Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Autumn Healthcare of Somerset,
(CCN: 365750),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-743

Decision No. CR4256

Date: September 25, 2015

DECISION

Autumn Healthcare of Somerset (Petitioner or the facility) challenges the determination of the Centers for Medicare & Medicaid Services (CMS) that it was not in substantial compliance with Medicare program participation requirements. CMS imposed against Petitioner a civil money penalty (CMP) of $4,550 per day from October 27, 2013 through October 28, 2013, and a $100 per day CMP from October 29, 2013 through November 20, 2013.

For the reasons discussed below, I grant summary judgment to CMS. I find the undisputed evidence shows that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25 (Tag F309, Quality of Care); 42 C.F.R. § 483.15(g)(1) (Tag F250, Medically Related Social Services); and 42 C.F.R. § 483.75 (l)(1) (Tag F514, Resident Record - Complete, Accurate and Accessible). I also find that CMS's determination of immediate jeopardy was not clearly erroneous, and the CMP that CMS imposed is reasonable in amount and duration.

I. Background

The Social Security Act (Act) sets forth requirements for skilled nursing facility participation in the Medicare program. The Act authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations implementing those statutory provisions. Act § 1819 (42 U.S.C. § 1395i-3). The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the program, a 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 agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a) (42 U.S.C. § 1395aa(a)); 42 C.F.R. §§ 488.10, 488.20. The Act and regulations require that facilities be surveyed on average every 12 months, and more often if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A) (42 U.S.C. § 1395i3(g)(2)(A)); 42 C.F.R. §§ 488.20(a), 488.308.

Here, surveyors from the Ohio Department of Health (state agency) completed a complaint survey at Petitioner's facility on November 14, 2013. Based on the findings of that survey, the state agency found Petitioner not to be in substantial compliance with the three participation requirements cited above. The state agency found Petitioner's noncompliance with 42 C.F.R. § 483.25 (Tag F309, Quality of Care) to be at an immediate jeopardy level where the potential harm was likely to result in serious injury or death. A revisit survey completed on January 29, 2014, found that Petitioner had achieved substantial compliance, effective November 21, 2013. As a result of the November 14, 2013 survey findings, CMS imposed against Petitioner a $4,550 per day CMP from October 27, 2013 through October 28, 2013, and a $100 per day CMP from October 29, 2013 through November 20, 2013, for a total penalty of $11,400.

By letter dated February 21, 2014, Petitioner requested an Administrative Law Judge (ALJ) hearing to dispute the determination that it was not in substantial compliance with program requirements and the associated proposed remedies. Petitioner's request was received at the Civil Remedies Division, assigned to me for hearing and decision, and on March 5, 2014, I issued an Acknowledgment and Initial Prehearing Order.

On June 4, 2014, CMS submitted its pre-hearing brief and a motion for summary judgment (CMS Br.) along with 22 proposed exhibits (CMS Exs. 1-22). As directed in my prehearing order regarding witness testimony, CMS submitted written direct testimony for its surveyor, its only witness. On July 7, 2014, Petitioner submitted a memorandum in opposition to CMS's motion for summary judgment and pre-hearing brief (P. Br.) along with three proposed exhibits (P. Exs. 1-3). Petitioner did not submit a witness list, any written direct testimony, and it did not request an opportunity to cross-

examine the surveyor. I admit all proposed exhibits into the record absent any objection from the parties.

II. Issues

Whether the undisputed evidence establishes:

1. Petitioner was in substantial compliance with 42 C.F.R. § 483.25 (Tag F309, Quality of Care);

2. Petitioner was in substantial compliance with 42 C.F.R. § 483.15(g)(1) (Tag F250, Medically Related Social Services);

3. Petitioner was in substantial compliance with 42 C.F.R. § 483.75(l)(1) (Tag F514, Resident Record - Complete, Accurate and Accessible);

4. CMS's determination of immediate jeopardy level noncompliance was clearly erroneous; and

5. The CMPs that CMS imposed are reasonable in amount and duration.

III. Findings of Fact and Conclusions of Law

A. Summary judgment is appropriate.

All the cited deficiencies involve one resident whom I reference as Resident 64 (R64). CMS moves for summary judgment relying on the following facts, which are undisputed. R64 was admitted to the facility on September 11, 2013, and was readmitted from the hospital on October 18, 2013, after a surgery for a fracture to his right hip following a fall. CMS Ex. 13 at 1, 6, 20, 46; CMS Ex. 12 at 6-7. R64 was a 74-year old man diagnosed with Parkinson's disease, moderate to severe dementia, aggression with agitated psychotic features, dementia with Alzheimer's disease, depression, and severely impaired cognitive skills. CMS Ex. 13 at 9, 39; P. Ex. 1 at 26.

The cited deficiencies involve the alleged failure of Petitioner's staff to immediately perform cardiopulmonary resuscitation (CPR) on R64 when staff found him with no vital signs. Petitioner's Director of Nursing (DON) summarized the undisputed facts in the facility's self-reporting of the incident that began at 4:05 p.m. on October 27, 2013:

> [Nurse 1, an] LPN, was alerted by a family member of [R64] of Change in Resident condition.[1] Upon her assessment, [R64] was without vital signs. She then had [a second] nurse confirm absence of same, chart was checked and [R64] was full measures. [Nurse 1] then proceeded to call on-call [a third] nurse and stated that [R64] was deceased and she had already told family member present that he was expired. Approx. ten minutes had already passed. She then called this DON at 4:30 pm and questioned what she should do. [DON, a fourth nurse] advised her that she could not call a code and must call [physician]/initiate same. At 4:30 pm, [a fifth nurse also an] LPN began CPR and instructed [Nurse 1], LPN to call 911 as she was made aware of situation by other nursing staff.

CMS Ex. 9 at 2; *see also* CMS Ex. 10 at 1-9.

The disciplinary report the DON sent to the Ohio Board of Nursing concerning Nurse 1 states:

> On 10/27/2013 at approx. 4:05 pm, Family of Resident made nurse aware of change of condition. Nurse [1] . . . found [R64] to have absence of vital signs, which she confirmed with another [a second] LPN. She was told to check [R64's] code status by 2nd LPN. It was noted that he was full code. She then stated she was calling the on-call [a third] nurse as she didn't think she should code him because it had been "too long." [The DON, a fourth nurse] was made aware at 4:21 pm that the above had occurred. At 4:30 pm, Nurse [1] asked [DON] what she should do because he was 'gone' And the family was aware of that. Made Nurse [1] aware that it was not in the scope of my practice to 'call a code' off and she would need to contact physician to not initiate a code. At this time almost 30 minutes had passed. Another [a fifth] nurse then came and began CPR at 4:35 pm and instructed Nurse [1] to call 911. On 10/28/2013, this DON reviewed the documentation of [Nurse 1], LPN and found said documentation was inaccurate as to the time line of events.

CMS Ex. 10 at 12.

Nurse 1 paged the on-call physician at some unspecified time during these events. The on-call physician returned the page and instructed the fifth nurse (referred to in the self-reported incident) to begin CPR. CMS Ex. 10 at 4. Between 4:30 p.m. and 4:35 p.m., staff initiated CPR and continued until 4:40 p.m. or 4:45 p.m. when paramedics arrived. CMS Ex. 10 at 2. Staff transferred R64 to the hospital. At the hospital, R64 had a faint

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[1] R64's family reported that he was sweating heavily and looked dehydrated. CMS Ex. 10 at 1.

pulse and was placed on a respirator. CMS Ex. 8 at 5. However, R64 died later that day at the hospital. CMS Ex. 5 at 5.

When R64 was originally admitted to the facility on September 11, 2013, R64's guardian signed a "Resuscitate/Do not Resuscitate" status form, which requested "Do Not Resuscitate Comfort Care (DNRCC)" for R64. CMS Ex. 13 at 62; CMS Ex. 16 at 1. The following sentence was printed at the bottom of this form: "If DNR is checked a DNR form must be completed and attached." CMS Ex. 13 at 62. The Director of Admissions and Social Services (social service director) informed R64's guardian that he must go to the nursing station and complete a Do Not Resuscitate (DNR) form and have a physician sign it. CMS Ex. 12 at 8. The social services director explained that staff would consider R64 a "full code" until R64's guardian and physician completed the paperwork. CMS Ex. 12 at 8. No one ever completed the DNR form. The facility's social service notes from the September 11, 2013 admission state that R64's guardian reported that R64 was a DNR, "however, [zero] paperwork or DNR consent [was completed]. [R64] will remain a full code at [the facility] until DNRCC & DNRCCA [Do Not Resuscitate Comfort Care Arrest] is explained & one or the other is chosen." CMS Ex. 13 at 48.

The facility's code status policy states:

> Code status must be addressed upon admission. The admitting nurse[2] will discuss options with the resident and or his/her responsible party. The code status will be "Full Code" in the event there is not a physician signed DNR in the admission packet and the family/resident fails to make a decision or is not reachable by phone.
>
> All Full Codes or code status not addressed upon admission will be followed up by Unit manager, D.O.N., or charge nurse the following day. Nurse's notes shall reflect the decision or if unable to reach upon admission. Failure to address code status upon admission will result in disciplinary action.
>
> DNR orders go into effect when signed by a physician . . . .

CMS Ex. 14 at 1.

The facility's advanced directive policy states: "Upon Admission Advanced Directives will be discussed and determined with the resident and or family, POA, Guardian as applicable. Please note all residents without a physician signed DNR will be treated as Full Code until signed by a physician." CMS Ex. 14 at 2.

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[2] The admitting nurse was the social service director.

The facility's performance checklist for code management requires that a nurse must be aware of the resident's code status, and CPR must be performed immediately after discovery of a resident's unresponsiveness or cardiac arrest. CMS Ex. 14 at 3-6.

The DON's investigation determined that the failure to provide timely CPR to R64 was a "deficient practice," R64's guardian thought that he had changed his code status when he signed the "Resuscitate/Do not Resuscitate" form upon admission, and R64's code status "was not followed up on by the social services designee," and consequently, the form was removed from the admissions packet. CMS Ex. 16 at 1.

After R64's death, on October 29, 2013, the DON explained to R64's guardian that there was no DNR order in R64's file. The DON further explained that consequently R64 was full code and the facility was "bound by law to perform CPR." CMS Ex. 10 at 8. The facility's October 31, 2013 Medical Director Report describes R64 as a "full code & not coded time appropriately." CMS Ex. 16 at 13.

The DON admitted that Nurse 1's documentation of events had a falsified timeline as well as an incorrect date (October 28). Nurse 1's documentation was written to appear as CPR began sooner than it did. CMS Ex. 10 at 7; CMS Ex. 12 at 8. Nurse 1's documentation specifically indicated that CPR was started at 4:15 pm, before the on-call physician called the facility. Nurse 1's documentation did not specify who started CPR on R64. CMS Ex. 13 at 41.

Petitioner terminated Nurse 1's employment on October 29, 2013 for "failure to perform CPR on a full code resident" and "falsification of documents." CMS Ex. 11 at 1; *see also* CMS Ex. 10-at 7-8. In its Plan of Correction (POC), the facility indicates that Nurse 1 admitted she did not follow proper procedure but believed she was following the family's wishes "because the family was at ease with the resident dying," she told the family that R64 was dead before checking the code status, and she became confused about what to do because so much time had elapsed. CMS Ex. 5 at 5.

Summary judgment is appropriate when a case presents no issue of material fact, and its resolution turns on questions of law. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48 (1986); *Livingston Care Ctr. v. United States Dep't of Health and Human Servs.*, 388 F.3d 168, 173 (6th Cir. 2004); *see also Illinois Knights Templar Home*, DAB No. 2274, at 3-4 (2009) (*citing Kingsville Nursing Ctr.*, DAB No. 2234, at 3-4 (2009)). The moving party may show the absence of a genuine factual dispute by presenting evidence so one-sided that it must prevail as a matter of law, or by showing that the non-moving party has presented no evidence "sufficient to establish the existence of an element essential to [that party's] case, and on which [that party] will bear the burden of proof at trial." *Livingston Care Ctr.*, 388 F.3d 168, 173 (*quoting Celotex Corp. v. Catrett*, 477 U.S. 317, 323-24 (1986)). To avoid summary judgment, the non-moving party must then act affirmatively by tendering evidence of specific facts showing that a dispute exists.

See Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 586 n.11 (1986); *see also Vandalia Park*, DAB No. 1939 (2004); *Lebanon Nursing & Rehab. Ctr.*, DAB No. 1918 (2004). To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but it must furnish evidence of a dispute concerning a material fact. *Illinois Knights Templar Home,* DAB No. 2274, at 4; *Livingston Care Ctr.*, DAB No. 1871, at 5 (2003).

In examining the evidence for purposes of determining the appropriateness of summary judgment, I must draw all reasonable inferences in the light most favorable to the non-moving party. *Brightview Care Ctr.*, DAB No. 2132, at 2, 9, 10 (2007); *Livingston Care Ctr.*, 388 F.3d at 168, 172; *Guardian Health Care Ctr.*, DAB No. 1943, at 8 (2004). However, drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions. *Cedar Lake*, DAB No. 2344, at 7 (2010); *Guardian Health Care Ctr.*, DAB No. 1943, at 11 ("A dispute over the conclusion to be drawn from applying relevant legal criteria to undisputed facts does not preclude summary judgment if the record is sufficiently developed and there is only one reasonable conclusion that can be drawn from those facts."). Here, all of the preceding material facts are not in dispute, and I am able to resolve the issues as matters of law.

B. The undisputed evidence establishes that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25 because Petitioner did not provide the necessary care and services to R64.

The opening provision of 42 C.F.R. § 483.25 (quality of care), which implements section 1819(b)(2) (Medicare) of the Act, requires:

> 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.

The quality of care legislation and regulatory requirements are "based on the premise that the facility has (or can contract for) the expertise to first assess what each resident's needs are (in order to attain or maintain the resident's highest practicable functional level) and then to plan for and provide care and services to meet the goal." *Spring Meadows Health Care Ctr.*, DAB No. 1966, at 16 (2005). The regulation thus "imposes on facilities an affirmative duty designed to achieve favorable outcomes to the highest practicable degree." *Windsor Health Care Ctr.*, DAB No. 1902, at 16-17 (2003), *aff'd, Windsor Health Care Ctr. v. Thompson*, No. 04-3018 (6th Cir. 2005). The facility must take reasonable steps and all practicable measures to achieve that regulatory end. *Clermont Nursing & Convalescent Ctr.*, DAB No. 1923, at 21 (2004), *aff'd, Clermont Nursing & Convalescent Ctr. v. Leavitt*, 142 F. App'x 900 (6th Cir. 2005).

The Departmental Appeals Board (Board) has concluded that the language of 42 C.F.R. § 483.25 not only requires skilled nursing facilities to furnish the care and services set forth in a resident's care plan but also to implement doctors' orders, monitor and document the resident's condition, and follow its own policies. *See, e.g., Alexandria Place*, DAB No. 2245 (2009) (upholding this deficiency when a petitioner did not provide care in accordance with a doctor's order); *Oxford Manor*, DAB No. 2167, at 5-6 (2008) (affirming an ALJ's reliance on a facility's policy as evidence of the standard of care the facility expected its staff to provide, noting "if facility staff exercise professional judgment in deciding not to follow facility policy with respect to a particular resident, they document that judgment and give a reason why not. In the absence of such contemporaneous documentation, it is certainly reasonable to infer, when staff do not follow the policy, either they are not aware of it or that they are simply disregarding it."). The quality of care provision also implicitly imposes on facilities a duty to provide care and services that, at a minimum, meet accepted professional standards of quality "since the regulations elsewhere require that the services provided or arranged by the facility must meet such standards." *Spring Meadows*, DAB No. 1966, at 17, *citing* 42 C.F.R. § 483.25.

1. The undisputed evidence establishes that R64 was a full code resident according to Petitioner's own policy.

R64 did not have a physician approved DNR order when facility staff found him without vital signs on October 27, 2013. The "Resuscitate/Do not Resuscitate" status form from the facility's admission packet that R64's guardian signed, on September 11, 2013, required a physician signed DNR form to become effective. At the bottom of the status form, the following sentence was printed: "If DNR is checked a DNR form must be completed and attached." CMS Ex. 13 at 62. The social services director reportedly informed R64's guardian that he must go to the nurse's station and complete a DNR form and have a physician sign it. CMS Ex. 12 at 8. The social services director explained that the facility staff would consider R64 a full code until he completed the required paperwork. CMS Ex. 12 at 8. It is undisputed that no one completed the required paperwork, and the social services director did not follow-up on it. The facility's social service notes, for September 11, 2013, also indicate that R64's guardian reported to the social services designee that R64 had a DNR status, "however, [zero] paperwork or DNR consent [was completed]. [R64] will remain a full code at [the facility] until DNRCC & DNRCCA is explained & one or the other is chosen." CMS Ex. 13 at 48.

The facility's code status policy and advanced directive policy both unequivocally state that DNR orders only go into effect when a physician signs them. CMS Ex. 14 at 1, 2. Petitioner's staff describes R64 as a full code resident in its self-report and in the DON's report to the Ohio Board of Nursing. CMS Ex. 9 at 2; CMS Ex. 10 at 12. One reason

that Petitioner terminated Nurse 1 on October 29, 2013 was for "failure to perform CPR on a full code resident." CMS Ex. 11 at 1; *see also* CMS Ex. 10-at 7-8.

Therefore, the undisputed evidence establishes the facility considered R64 a full code resident in accordance with its own policies.

2. The undisputed evidence establishes Petitioner did not provide the necessary care and services to R64 when it did not comply with its policy and professional standards of care after R64's guardian requested that the facility designate R64 a DNR resident.

A facility's failure to follow or implement its own resident care policy may constitute a deficiency under 42 C.F.R. § 483.25. *The Laurels at Forest Glenn*, DAB No. 2182, at 18 (2008). According to the facility's code status policy, a "code status not addressed upon admission will be followed up by the Unit Manager, the DON, or the charge nurse the following day." CMS Ex. 14 at 1.

No one disputes that R64's guardian intended, on the date of initial admission, to designate R64 as a DNR resident. The DON's root cause investigation determined that R64's guardian thought that he had selected R64's code status when he signed the "Resuscitate/Do not Resuscitate" status form upon R64's admission, but R64's code status "was not followed up on by the social services designee," and consequently staff removed the form from the admissions packet. CMS Ex. 16 at 1. A physician must sign a DNR designation form for the DNR designation form to become valid. Petitioner's social services note explains that R64's code status would remain full code until staff explained the DNR options to the guardian. Petitioner comes forward, however, with no argument or evidence to suggest that the social services designee, the Unit Manager, the DON, or the charge nurse followed up on the guardian's DNR request, as Petitioner's code status policy required. Therefore, I find Petitioner's noncompliance with its own policy not in dispute.

A resident care policy "is also evidence of the standard of care the facility expect[s] its staff to provide" and of professional standards of care. *The Laurels at Forest Glenn*, DAB No. 2182, at 18. Again, here I find it undisputed that Petitioner did not comply with its policy to follow-up regarding the required discussion between R64's physician and R64 or his guardian, and this is further support of a violation of 42 C.F.R. § 483.25. Because no one at the facility followed-up on R64 guardian's DNR request, all the DNR options were not fully explained to R64 or his guardian. The staff's lack of communication with R64 or his guardian deprived them of the benefit of a truly informed resuscitation decision based on consultation with the resident's physician.

3. The undisputed evidence establishes that Petitioner did not provide the necessary care and services to R64 when it did not initiate CPR immediately to a full code resident in accordance with its code management policy.

It is undisputed that Petitioner had a code management policy that states that a nurse must be aware of the resident's code status and immediately perform CPR after discovery of a resident who is unresponsive or in cardiac arrest. CMS Ex. 14 at 3-6. The policy specifically requires that staff check the resident's code status, immediately activate the emergency response system, and initiate CPR if the resident does not have a valid DNR order. CMS Ex. 14 at 3. This policy is consistent with Petitioner's own October 27, 2014 root cause investigation findings confirming that a nurse, upon finding an unresponsive resident, must "check code status immediately, and if a full code to call code blue, initiate CPR and notify 911." CMS Ex. 16 at 1.

It is undisputed that R64 was sweating heavily and looked dehydrated shortly before Nurse 1 went in to check on him at 4:05 p.m., when she found him without vital signs. As found in the DON's investigation, it is undisputed that Petitioner's staff did not initiate CPR until approximately 4:35 p.m., 30 minutes after staff discovered the full code resident unresponsive. CMS Ex. 10 at 6. It is undisputed that several other nursing staff members were also aware of R64's lack of vital signs, but none of them immediately initiated CPR either. CMS Ex. 9 at 12; *see also* CMS Ex. 10 at 1-6.

The uncontroverted evidence thus establishes that Petitioner's staff did not follow the code management policy's plain language to immediately initiate CPR for a full code resident when facility staff observed R64 unresponsive and with no vital signs. This is further justification that Petitioner, therefore, failed to provide the necessary care and services to R64 under 42 C.F.R. § 483.25.

Petitioner argues that it attempted to provide the care that complied with R64's family's wishes. P. Br. at 1, 9. R64's guardian completed a Do Not Resuscitate status form on admission, only one month before the incident described above. P. Ex. 1 at 24. Petitioner argues that where R64 had a valid advanced directive, it was not required to administer CPR. P. Br. at 7-9. Petitioner points to the fact that R64's family filed a complaint against Petitioner because CPR was performed on R64, and R64 was transferred to a hospital against the family's wishes when the family wanted R64 to expire peacefully at the facility. CMS Ex. 8 at 4-5. Petitioner therefore ultimately argues that Nurse 1's 30 minute delay in initiating CPR was justifiable because R64's family created an ambiguity to the resident's advance directive by failing to obtain a physician's order to not resuscitate R64. P. Br. at 9.

However, even if I accept all of those facts as true, due to Petitioner's inactions R64 was technically a full code resident, and the form R64's guardian signed, without the required

physician's order, was not valid according to Petitioner's own policy. Moreover, the facility's advanced directive policy similarly stated that "all residents without a physician signed DNR will be treated as Full Code until signed by a physician." CMS Ex. 14 at 2. The facility staff simply did not take the necessary steps *at the time* the guardian informed the admissions staff of those wishes. To attempt to later comply with the guardian's true wishes at the moment when R64 showed no vital signs was too late and illustrates the need for Petitioner to follow its policies in order to avoid the unnecessary confusion occurring at the time of this emergency.

4. The undisputed evidence establishes that Petitioner did not provide necessary care and services to R64 when Petitioner did not initiate CPR immediately to a full code resident in accordance with AHA Guidelines, the accepted professional standards of care.

The Board has recognized AHA Guidelines as the accepted standard of professional care in situations where a nurse finds a resident with no vital signs under 42 C.F.R. § 483.25. *Woodland Oaks Healthcare Facility*, DAB No. 2355, at 15-16 (2010); *Lakeridge Villa Healthcare Ctr.*, DAB No. 2396, at 7-13 (2011); *John J. Kane Reg'l Ctr.-Glen Hazel*, DAB No. 2068, at 10-18 (2007). AHA guidelines on CPR state that potential rescuers should immediately provide CPR unless: (1) there is a DNR order; (2) there are signs of irreversible death, such as rigor mortis, decapitation, decomposition, or dependent lividity; (3) no physiological benefit can be expected because vital signs have deteriorated despite maximal therapy (e.g., progressive septic or cardiogenic shock); or (4) an attempt to perform CPR would put the rescuer at risk for physical injury. CMS Ex. 21 at 17; CMS Ex. 20 at 3, ¶7. Petitioner does not claim that any of the AHA exceptions to providing CPR were applicable in this case, and the contemporaneous nursing records do not indicate that nursing assessed R64 for possible excepted signs such as rigor mortis or dependent lividity.

The surveyor asserts, and Petitioner does not dispute, that nurses are trained in AHA Guidelines. Even if a resident exhibits signs of death, the caregiver still has a duty to provide CPR because one of the goals of CPR, according to AHA Guidelines, is the reversal of clinical death even though the outcome is achieved in only a minority of cases. *John J. Kane Reg'l Ctr.-Glen Hazel*, DAB No. 2068, at 17. AHA Guidelines state that basic life support training directs that potential rescuers immediately start CPR for a resident without a valid DNR order or other properly signed advanced directive because any delay dramatically reduces the chances of survival. CMS Ex. 21 at 17.

The DON's disciplinary report concerning Nurse 1, sent to the Ohio Board of Nursing, reports that four nurses knew about R64's full code status, and none of them initiated CPR until a fifth nurse initiated CPR at 4:35 p.m., 20-30 minutes after Nurse 1 discovered R64 without vital signs. CMS Ex. 10 at 12. The standard of practice does not allow a nurse discretion to decide not to perform CPR on a full code resident. CMS Ex.

20 at 3-4, ¶ 8; *see Lakeridge Villa*, DAB No. 2396, at 19. The facility's root cause analysis states that an interview with Nurse 1 revealed that "she was in fact aware that she should have verified the code status immediately upon finding [R64] without vital signs and initiated CPR as per nursing standards of practice." CMS Ex. 16 at 1.

5. Petitioner was responsible for its employee's actions as a matter of law.

Petitioner acknowledged its employee's noncompliance when it terminated Nurse 1 on October 29, 2013 for "failure to perform CPR on a full code resident" and "falsification of documents." CMS Ex. 11 at 1; *see also* CMS Ex. 10-at 7-8. The disciplinary report Petitioner sent to the Ohio Board of Nursing concerning Nurse 1 (CMS Ex. 10 at 12) and the root cause investigation that determined that the failure to provide timely CPR to R64 was a "deficient practice" also highlight nursing staff's noncompliance. CMS Ex. 16 at 1.

Petitioner argues, however, that it cannot be held liable for the actions of Nurse 1, an employee with 17 years of experience, who had received appropriate training from the facility and who had an unblemished work record while the facility employed her. P. Br. at 12-13. Petitioner asserts that it did the required background checks on Nurse 1, it adequately supervised Nurse 1, and Nurse 1 successfully completed a course entitled "CPR/AED for the Professional Rescuer and the Healthcare Provider Challenge." P. Br. at 4, 13; P. Ex. 2 at 83.

For purposes of summary judgment, I will assume all of these assertions are true. Despite Petitioner's assertions regarding the vigilance of its screening, training, and supervision, a facility is accountable for the actions of its staff because it is those actions which comprise the care the residents receive. A "facility acts through its staff, and is correspondingly responsible for their actions as employees." *Royal Manor*, DAB No. 1990, at 12 (2005). Employees are the agents of their employers, "empowered to make and carry out daily care decisions." *Emerald Oaks*, DAB No. 1800, at 7 n.3 (2001). The fact that Petitioner investigated and then terminated the offending employee does not insulate it from a finding of noncompliance. *Sunshine Haven Lordsburg*, DAB No. 2456, at 16-17 (2012); *Franklin Care Ctr.,* DAB No. 1900, at 8 n.4 (2003). When an employee errs, that error must be evaluated as if committed by the facility itself. *See Life Care Ctr. of Gwinnett,* DAB No. 2240, at 13 n.9 (2009).

C. The undisputed evidence establishes that Petitioner was not in substantial compliance with 42 C.F.R. § 483.15(g)(1) because Petitioner's social services director failed to comply with Petitioner's policy and ensure that R64's code status documentation was completed.

A facility must provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for each resident. 42 C.F.R. § 483.15(g). The facility's code status policy assigns the duty to follow-up on code status to both the nursing staff and the social services director. The code status policy states that, "[t]he admitting nurse will discuss options with the resident and or his/her responsible party. . . . All Full Code or code status not addressed upon admission will be followed up by the Unit manager, D.O.N., or charge nurse the following day. . . . Failure to address code status upon admission will result in disciplinary action." CMS Ex. 14 at 1.

The facility's social service director's notes for September 11, 2013 state that R64's guardian reported that R64 was a DNR, "however, [zero] paperwork or DNR consent [was completed]. [R64] will remain a full code at [the facility] until DNRCC & DNRCCA is explained & one or the other is chosen." CMS Ex. 13 at 48. The social services director, who was also the admitting nurse, told the surveyor that she told R64's guardian to go to the nurse's station to complete the DNR form and have a physician sign it. She reportedly further explained to the family member that R64 would be considered full code until the proper paperwork had been completed. CMS Ex. 12 at 8. However it is undisputed that the social services director never followed up with the family when she did not get a properly signed DNR form. As stated in the facility's root cause analysis, R64's "code status was not followed up on by the social services designee . . . . [and consequently] the Resuscitate/Do Not Resuscitate [the status form] was removed from the admission paperwork." CMS Ex. 16 at 1. The social services director's noncompliance with the policy to follow up on R64's DNR status ultimately deprived the resident and his guardian of the choice to not have resuscitation efforts when staff found him without vital signs.

D. The undisputed evidence establishes that Petitioner was not in substantial compliance with 42 C.F.R. § 483.75(l)(1) because Petitioner's medical records included inaccurate documentation.

A facility must maintain clinical records that are complete and accurately documented in accordance with professional standards. 42 C.F.R. § 483.75(l)(1). Nurse 1's nursing notes indicated the wrong date (October 28 instead of October 27) and falsified records to make it look like CPR was initiated immediately to R64. Specifically, Nurse 1's nursing notes stated that at 4:15 p.m. R64's vital signs ceased and that CPR was immediately started when Petitioner's investigation actually established that Nurse 5 started CPR at 4:35 p.m. CMS Ex. 13 at 41; CMS Ex. 10 at 7; CMS Ex. 12 at 8. The DON reported

Nurse 1's falsification to the Ohio Board of Nursing and "falsification of documents" was one of the grounds for terminating Nurse 1. CMS Ex. 10 at 12, CMS Ex. 11 at 1. Petitioner agrees that the DON reviewed R64's medical records and found that the nurse had incorrectly documented the relevant events. P. Br. at 5; P Ex. 2 at 15.

Petitioner asserts that it kept records in accordance with state law, took corrective action by auditing files on resident code status, self-reporting the incident within 24 hours, and terminating Nurse 1. P. Br. at 5, 9-12. For purposes of summary judgment I accept all those facts as true. However, it is undisputed that Petitioner terminated Nurse 1, in part, because of falsification of documents, and Petitioner sent a disciplinary report about Nurse 1 to the Ohio Board of Nursing for inaccurate documentation, which is sufficient to sustain the deficiency here.

E. The undisputed evidence establishes that CMS's determination of immediate jeopardy was not clearly erroneous.

The state agency and CMS assert that Petitioner's noncompliance with the quality of care deficiency constituted immediate jeopardy for two days from October 27, 2013 through October 28, 2013. "Immediate jeopardy" exists if a 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. The regulation does not require that a resident actually be harmed. *See Lakeport Skilled Nursing Ctr.*, DAB No. 2435, at 8 (2012). An immediate jeopardy determination must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board directs that the "clearly erroneous" standard imposes a heavy burden on facilities to overcome and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *See Barbourville Nursing Home*, DAB No. 1962, at 11 (2005) (*citing Florence Park Care Ctr.*, DAB No. 1931, at 27-28 (2004)).

Petitioner argues that CMS could only sustain its burden of proof by showing that Nurse 1's delay in administering CPR was "more probable than not" the cause of R64's death. P. Br. at 14. However, there is no requirement that a resident actually suffer harm for an immediate jeopardy determination. CMS's determination is not clearly erroneous here because the undisputed evidence establishes several nurses on Petitioner's staff did not immediately initiate CPR to a full code resident despite the multiple requirements to do so, and any delay in initiating CPR dramatically reduces chances of survival. *See* CMS Ex. 21 at 17 (*2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science*).

In a similar case, the Board affirmed a $4550 per day CMP as reasonable when it was imposed for the immediate jeopardy level noncompliance involving the failure to perform CPR and characterized it as a "basic life-saving procedure." *Brian Ctr. Health & Rehab./Goldsboro*, DAB No. 2336, at 13 (2010).

The facility's burden of demonstrating clear error in CMS's immediate jeopardy determination "extends to overcoming CMS's determination as to how long the noncompliance remained at the immediate jeopardy level." *Azalea Court*, DAB No. 2352, at 17 (2010), *citing Brian Ctr. Health & Rehab./Goldsboro*, DAB No. 2336, at 7. As the Board concluded in *Brian Ctr.*, "[a] determination by CMS that a [facility's] ongoing [noncompliance] remains at the level of immediate jeopardy during a given period constitutes a determination about the 'level of noncompliance' and, therefore, is subject to the clearly erroneous standard of review under section 498.60(c)(2)." *Brian Ctr.* at 7-8. The Board has also concluded that "[t]he burden is on the facility to show that it timely completed the implementation of [its] plan [of correction] and in fact abated the jeopardy (to reduce the applicable CMP range) or achieved substantial compliance (to end the application of remedies)." *Lake Mary Healthcare*, DAB No. 2081, at 29 (2007), *citing*, *e.g.*, *Spring Meadows Health Care Ctr.*, DAB No. 1966; *see also Brian Ctr.* at 9; *Azalea Court* at 21 (*both citing Lake Mary*).

Petitioner argues it should not be subject to immediate jeopardy determinations for two days when it has taken corrective action to resolve any allegations of immediate jeopardy within 24 hours. P. Br. at 15-16. For purposes of summary judgment, I will assume Petitioner abated the immediate jeopardy causes within 24 hours. Nevertheless, it is undisputed that Petitioner's corrective actions spread out over both October 27 and 28, 2013, which is enough to sustain CMS's determination for the duration including both dates. P. Br. at 15-16.

F. The undisputed evidence establishes the CMPs that CMS imposed are reasonable in amount and duration.

CMS must consider several factors when determining the amount of a CMP, which an ALJ considers de novo when evaluating the reasonableness of the CMP that CMS imposed: (1) the facility's history of noncompliance; (2) the facility's financial condition, i.e., its ability to pay the CMP; (3) the severity and scope of the noncompliance, the "relationship of the one deficiency to other deficiencies resulting in noncompliance," and the facility's prior history of noncompliance; and (4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. 42 C.F.R. §§ 488.438(f), 488.404(b), (c).

A CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of a CMP, $3,050 per day to $10,000 per day, is reserved for deficiencies that pose immediate jeopardy to the health and safety of 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, $50 to $3,000 per day, is reserved for deficiencies that do not pose 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). In assessing the reasonableness of a CMP amount, an ALJ looks at the per day amount, rather than the total accrual. *Kenton Healthcare, LLC*, DAB No. 2186, at 28 (2008). The regulations leave the decision regarding the choice of remedy to CMS and the amount of the remedy to CMS and the ALJ, requiring only that the regulatory factors at 42 C.F.R. §§ 488.438(f) and 488.404 be considered when determining the amount of a CMP within a particular range. 42 C.F.R. §§ 488.408,(g)(2), 498.3(d)(11); *see also* 42 C.F.R. § 488.438(e)(2); *Alexandria Place*, DAB No. 2245, at 27; *Kenton Healthcare, LLC*, DAB No. 2186, at 28-29. Unless a facility contends that a particular regulatory factor does not support the CMP amount that CMS imposed, the ALJ must sustain it. *Coquina Ctr.*, DAB No. 1860, at 32 (2002).

Petitioner has the burden to introduce evidence or argument challenging the specific regulatory factors for determining the reasonableness of the CMP amount. *Ridgecrest Healthcare Ctr.*, DAB No. 2493, at 12 (2013), *quoting The Windsor House*, DAB No. 1942, at 62 (2004). Moreover, there is "a presumption that CMS has considered the regulatory factors" in setting the amount of the CMP "and that those factors support" the CMP amount CMS imposed. *Id.* at 13, *quoting Coquina Ctr.*, DAB No. 1860, at 32 (2002).

Here, Petitioner does not come forward with evidence challenging any regulatory factor or that it came into substantial compliance earlier that November 21, 2013. Petitioner's plan of correction stated that its DON would conduct an in-service on November 20, 2013 on how to address code status upon admission, how to find code status documents in the medical record, falsification of medical records, and revised policies. CMS Ex. 5, at 2, 6, 16. Petitioner did not complete this training until November 20, 2014. CMS Ex. 16 at 23-26. The plan of correction also stated that Petitioner's unit managers completed the verification of all resident code statuses with the residents, or their responsible parties, by November 21, 2013. CMS Ex. 5 at 6; CMS Ex. 16 at 19-22.

IV. Conclusion

I grant CMS's motion for summary judgment finding the undisputed evidence established that Petitioner was not in compliance with Medicare requirements and that CMS's determination of immediate jeopardy to residents' health and safety was not clearly erroneous. Petitioner has not come forward with any evidence to successfully challenge

the deficiencies or the reasonableness of the CMP that CMS imposed, and Petitioner must pay the $11,400 total penalty.

/s/
Joseph Grow
Administrative Law Judge