the resident chart causes unnecessary delays. CMS also faults the facility policy because it did not address the potential problem of a missing chart. Finally, CMS argues that the policy was not effectively implemented.

I need not decide the adequacy of the facility's written procedure for determining code status because I decide that staff's failure to comply with and enforce the facility's written policy governing advance directives puts the facility out of substantial compliance with 42 C.F.R. § 483.75. *See Sunbridge Care and Rehabilitation for Pembroke*, DAB No. 2170, at 33 (2008), *aff'd*, *Sunbridge Care and Rehabilitation for Pembroke v. Leavitt*, No. 08-1603 (4th Cir. 2009).

Petitioner argues that it should not be held accountable for its staff's failure to follow the policy because it provided them adequate training. It is long settled that the facility "cannot disown the consequences" of inadequate care by the simple expedient of pointing the finger at staff who are the agents of the facility, "empowered to make and carry out daily care decisions." *Emerald Oaks*, DAB No. 1800, at n.3 (2001); *accord*, *Ridge Terrace*, DAB No. 1834, at 8 (2002).

Moreover, the errors here went beyond one employee's misunderstanding of facility policy. Nurse Gray was not simply a staff member; she was the charge nurse, and, in that capacity, presumably bore at least some supervisory responsibility. RN Lessard also declined to provide R101 with CPR, and, apparently, neither she nor any of the other 3-4 staff members witnessing the incident disabused Charge Nurse Gray of her erroneous

notions regarding the facility's resuscitation policy. In fact, no one even told her that R101's collapse had been witnessed, which presumably would have induced her to begin CPR (albeit for the wrong reason).

In any event, a facility's responsibility is not limited to providing its staff with in-service training. The facility also must follow-up to determine the effectiveness of the training, and, must adequately supervise its staff.

This facility had ample cause for concern about its staff's understanding and respect for facility policies regarding when to administer CPR. On July 1, 2006, another facility nurse deliberately misstated a resident's code status to a nurse practitioner, telling the nurse practitioner that the resident was "no code" when she knew that the resident was "full code." Apparently, because of his very frail condition (he suffered from terminal lung cancer) she thought the resident was not an "appropriate" candidate for CPR. Two other nurses, also fully aware of the resident's code status, witnessed the deceit, but delayed reporting it. CMS Ex. 16. Given this history, the administration should have been hyper-vigilant in monitoring its staff's attitudes and practices regarding code status.

B. CMS's finding of immediate jeopardy is not clearly erroneous.

I next consider whether CMS's immediate jeopardy finding was "clearly erroneous."

Immediate jeopardy exists if the facility's noncompliance has caused or is likely to cause "serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination as to the level of a facility's noncompliance (which would include an immediate jeopardy finding) must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy, and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1962, at 11 (2005) (citing *Florence Park Care Center*, DAB No. 1931, at 27-28 (2004), citing *Koester Pavilion*, DAB No. 1750 (2000)); *Daughters of Miriam Center*, DAB No. 2067, at 7, 9 (2007).

Petitioner claims that R101's death was inevitable, so staff errors caused no actual harm. Relying on the residents' purported statements that "their choices regarding code and no-code preferences were being honored," Petitioner also argues that no other residents were at risk. P. Br. at 32, citing P. Ex. 12, at 118-19. Petitioner is relying on state hearing testimony from the state surveyor, Denise Young-Bean, RN, MSN. Surveyor Young-Bean testified that she interviewed residents to find out if they had been offered a choice as to code status, and, like R101, they had indicated their preferences. P. Ex. 12, at 118-19. But, this evidence says nothing about whether their choices would ultimately be honored or disregarded. Indeed, until someone actually goes into cardiac arrest, and there

I find that as a result of Petitioner's conviction, the I.G. was required to exclude him pursuant to 1128(a)(3) of the Act, for at least five years.

D. The regulations do not permit me to change the effective date of Petitioner's exclusion.

Petitioner requests a retroactive application of his exclusion, thus setting the commencement of his exclusion to an earlier date than January 29, 2009 (20 days from the I.G.'s December 31, 2008 notice of exclusion). As grounds for his request, Petitioner reasons that since "exclusion is mandated by law upon conviction," the exclusion should be retroactive to the date of his conviction, October 10, 2007. *See* Request for Hearing.

As a matter of law, an exclusion pursuant to 1128(a)(3) of the Act must become effective 20 days from the date of the I.G.'s notice of exclusion. 42 C.F.R. § 1001.2002. An ALJ has no authority to review the timing of the I.G.'s determination to impose an exclusion or to alter retroactively the date of the imposition of the exclusion. *Lisa Alice Gantt*, DAB No. 2065 (2007); *Thomas Edward Musial*, DAB No. 1991, at 4-5 (2005), citing *Douglas Schram, R.Ph.*, DAB No. 1372, at 11 (1992) ("Neither the ALJ nor this Board may change the beginning date of Petitioner's exclusion."); *David D. DeFries*, DAB No.1317, at 6 (1992) ("The ALJ cannot . . . decide when [the exclusion] is to begin."); *Richard D. Phillips*, DAB No. 1279(1991) (An ALJ does not have "discretion . . . to adjust the effective date of an exclusion, which is set by regulation."); *Samuel W. Chang*, M.D., DAB No. 1198, at 10 (1990) ("The ALJ has no power to change . . . [an exclusion's] beginning date."). Therefore, I do not have the authority to grant the relief that Petitioner seeks, and the effective date of his exclusion remains January 20, 2009.

V. Conclusion

For the reasons set out above, I conclude that the I.G. has the authority to exclude Petitioner from Medicare, Medicaid, and all other federal health care programs for a period of five years. I further conclude that the effective date of Petitioner's exclusion is 20 days from the I.G.'s December 31, 2008 notice letter. Therefore, I sustain Petitioner's five-year exclusion pursuant to section 1128(a)(3) of the Act, effective January 20, 2009.

/s/ Alfonso J. Montaño
Administrative Law Judge