Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Lakeridge Villa Healthcare Center
(CCN: 366145),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-09-262

Decision No. CR2249

Date: September 23, 2010

DECISION

I sustain the determination of the Centers for Medicare and Medicaid Services (CMS) to impose remedies against Petitioner Lakeridge Villa Healthcare Center. The remedies that I sustain include two per-instance civil money penalties (PICMPs) in amounts of $5,100 for failing to comply with 42 C.F.R. § 483.13(b) (F-tag 223) and $4,900 for failing to comply with 42 C.F.R. § 483.25 (F-tag 309).

I. Background

Petitioner is a nursing facility (NF) located in Cincinnati, Ohio. On November 19, 2008, a survey was completed at Petitioner's facility to determine if the facility was in compliance with federal requirements for nursing homes participating in the Medicare and Medicaid programs. The survey found that the facility was not in substantial compliance. The deficiencies were cited as: F-tag 223, 42 C.F.R. § 483.13(b) concerning abuse; and F-tag 309, 42 C.F.R. § 483.25, concerning failure to perform Cardio-Pulmonary Resuscitation (CPR).

As a result of the survey findings, CMS determined to impose two PICMPs one of $5,100 for failing to comply with 42 C.F.R. § 483.13(b), (F-tag 223) and one of $4,900 for failing to comply with 42 C.F.R. § 483.25, (F-tag 309). CMS also determined to impose a denial of payments for new Medicare and Medicaid admissions (DPNA) effective February 19, 2009. By letter dated March 11, 2009, CMS indicated that the DPNA would not go into effect because Petitioner had returned to substantial compliance. CMS Ex. 2.

Petitioner timely requested a hearing before an administrative law judge (ALJ), and the case was assigned to Judge Alfonso J. Montaño for hearing and decision.

On June 5, 2009, CMS filed its Motion for Summary Judgment arguing that Judge Montaño should grant summary judgment on the two PICMPs imposed against Petitioner. On September 29, 2009, Judge Montaño granted summary judgment to CMS on F-tag 223 concerning the failure of Petitioner to ensure that Resident 46 (R-46) remained free from physical abuse. I discuss this F-tag later in this decision. However, Judge Montaño ruled that there were material facts in dispute concerning F-tag 309 that required a hearing.

Judge Montaño conducted an in-person hearing in Cincinnati, Ohio, on January 12, 2010. CMS offered exhibits (CMS Exs.) 1 through 38, which were admitted into evidence. Petitioner offered exhibits (P. Exs.) 1 through 20, which were also admitted into evidence. P. Ex. 21 was admitted on January 14, 2010, after the in-person hearing. CMS elicited testimony from Laura McClure, a surveyor with the State agency, and Alice Cox, supervising surveyor with the State agency. Petitioner elicited testimony from Bernard Moskowitz, Petitioner's Assistant Administrator and President; Dr. Syed Moqeeth, M.D., Medical Director and attending physician to Resident 100 (R-100), Dinah Lynn Studt, R.N., Petitioner's Director of Nursing (DON), and Debbie Ohl, Petitioner's expert witness. On April 8, 2010, the hearing was continued by telephone. Telephone testimony was elicited by CMS from Roberta Ann Kaplow, CMS's expert witness. During the telephone hearing, CMS Exs. 39-41 were admitted into evidence. Each party submitted a post hearing brief (CMS Brief and P. Brief, respectively) and a reply brief (CMS Reply and P. Reply, respectively) and each party received a copy of the in-person hearing transcript (Tr.) and the telephone hearing transcript (Tr.2). Petitioner submitted two attachments, identified as O.A.C. 4731-14-01(B) entitled Pronouncement of Death and the Ohio Board of Nursing Pronouncement of Death Pub. No. OBN-102, with its reply brief. I have labeled these two attachments as ALJ Exs. 1 and 2 respectively, and in the absence of objection, have admitted ALJ Exs. 1 and 2 into evidence.

This case was reassigned to me when Judge Montaño left the Departmental Appeals Board's Civil Remedies Division in August 2010. On August 23, 2010, I issued an Order informing that parties that I was prepared to decide the case and giving the parties 10

days in which to object to my proceeding. Neither party objected to my deciding the case. On September 8, 2010, I closed the record of this case.

II. Issues, Applicable Law, Findings of Fact, and Conclusions of Law

A. Issues

The issues in this case are:

1. Whether Petitioner failed to comply with one or more Medicare participation requirements; and

2. Whether the remedies imposed are reasonable.

B. Applicable Law and Regulations

Petitioner is considered a long-term care facility under the Social Security Act (Act) and regulations promulgated by the Secretary of Health and Human Services (Secretary). The statutory requirements for participation by a long-term care facility are found at sections 1819 and 1919 of the Act, and at 42 C.F.R. Part 483. Sections 1819 and 1919 of the Act vest the Secretary with authority to impose civil money penalties (CMPs) and other remedies against a long-term care facility for failure to comply substantially with participation requirements.

Pursuant to the Act, the Secretary has delegated to CMS the authority to impose various remedies against a long-term care facility that is not complying substantially with federal participation requirements. Facilities which participate in Medicare may be surveyed on behalf of CMS by State survey agencies in order to ascertain whether the facilities are complying with participation requirements. 42 C.F.R. §§ 488.10-488.28; 42 C.F.R. §§ 488.300-488.335. Under Part 488, CMS may impose a per-instance or per day CMP against a long-term care facility when a State survey agency ascertains that the facility is not complying substantially with participation requirements. 42 C.F.R. §§ 488.406, 488.408, 488.430. The regulations in 42 C.F.R. Part 488 also give CMS a number of other remedies that can be imposed if a facility is not in compliance with Medicare requirements.

Pursuant to 42 C.F.R. Part 488, CMS may terminate a long-term care facility's provider agreement when a survey agency concludes that the facility is not complying substantially with federal participation requirements. CMS may also impose a number of alternative enforcement remedies in lieu of or in addition to termination. 42 C.F.R. §§ 488.406; 488.408; 488.430. In addition to termination and the alternative remedies CMS is authorized to impose, pursuant to section 1819(h)(2)(D) of the Act and 42 C.F.R.

§ 488.417(b), CMS must impose the "mandatory" or "statutory" DPNA. Section 1819(h)(2)(D) requires the Secretary to deny Medicare payments for all new admissions to a SNF, beginning 3 months after the date on which such facility is determined not to be in substantial compliance with program participation requirements. The Secretary has codified this requirement at 42 C.F.R. § 488.417(b).

The regulations specify that a CMP that is imposed against a facility on a per day basis will fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP, of from $3,050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents, and in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i), (d)(2). The lower range of CMP, from $50 per day to $3,000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). There is only a single range of $1000 to $10,000 for a PICMP, which applies whether or not immediate jeopardy is present. 42 C.F.R. §§ 488.408(d)(1)(iv); 488.438(a)(2).

The regulations define the term "substantial compliance" to mean "a 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." 42 C.F.R. § 488.301. Non-compliance that is 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." *Id.* The Act and regulations make a hearing before an ALJ available to a long-term care facility against whom CMS has determined to impose a CMP. Act, section 1128A(c)(2); 42 C.F.R. §§ 488.408(g); 498.3(b)(13). The hearing before an ALJ is a de novo proceeding. *Anesthesiologists Affiliated, et al*, DAB CR65 (1990), *aff'd*, 941 F2d. 678 (8th Cir. 1991).

A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); *see also* 42 C.F.R. §§ 488.330(e) and 498.3. However, the choice of remedies by CMS or the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance found by CMS if a successful challenge would affect the amount of the CMP that could be collected by CMS or impact upon the facility's nurse aide training program. 42 C.F.R. §§ 498.3(b)(14) and (d)(10)(I). CMS's determination as to the level of noncompliance "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). This includes CMS's finding of immediate jeopardy. *Woodstock Care Center*, DAB No. 1726, at 9, 38 (2000), *aff'd*, *Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board or DAB) has long held that the net effect of the regulations is

that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g*., *Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). Review of a CMP by an ALJ is governed by 42 C.F.R. § 488.438(e).

In a CMP case, CMS must make a prima facie case that the facility has failed to comply substantially with participation requirements. To prevail, a long-term care facility must overcome CMS's showing by a preponderance of the evidence. *Hillman Rehabilitation Center*, DAB No. 1611 (1997); *aff'd*, *Hillman Rehabilitation Center v. U. S. Dept. of Health & Human Services*, No. 98-3789, 1999 WL 34813783 (D.N.J. May 13, 1999).

C. Findings of Fact, Conclusions of Law, and Discussion

I make findings of fact and conclusions of law to support this decision. I set them forth below as separate headings in bold type, and then discuss each in detail.

1. Petitioner failed to comply substantially with the requirement at 42 C.F.R. § 483.13(b) (F-tag 223) that Petitioner's residents be protected from physical abuse.

Judge Montaño granted summary judgment to CMS on F-tag 223, 42 C.F.R. § 483.13(b), concerning the failure of Petitioner to ensure that R-46 remained free from physical abuse. This deficiency was determined to be at a scope and severity (s/s) level J.[1] The regulation at 42 C.F.R. § 483.13(b) provides that a resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary

[1] Scope and severity levels are used by CMS and a state when selecting remedies. The scope and severity level is designated by an alpha character, A through L, selected by CMS or the state agency from the scope and severity matrix published in the SOM, Chap. 7, § 7400E. A scope and severity level of A, B, or C indicates a deficiency that presents no actual harm but has the potential for minimal harm, which is an insufficient basis for imposing an enforcement remedy. Facilities with deficiencies of a level no greater than C remain in substantial compliance. 42 C.F.R. § 488.301. A scope and severity level of D, E, or F indicates a deficiency that presents no actual harm but has the potential for more than minimal harm that does not amount to immediate jeopardy. A scope and severity level of G, H, or I indicates a deficiency that involves actual harm that does not amount to immediate jeopardy. Scope and severity levels J, K, and L are deficiencies that constitute immediate jeopardy to resident health or safety. The matrix, which is based on 42 C.F.R. § 488.408, specifies which remedies are required and optional at each level based upon the frequency of the deficiency.

seclusion. In his Order granting summary judgment dated September 29, 2009, Judge Montaño stated that:

> The facts are undisputed that on September 23, 2008, Housekeeper #9 (H9) pulled R46 across a corridor in the behavior unit on the second floor of the facility, then pushed her into a wall, grabbed her neck, and struck her at least once in the left eye and on her face. CMS Exs. 9, at 2, 3-4; CMS Ex. 11, at 5, 10; CMS Ex. 12, at 7; CMS Ex. 18, at 1; P. Ex. 2; P. Ex. 5, at 3, 5, 12. Petitioner admits that H9 did injure R46. P. Summary Judgment Reply Br. at 9. Immediately subsequent to this incident, H9 was left alone with R46 and another resident while Laundry Aide #7 (LA7), who reported H9 hitting R46 two or three times, went to find the Director of Nursing (DON). Activity Aide #2 (AA2) saw R46 after this incident and reported that R46's eye was bloodshot, red and swollen. CMS Ex. 9, at 5; CMS Ex. 11, at 11. Additionally, nursing notes indicate that the white of R46's eye was "very red" with "clear drainage" and "excessive tearing." CMS Ex. 9, at 4; CMS Ex. 18, at 1; P. Ex. 5, at 7. It is well settled that a facility is liable for the actions of its employee acting within the scope of his employment. *North Carolina State Veterans Nursing Home, Salisbury*, DAB No. 2256 (2009). H9, a staff member who was hired by Petitioner, was on duty as a member of Petitioner's staff at the time of the incident and was thus acting as Petitioner's agent. Petitioner's argument that it had no way of knowing that H9 would hit R46 does not present a dispute as to a genuine issue of material fact. What Petitioner knew or did not know relative to what its employee would do does not negate well settled case law and the undisputed fact that the resident was hit by Petitioner's employee and Petitioner is responsible for the conduct of its employee.

I agree with Judge Montaño's view of the evidence and his analysis of the legal principles involved. For purposes of this decision, I adopt his Order of September 29, 2009 and find that Petitioner was deficient with F-tag 223, 42 C.F.R. § 483.13(b), concerning the failure of Petitioner to ensure that R-46 remained free from physical abuse.

2. Petitioner failed to comply substantially with the requirement at 42 C.F.R. § 483.25 (F-tag 309, s/s J) that it provide CPR to a full code resident.

The quality of care regulation at 42 C.F.R. § 483.25 provides:

> Each 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, in accordance with the comprehensive assessment and plan of care.

It is undisputed that R-100 was a "full code" resident as confirmed by a July 2008 order by her physician. CMS Ex. 24, at 6; P. Ex. 6, at 1. On the facility's Full Measures form, R-100 had requested that, in the event that she required emergency medical treatment, facility staff would provide her with "resuscitative, life sustaining and/or life-support measures." CMS Ex. 24, at 3. The Full Measures form specifies that R-100 did not have a "Do Not Resuscitate" (DNR) order. *Id*.

R-100 was an 80-year-old female and had a tracheotomy that required suctioning and a gastrointestinal tube, and whose diagnoses included leukemia, cerebral aneurysm, respiratory failure and an enlarged goiter. *Id*. at 13, 17. On July 19, 2008 at 1:45 a.m., R-100 was transported to the hospital because of low oxygen saturation levels. At that time, R-100 was described as "ashen in color." R-100 was returned to the facility by 4:00 a.m. that same morning with oxygen saturation levels at 97 percent. *Id*. at 2.

That afternoon R-100 was taken to the bathroom by a licensed practical nurse (LPN), identified as LPN-30, at 3:45 p.m.[2] The nurse's notes indicate that R-100 was taken to the bathroom, tracheotomy care was given, R-100 was resting comfortably, vital signs were stable, oxygen saturation was at 93-94 percent per cool air mist and two liters of oxygen and no distress was noted. CMS Ex. 24, at 1, 2; P. Ex. 3, at 1, 2.[3]

LPN-30's next entry in the nurse's notes is at either 4:10 p.m. or 4:15 p.m. on July 19, 2008, and it indicates that R-100 was stiff with eyes closed, unresponsive, skin cool, vital signs absent, no blood pressure, no pulse, and no heart rate.[4] LPN-30 notified her supervisor of R-100's condition. *Id*. It is undisputed that LPN-30 failed to initiate CPR

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[2] It is unclear from the nurse's notes the exact time LPN-30 took R-100 to the bathroom. The handwriting is not clear but it was either 3:35 p.m., 3:45 p.m., or even 3:55 p.m. The exhibit submitted by Petitioner, P. Ex. 3, at 1, 2, is clearer and seems to indicate that the time was really 3:55 p.m. For ease of discussion I use 3:45 p.m. as the time of this entry. CMS Ex. 24, at 1, 2; P. Ex. 3, at 1, 2.

[3] There are two separate entries in R-100's nurse's notes, similar but not identical, for the 3:45 p.m. entry on July 19, 2008. CMS Ex. 24, at 1, 2; P Ex. 3, at 1, 2.

[4] Again, the handwriting of this entry is not clear. For ease of discussion I use 4:10 p.m. as the time of this nurse note entry.

when she discovered R-100 unresponsive at 4:10 p.m. LPN-30's supervisor, a Registered Nurse (RN), identified as RN-20, also failed to initiate CPR when she was informed of R-100's condition. It is undisputed that CPR was not attempted or performed by anyone at the facility.

Surveyor McClure interviewed RN-20. According to the surveyor's notes of that interview (CMS Ex. 12, at 9) and Ms. McClure's testimony (Tr. at 24-25), RN-20 stated that LPN-30 came to her and told her that R-100 had died. RN-20 notified the family, called the doctor, and left a message for the DON. This call to the physician was made at 4:30 p.m., 20 minutes after R-100 was discovered unresponsive by LPN-30. CMS Ex. 24, at 1, 7. The DON returned RN-20's call at about 5:00 p.m. and RN-20 notified the DON that R-100 had died. CMS Ex. 25, at 5. The DON asked if R-100 was a full code and then, evidently for the first time, RN-20 checked R-100's code status. *Id*. There is no indication that LPN-30 or RN-20 ever checked R-100's code status until 5:00 p.m., 50 minutes after R-100 was discovered unresponsive. Upon discovering R-100's full code status, the DON instructed LPN-30 to call the doctor. *Id*. During this second call to the doctor at approximately 5:00 p.m., the doctor stated that it was too late to perform CPR because too much time had passed. Surveyor McClure asked RN-20 if she had looked in R-100's chart for R-100's code status. RN-20 replied that she had not. According to the surveyor's interview, RN-20 then went to see R-100. R-100 was described as having no pulse and not breathing but R-100 was not cold and stiff. Tr. at 25; CMS Ex. 12, at 9.

The information obtained during the surveyor's interview of RN-20 was confirmed by the testimony of Dr. Moqeeth. Dr. Moqeeth, Petitioner's Medical Director and R-100's attending physician, testified that he received two telephone calls from the facility. In the first telephone call Dr. Moqeeth was notified that R-100 was found dead and he was asked if the facility could release the body. During the first call CPR was not discussed. Tr. at 29. During the second telephone call, approximately 20 minutes later, CPR was discussed but CPR was not started because "[b]y that time it was too late, there was no reason for doing CPR then." *Id.* R-100's time of death is listed as 4:25 p.m. on the Record of Death form. CMS Ex. 24, at 7; P. Ex. 10, at 9.

In an undated report, the DON indicated that she asked LPN-30 why she had not performed CPR. According to the report, LPN-30 had stated to the DON that R-100 "was dead obviously for some time" and indicated that R-100 was stiff, dusky, and very cold. CMS Ex. 25, at 5. LPN-30 was not called to testify. RN-20 was not called to testify.

As a result of LPN-30's failure to perform CPR, LPN-30 was terminated as an employee. As a result of RN-20's failure to properly supervise LPN-30 who failed to perform CPR, RN-20 was suspended for three days. *Id*. at 1-4. In taking this action against LPN-30, Petitioner noted on LPN-30's Termination Report that LPN-30 did not follow proper

nursing clinical practice standards. *Id*. at 2. In a written statement made on July 22, 2008, three days after the incident with R-100, the DON stated that LPN-30's failure to institute CPR and life saving measures until R-100 was properly pronounced dead by a physician or by an emergency squad is "against policies and professional nursing practices." *Id.* at 1. On Petitioner's disciplinary form for RN-20, it is noted that when a resident "dies" the nurse must immediately check the code status and if the resident is full code then the nurse must "start CPR immediately and/or follow advanced directives as stated." *Id*. at 4. The Facility Incident Report described this incident as "not following nursing clinical practice standards." *Id*. at 6. In addition, Petitioner inserviced its entire staff on advanced directives. P. Exs. 1, 12; Tr. at 151.

Four months later, during the November 2008 survey and based on a record review, CMS cited Petitioner under the deficiency before me. The issue under this deficiency is whether LPN-30's failure to initiate CPR upon discovering a full code resident unresponsive at 4:10 p.m. on July 19, 2008 was a violation of the regulation at 42 C.F.R. § 483.25.

Petitioner's CPR policy states that proper CPR procedure includes following the American Heart Association (AHA) CPR guidelines, checking the resident's care plan to determine whether or not a CPR order exists, initiating CPR and continuing to perform CPR until paramedics arrive or a physician pronounces the resident dead and gives orders to discontinue CPR. CMS Ex. 26, at 1-3; Tr. at 113-14, 148-49. Clearly neither LPN-30, RN-20, nor anyone else at the facility followed Petitioner's own CPR policy.

CPR is designed to be given when an individual shows no signs of life. Tr. at 55, 148. The administration of CPR assumes signs of clinical death. Petitioner's own CPR policy states that the purpose of CPR is to "establish circulation on a resident with absence of respiration and pulse." CMS Ex. 26, at 1. AHA guidelines state that CPR should be provided unless there is a Do Not Resuscitate (DNR) order; there are signs of irreversible death, such as rigor mortis, decapitation, decomposition, or dependent lividity; or no physiological benefit can be expected because vital signs have deteriorated despite maximal therapy (e.g., progressive septic or cardiogenic shock). CMS Ex. 37, at 14. None of the AHA exceptions to providing CPR are present in the case of R-100. ALJs and the Board have recognized the AHA guidelines as authoritative. *Epsom Healthcare Center*, CR1749 (2008); *John J. Kane Regional Center – Glen Hazel*, DAB No. 2068 (2007). I also accept these guidelines as authoritative.

LPN-30 was neither authorized to decide nor qualified to decide to not perform CPR on R-100. Nor was LPN-30 authorized or qualified to determine how much time had elapsed since R-100 had become unresponsive, because in this situation the nurse came upon a resident who was already unresponsive. Tr. at 83. Neither was LPN-30 authorized or qualified to decide if it would be futile to perform CPR. In Ohio, according

to the Ohio Board of Nursing, a nurse may not, by herself or himself, pronounce a patient dead. ALJ Ex. 2. Petitioner's DON testified that only a physician can make the decision to stop CPR or not to begin it. Tr. at 55, 148-50, 157-58. Petitioner's expert witness agreed that a nurse could not pronounce death. Tr. at 186-88. The evidence shows that R-100 was found unresponsive at either 4:10 or 4:15 p.m. and RN-20 notified Dr. Moqeeth at 4:30 p.m. but CPR was not discussed at that time. Dr Moqeeth's testimony about the first telephone call was that the nurse told him that the "patient was found dead, you know, cold, clammy, can we release the body." Tr. at 129. At no point in Dr. Moqeeth's testimony did he state that he pronounced R-100 dead. At approximately 5:00 p.m. when the DON confirmed R-100's full code status, the DON instructed LPN-30 to place a second telephone call to Dr. Moqeeth and CPR was discussed for the first time. Dr. Moqeeth indicated that it was then too late to perform CPR on R-100. There is no evidence that LPN-30 consulted with or was advised by a physician at 4:10 p.m. that she should not initiate CPR. The evidence shows that LPN-30 did not have any contact with a physician until approximately 5:00 p.m. RN-20, when informed of R-100's condition, also did not initiate CPR. LPN-30 and RN-20 both failed to perform CPR against accepted nursing policy, the physician's order, the facility's CPR policy, and accepted AHA guidelines.

It was the surveyor's opinion that LPN-30 should have performed CPR on R-100. CMS Ex. 38. R-100 was a full code resident and no evidence was presented that either LPN-30 or RN-20 checked R-100's code status until the DON requested R-100's code status at approximately 5:00 p.m. Roberta Kaplow testified as an expert on the performance of CPR on a patient without a pulse. Tr.2 at 21. She has been a Basic and Advanced Cardiac Life Support Instructor and an AHA Instructor. Ms. Kaplow confirmed the surveyor's conclusion, stating that LPN-30 violated standard nursing practice as well as her facility's CPR policy by failing to immediately initiate CPR on R-100. CMS Ex. 40, at 2. Further, Ms. Kaplow stated that, "LPN-30 did not have the discretion, and it was not in the scope of her practice, to determine that CPR would be futile, and to decide . . . not to perform CPR on R-100 . . . especially since R-100 had been noted to be in no distress less than 30 (and probably less than 20) minutes earlier." *Id*. Ms. Kaplow concluded that, "LPN-30 should have immediately commenced CPR when she found R-100 unresponsive. CPR was R-100's only chance of being resuscitated (however small it might have been), and LPN-30's failure to perform CPR on R-100 deprived R-100 of this chance." *Id*. In addition, Petitioner's DON, Medical Director, and Assistant Administrator all testified that CPR should have been done. Tr. at 55-56, 100, 131.

Petitioner argues that CPR should not have been performed on R-100 because the resident was obviously dead and clearly beyond resuscitation. P. Br. at 4-5. Petitioner claims that the survey was done four months after R-100's death and is based solely on a record review. Petitioner argues that LPN-30 was experienced and had completed all the course work to become a Registered Nurse, except for taking the licensing exam.

According to Petitioner LPN-30 assessed R-100, concluded that R-100 had been dead for some time, that emergency treatment was not needed (according to Petitioner) and, Dr. Moqeeth agreed that R-100 had been dead between 20-30 minutes. CMS Ex. 24, at 1, CMS Ex. 25, at 5, Tr. at 125-26, 128-31 In essence, Petitioner asserts that "LPN-30 made a clinical decision not to commence CPR because R-100 was beyond the need for the 'emergency medical services' called for by the facility's full measure policy." P. Reply Br. at 2. Petitioner argues that, in Ohio, a nurse is authorized to "assess whether a patient is deceased and phone the patient's death in to a physician who, upon reliance of the nurse's assessment, pronounces death without personally examining the body." P. Reply Br. at 2-3; ALJ Exs. 1; 2. Petitioner claims that based on LPN-30's assessment of R-100, Dr. Moqeeth pronounced R-100 dead by telephone, citing the Record of Death. P. Reply Br. at 2-3; P. Ex. 10, at 9. However, Petitioner's argument is without merit. The Record of Death does not show that Dr. Moqeeth pronounced R-100 dead. It merely indicates that Dr. Moqeeth was R-100's attending physician and that he was notified of R-100's death at 4:30 p.m. Nowhere in Dr. Moqeeth's declaration or his testimony at hearing does he state that he pronounced R-100 dead by telephone based on LPN-30's assessment. P. Ex. 17; Tr. at 121-32. The evidence clearly shows that Dr. Moqeeth was not notified until 4:30 p.m. and this was done by RN-20, not LPN-30, since the nurse note at 4:30 p.m. indicates that, "Supervisor [RN-20] notified MD and DON at this time." CMS 24, at 1. Finally, even if Dr. Moqeeth did pronounce R-100's death at 4:30 p.m., that would still not have relieved LPN-30 of her duty to initiate CPR at 4:10 p.m. — as soon as she discovered R-100 to be unresponsive — and to continue performing CPR until R-100's death was pronounced by a professional competent to do so.

Petitioner also argues that CPR would have been futile and that to begin CPR on R-100 would have been to "violate her body." P. Br. at 11. Petitioner relies on Dr. Moqeeth's opinion and the opinion of Ms. Ohl, Petitioner's expert witness. This argument is unpersuasive. First, neither a LPN nor a RN is authorized to determine medical futility. Tr.2 at 29. The intended audience of the discussion of medical futility in the AHA guidelines is physicians, not nurses. Tr.2 at 30. Therefore, neither LPN-30 nor RN-20 were authorized or qualified to decide that CPR would have been futile for R-100. Second, no matter what Dr. Moqeeth's opinion concerning futility, the fact is that his opinion is irrelevant since he did not even discuss CPR until sometime after 5:00 p.m., 45-50 minutes after R-100 was discovered unresponsive. At the time Dr. Moqeeth first considered CPR, it was indeed too late to initiate CPR. Dr. Moqeeth clearly testified that LPN-30 was not authorized to decide not to do CPR on her own judgment and that she should have started CPR when she discovered R-100 was unresponsive. Tr. at 131. Third, R-100 was unquestionably alive 25 minutes before being discovered unresponsive. After that observation, the time at which R-100 became unresponsive is the merest speculation. Even assuming that R-100's chances of being resuscitated were extremely low, that assessment of her chances was simply not LPN-30's call to make. Additionally,

RN-20 should have intervened and started CPR herself as soon as she discovered that LPN-30 had not initiated CPR.

Ms. Ohl's opinion relies on nursing judgment and nursing assessment. Ms. Ohl testified that from a clinical standpoint she would have acted the same as LPN-30. Tr. at 182. However, Ms. Ohl also testified that if a nurse did not know whether a resident was a full code patient, then the nurse should have started resuscitation, and that once CPR is started it is not stopped until the patient is pronounced dead. Tr. at 185-86. At the hearing Judge Montaño directly questioned Ms. Ohl as follows:

> Judge Montano: So when you studied as an RN and you worked as an RN, did you have it in your mind or during your course of study as an RN, were you ever instructed that you can make a decision whether a person should have CPR?
>
> Ms. Ohl: No, but clinical judgment, you look at, but no, they don't say you can't—
>
> Judge Montano: Let me finish the question. All right. So nobody told you in nursing school you can decide who gets CPR and who doesn't get CPR?
>
> Ms. Ohl: Right.
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> Judge Montano: Who has the authority, the physician?
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> Ms. Ohl: The physician.
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> * * * * *
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> Judge Montano: Okay. So there is nothing legally that would give an RN the authority to decide not to give CPR?
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> Ms. Ohl: No.
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> * * * * *
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> Judge Montano: Okay. Is there a legal nursing standard that says that's appropriate [not initiating CPR]?
>
> Ms. Ohl: No. That's a judgment.
>
> Judge Montano: And does the nursing standard say that you have the judgment to decide?

> Ms. Ohl: No, but there is a standard there that you respect all life and that you respect every human being, whether they are alive or dead, and how you treat and care for them in their body.

Tr. at 186-88.

As Ms. Ohl's opinion is based on what she describes as nursing judgment and not on any objective standard of care, I give Ms. Ohl's testimony little weight. Ms. Kaplow's opinion however, carries great weight because of her background and the fact that she is an expert in the subject of giving CPR to a patient without a pulse.

There was some discussion at the hearing about the time at which LPN-30 took R-100 to the bathroom prior to R-100's being found unresponsive. Whether the time lapse between these two nurse's notes was 15 minutes, 25 minutes or 35 minutes makes no difference to my decision. The point at which R-100 ceased to have a pulse, blood pressure, or heart rate was undetermined since R-100 was alone at the time. It could have happened immediately after she was taken to the bathroom or immediately before she was discovered. In either case, once R-100 was discovered to be unresponsive, the facility had a duty to initiate CPR in accordance with R-100's wishes on the Full Measures form and her physician's order. R-100's only chance of resuscitation was CPR and Petitioner's staff failed to perform CPR. Where, as here, a resident's advance directive explicitly calls for CPR, the universally accepted standard of care mandates that facilities honor that instruction. *Oceana County Medical Care Facility*, CR1993 (2009). Here, a physician did not pronounce death and none of the signs of irreversible death as described by the AHA guidelines existed. CMS Ex. 37, at 14-15. Once a resident has expressly decided that a facility should attempt resuscitation, a facility may not refuse to provide the services that it promised to provide absent a pronouncement of death by a physician or signs of irreversible death as described in the AHA guidelines.

There is also no evidence to demonstrate that either LPN-30 or RN-20 checked R-100's code status prior to 5:00.p.m. If either of them checked the code status, neither of them acted on that knowledge. RN-20 only checked R-100's code status when directed to by the DON, 50 minutes after R-100 was found unresponsive. R-100's only chance to be resuscitated was ignored by two staff members at the facility, one of whom was a supervisor. I find that LPN-30 and RN-20 failed to provide R-100 with CPR, depriving R-100 of her only chance at resuscitation, in disregard of professional nursing practice, facility policy, her physician's order, and R-100's wishes as expressed in her advance directive. All of these facts demonstrate that Petitioner was not in substantial compliance with the regulation at 42 C.F.R. § 483.25.

3. Petitioner's objections to CMS Exs. 6 and 41 are overruled.

Petitioner objected to CMS Ex. 6, a 2006 Medicare cost report, as irrelevant because it does not report Petitioner's current financial condition. Judge Montaño admitted CMS Ex. 6 into evidence and I see no reason to disturb his ruling. As CMS points out, the 2006 cost report was the most recent information available to CMS. Petitioner was free to produce any evidence it could produce if it hoped to show its inability to pay the PICMP or its current financial position. It failed to do so. Petitioner's objection to CMS Ex. 6 is overruled.

Petitioner also objected to CMS Ex. 41, a 2007 bulletin from the Ohio Health Care Association (OHCA) on CPR, because it was not new evidence. Petitioner claims that the hearing was essentially closed at the time it was submitted. However, CMS Ex. 41 was submitted after the in-person hearing was completed but *not* after the telephone hearing was completed. CMS Ex. 41 was received into evidence during the telephone hearing. Neither the hearing nor the record was closed when this Exhibit was proffered. Petitioner's objection to CMS Ex. 41 is overruled. But beyond that, although CMS Ex. 41 is admitted as evidence, I have not relied on it in my decision. Therefore, Petitioner's objection to it must be regarded as moot.

4. The alleged scope and severity of the deficiencies is not subject to my review, as the scope and severity of the deficiencies has no effect on the range of the PICMPs that may be imposed. 42 C.F.R. §§ 488.438(a)(2), 488.438(e), 498.3(b)(14), 498.3(d)(10)(ii).

CMS may impose a CMP for the number of days that the facility is not in compliance or for each instance that a facility is not in substantial compliance. 42 C.F.R. § 488.430(a). In this case, CMS has imposed PICMPs totaling $10,000, consisting of $5,100 for failing to comply with 42 C.F.R. § 483.13(b) (F-tag 223) and $4,900 for failing to comply with 42 C.F.R. § 483.25 (F-tag 309).

Although Petitioner disagrees with CMS's determination that its deficiencies posed immediate jeopardy, that determination is not subject to my review. A facility may only challenge the scope and severity level of noncompliance found by CMS if a successful challenge could affect the range of the CMP that CMS could impose or impair the facility's authority to conduct nurse aide training and competency evaluation programs. 42 C.F.R. §§ 498.3(b)(14) and (d)(10)(i). Per-instance penalty amounts are not limited by the presence or absence of immediate jeopardy. In other words, CMS may impose any amount within the range of $1,000 to $10,000 for each PICMP regardless of whether immediate jeopardy was found. 42 C.F.R. § 488.438(a)(2).

5. Petitioner's regulatory violations provide a basis for the imposition of two PICMPs, and the PICMPs imposed, totaling $10,000, are reasonable.

In determining whether the amounts of the PICMPs are reasonable, the following factors specified at 42 C.F.R. § 488.438(f) must be considered: (1) the facility's history of noncompliance, including repeated deficiencies; (2) the facility's financial condition; (3) the seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404; and (4) the facility's degree of culpability, i.e., neglect, indifference, or disregard for resident care, comfort, or safety.

I have been shown no evidence concerning the facility's history of noncompliance. The only evidence I have been shown concerning Petitioner's financial condition is the 2006 Medicare cost report. CMS Ex. 6. That cost report indicates that Petitioner is in a financial condition that would allow it to pay a PICMP totaling $10,000. The deficiencies are extremely serious. Physical abuse of a resident is very serious and H9 was a possible threat to other residents. Petitioner does not deny that R-46 was injured by H9. As to the deficiency based on failure to perform CPR, Petitioner in essence maintains that a dead person cannot suffer harm. However, failure to perform CPR on a resident who had the full expectation that she would receive CPR based on her code status, her physician's order, and the facility's own policies, deprived her of her only chance to be resuscitated. Petitioner's failure to provide CPR to R-100 revealed a similar threat to other full code residents. Both deficiencies demonstrate a complete disregard for the safety of its residents and thus a high degree of culpability. In light of the potential for harm, the PICMPs imposed are reasonable.

III. Conclusion

For the foregoing reasons I conclude that Petitioner violated 42 C.F.R. §§ 483.13(b) and 483.25 and that PICMPs totaling $10,000 are reasonable.

/s/
Richard J. Smith
Administrative Law Judge