Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Woodland Oaks Healthcare Facility
(CCN: 18-5392),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-09-340

Decision No. CR2175

Date: July 07, 2010

DECISION

Petitioner, Woodland Oaks Healthcare Facility (Petitioner or facility), is a long-term care facility, located in Ashland, Kentucky, that participates in the Medicare program. The Centers for Medicare and Medicaid Services (CMS) determined that the facility was not in substantial compliance with Medicare requirements and that its deficiencies posed immediate jeopardy to resident health and safety. Among other problems, facility staff disregarded a resident's advance directive and failed to administer cardio-pulmonary resuscitation (CPR) to her when she went into cardiac arrest. CMS has imposed a civil money penalty (CMP) of $4,550 per day for 23 days of immediate jeopardy (total $104,650). Although Petitioner concedes its substantial noncompliance, it challenges the immediate jeopardy level deficiencies and the amount of the civil money penalty.

For the reasons set forth below, I find that the facility was not in substantial compliance with Medicare program requirements; its deficiencies posed immediate jeopardy to resident health and safety; and the penalty imposed is reasonable.

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 other 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 January 12, 2009, CMS determined that the facility was not in substantial compliance with the following Medicare participation requirements:

- 42 C.F.R. § 483.10(b)(11) (Tag F157 – notification of changes) at a D level of scope and severity (isolated instance of noncompliance that causes no actual harm with the potential for more than minimal harm);

- 42 C.F.R. § 483.13(c) (Tag F224 – staff treatment of residents) at a K level of scope and severity (pattern of noncompliance that poses immediate jeopardy to resident health and safety);

- 42 C.F.R. §§ 483.20(d)[1] and 483.10.(k)(2) (Tag F280 – comprehensive care plans) at a D level of scope and severity;

- 42 C.F.R. § 483.20(k)(3)(ii) (Tag F 282 – comprehensive care plans) at a K level of scope and severity;

- 42 C.F.R. § 483.25 (Tag F309 – quality of care) at a K level of scope and severity;

- 42 C.F.R. § 483.75 (Tag F490 – administration) at a K level of scope and severity;

[1] CMS cites to 42 C.F.R. § 483.20(d)(3), but that regulation contains no sub-section (3).

- 42 C.F.R. § 483.75(l)(1) (Tag F514 – clinical records) at an E level of scope and severity (pattern of noncompliance that causes no actual harm with the potential for more than minimal harm); and

- 42 C.F.R. § 483.75(o)(1) (Tag F520 – quality assessment and assurance) at a K level of scope and severity.

CMS Ex. 1; CMS Ex. 10 at 7. CMS subsequently determined that the facility returned to substantial compliance on January 16, 2009. CMS has imposed a CMP of $4,550 per day for 23 days of substantial noncompliance (December 24, 2008 -- January 15, 2009) against the facility, for a total CMP of $104,650. CMS Closing Brief (CMS Cl. Br.), Attachments A and B.

Petitioner timely requested a hearing. In its hearing request, Petitioner disputes the five deficiencies cited at the immediate jeopardy level: 42 C.F.R. §§ 483.13(c); 483.20(k)(3)(ii); 483.25, 483.75; and 483.75(o)(1). Tr. at 5-6. Petitioner does not dispute the remaining three deficiencies, which are therefore final and binding and establish that the facility was not in substantial compliance with program requirements. 42 C.F.R. § 498.20(b). By themselves, these three deficiencies provide a sufficient basis for imposing a penalty. Act § 1819(h); 42 C.F.R. § 488.402.

I convened a hearing via video teleconference on January 14, 2010. Because one of Petitioner's witnesses was not then available, we completed the hearing by telephone conference call on January 22, 2010. Ms. Cheryl A. Harrison appeared on behalf of Petitioner, and Ms. Gwendolyn L. Johnson appeared on behalf of CMS. I have admitted into evidence CMS Exs. 1-13 and CMS Ex. 15, as well as P. Exs. 1-7 and P. Exs. 9-11. Tr. at 10. The parties have filed pre-hearing briefs (CMS Br.; P. Br.), closing briefs (CMS Cl. Br.; P. Cl. Br.), and reply briefs (CMS Reply; P. Reply).

II. Issues

1. Whether, from December 24, 2008, through January 15, 2009, the facility was in substantial compliance with 42 C.F.R. §§ 483.13(c) (Tag F224), 483.20(k)(3)(ii) (Tag F282), 483.25 (Tag F309), 483.75 (Tag F490), and 483.75(o)(1) (Tag F520).

2. Did the facility's deficiencies pose immediate jeopardy to resident health and safety?

3. Is the CMP imposed -- $4,550 per day -- reasonable?

Summary of Prehearing Conference at 2; Tr. at 9.

III. Discussion

A. Because facility staff failed to honor a resident's advance directive that she be administered CPR, the facility was not in substantial compliance with 42 C.F.R. §§ 483.13(c), 483.20(k)(3)(ii), 483.25, and 483.75.[2]

Regulatory requirements: Under the statute and the "quality of care" regulation, each resident must receive, and the facility must 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. Act § 1819(b); 42 C.F.R. § 483.25.

The facility must develop for each resident a comprehensive care plan that describes the services that are to be furnished, and those services *must* be provided by qualified persons "in accordance with each resident's written plan of care." 42 C.F.R. § 483.20(k)(3)(ii).

Facilities must develop and implement written policies and procedures that prohibit resident neglect. 42 C.F.R. § 483.13(c). "Neglect" means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. 42 C.F.R. § 488.301. *See Jennifer Matthew Nursing & Rehab. Ctr.*, DAB No. 2192, at 19 (2008). Among other requirements, the facility must ensure that all alleged violations involving neglect are "reported immediately" to the facility's administrator and to the appropriate state officials. 42 C.F.R. § 483.13(c)(2). It must have evidence that all alleged violations are thoroughly investigated, and the results of any investigation must be reported to the administrator or his designee and to the appropriate state officials within five working days. 42 C.F.R. § 483.13(c)(3), (4).

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

---

[2] My findings of fact/conclusions of law are set forth, in italics and bold, in the discussion captions of this decision. I do not here address the facility's compliance with 42 C.F.R. § 483.75(o)(1), because I find that the other cited deficiencies are sufficient to support the remedies imposed. (42 C.F.R. §§ 483.13(c), 483.20(k)(3)(ii), 483.25, and 483.75 along with the deficiencies that Petitioner did not appeal (42 C.F.R. §§ 483.10(b)(11), 483.20(d), 483.10(k)(2), and 483.75(l)(1)). *See Claiborne-Hughes Health Ctr., No. 09-3239 at 11 (6th Cir. 2010); Carrington Place of Muscatine*, DAB No. 2321, at 20-21 (2010).

Facility policies. The facility had in place written policies, with which CMS apparently finds no fault, that generally reflect the regulatory requirements. Its written policy prohibiting abuse and neglect provides:

> any employee who has reasonable cause to believe or even suspect that a resident has suffered . . . neglect must report the incident immediately. . . . Abuse or suspicion of abuse includes . . . neglect or failure to respond to a resident's needs. . . . This report must be given **immediately** to his/her supervisor and the Administrator or his/her designee.
>
> The incident will then be reported **immediately** to Licensing and Regulation and Adult Protective Services, according to Kentucky State Statute. An in-house investigation will be conducted and completed within 5 working days.

P. Ex. 1 at 12 (emphasis in original). A separate policy defines neglect as "failure to provide the services necessary to avoid physical harm, mental anguish, or mental illness." P. Ex. 1 at 28.

With respect to honoring a resident's advance directive, the facility's policy statement mandates that advance directives be determined at the time of a resident's admission and that "facility staff will comply to [sic] their decision." CMS Ex. 5 at 49. To accomplish this, new admissions were to complete either a "Do Not Resuscitate" (DNR) form or a "Full Code" form, which would be placed under the advance directives section of the resident's chart. A red dot sticker would be put on the exterior spine of the resident record for those requesting DNR code status, and the resident's code status would be listed in his/her comprehensive care plan. CMS Ex. 5 at 49; Tr. at 145. According to Tiffany Evans, the facility's Director of Nursing (DON), before initiating or withholding CPR, a nurse could not rely on the presence or absence of the red sticker but was required to "confirm the status by reviewing the physician's orders. . .." P. Ex. 7 at 2 (Evans Decl. ¶ 10). She estimated that it would "probably" take only 30 to 45 seconds to ascertain a resident's code status. Tr. at 72.[3]

[3] Petitioner concedes that the surveyors found two instances in which a red dot was not affixed to the record of a resident requesting DNR status. P. Cl. Br. at 14-15. Citing the testimony of DON Evans (but no actual written policy or training materials), Petitioner argues that the errors are not significant, because nurses were also required to review the physician's order. I disagree. By incorporating the red sticker system into its procedures, that facility showed that it considered the practice necessary to ensure that staff honor its residents' advance directives. A facility "cannot complain about the surveyor's reliance on the facility's chosen methods." *Claiborne-Hughes Health Ctr.*, No. 09-3239 at 10.

(continued…)

Events surrounding Resident 8's death. Much of this case centers around the care (or lack of care) facility staff provided to Resident 8 (R8) on the day before Christmas, 2008. R8 was an 85-year-old woman suffering from a long list of ailments, including chronic obstructive pulmonary disease, respiratory failure, cerebral palsy, dementia, and depression. She had undergone hip replacement surgery. CMS Ex. 5 at 41; P. Ex. 3 at 1; Tr. at 157-58. Her daughter, who was her legal representative, signed a "Full Code Consent Form" directing that, "in the case of death," staff "use cardiac massage or artificial ventilation to resuscitate . . . her." CMS Ex. 5 at 43.

R8's care plan instructed staff to honor her full code advance directive. CMS Ex. 5 at 75; CMS Ex. 13 at 2-3 (Combs Decl. ¶ 8). Her chart did not have a red dot sticker on its spine. CMS Ex. 13 at 3 (Combs Decl. ¶ 8); CMS Ex. 15 at 3 (Vanlandingham Decl. ¶ 10); Tr. at 25.

Evidence is sparse regarding the events surrounding R8's death. The facility's only contemporaneous documents were a brief nurse's note that Licensed Practical Nurse (LPN) Crystal Shamblin, the LPN assigned to care for R8 that day, wrote and an even briefer Nursing Discharge Summary that LPN Shamblin also prepared. Other nurses were involved in the decision not to resuscitate R8, but they did not then document the events. Until the time of the survey, the facility conducted no investigation at all, and, as discussed below, its belated inquiry was simply inadequate.

Nevertheless, the most reliable evidence establishes the following:

According to the nurses' notes, on the night of December 23, 2008, R8 was alert and oriented, her breathing unlabored, displaying no signs or symptoms of distress. CMS Ex. 5 at 31.

Yvonne Meadows, the LPN assigned to care for R8 during the night, told Surveyor Timothy Combs that, at 6:00 a.m. on December 24, 2008, a family member, who was also a facility employee, visited R8. The resident was "alert and acting normally." CMS Ex. 13 at 3 (Combs Decl. ¶ 9); Tr. at 66, 67.

Nursing Assistant Randi Shannon told Surveyor Combs that, while preparing residents for breakfast at about 7:00 a.m., she found R8 unresponsive and breathing with difficulty. She repositioned the resident so that she could breathe more easily and called LPN Shamblin. CMS Ex. 13 at 3 (Combs Decl. ¶ 9); CMS Ex. 5 at 23; Tr. at 59, 67.

---

[3](…continued)
Nevertheless, I need not rely on that finding, because the staff's failure to honor R8's wishes is, by itself, sufficient to establish the facility's substantial noncompliance.

In a nurse's note, LPN Shamblin wrote that, when she entered R8's room at 7:15 a.m., R8's respiration "seemed shallow, no pulse [was] palpable." She was "unable to obtain [R8's] blood pressure." LPN Shamblin called in a second nurse "to confirm no pulse, resp[iration, or] blood pressure." CMS Ex. 5 at 31. According to a late entry in the notes, at 7:22 a.m., "after assessing [the] resident, nurse aid[e] brought crash cart to room," another nurse was called over to assist, and the DON was notified. At 7:28 a.m., LPN Shamblin notified the family. At 7:31, she called the attending physician who pronounced R8 dead. The funeral home picked up the remains at 8:55 a.m. CMS Ex. 5 at 31; P. Ex. 1 at 15.[4]

LPN Shamblin's note likely misstates the exact timing of events, since Emergency Medical Service (EMS) records reflect that the facility called them at 7:09 a.m. and called back four minutes later (7:13 a.m.) to cancel, advising that the resident "has been down for approx[imately] 30 min[utes]." CMS Ex. 5 at 33. Nevertheless, the documents are consistent in establishing that mere minutes elapsed between staff's discovery of R8 in respiratory distress and staff's decision to deny her CPR.

The discharge summary provides no additional information. It says that, at the time of discharge, the resident's respiratory status was "absent," and her skin was "cool, pale." In the section labeled "complete summary from admission to discharge," the form says only: "absent pulse, resp[iration,] blood pressure." It says that the resident was pronounced dead at 7:31 a.m. CMS Ex. 5 at 57.

Petitioner concedes, as it must, that its nurses failed to honor R8's advance directive, but argues that any attempt to resuscitate R8 would have been futile, so they were not required to try. Petitioner points to a 2003 advisory opinion from the Kentucky Nursing Board that says a nurse would not start CPR if "obvious signs of death" are present and lists as the most reliable signs of death: dependent livido (general bluish discoloration of the skin as in pooling of blood in dependent body parts); rigor mortis (hardening of muscle or rigidity); algo mortis (cooling of the body following death); and injuries that are incompatible with life. P. Ex. 1 at 31. Similarly, the American Heart Association guidelines provide that CPR should not be administered if the patient has "signs of irreversible death" (e.g. rigor mortis, decapitation, decomposition, or dependent lividity). P. Ex. 2 at 3-4.

---

[4] The record is a little confusing as to how staff determined R8's code status. LPN Shamblin told the surveyors that she did not know R8's code status (nor the code status of any other resident in the facility). She did not check R8's chart. She simply assumed that she was a no-code and made no effort to resuscitate the resident. CMS Ex. 13 at 3 (Combs Decl. ¶ 10); CMS Ex. 5 at 20; Tr. 44. On the other hand, it appears that one of the nurses correctly ascertained R8's code status, and staff started to respond – calling EMS and taking the crash cart to R8's room – so identifying R8's code status does not seem to have been the problem here.

I accept that nurses should not attempt CPR if the individual is obviously "irreversibly dead," and I accept that the signs of irreversible death include lividity, rigor mortis, and algo mortis. I do not accept that R8 displayed any of these symptoms when staff declined to honor her advance directive. I find self-serving and unreliable the unsworn and after-the-fact nurses' statements that Petitioner relies on to establish that R8 was irreversibly dead when they declined to administer CPR.

As noted in the above discussion, only LPN Shamblin contemporaneously documented the events surrounding R8's death, and she did not mention any signs of irreversible death. After the surveyors raised their concerns about the incident, facility management obtained statements from the other nurses, along with a new, and not completely consistent, statement from LPN Shamblin. Tr. at 76.

In her undated statement, LPN Shamblin says that, when the nurse aide called her to R8's room at 7:00 a.m., she could not find a pulse or obtain a blood pressure reading. Except for the time difference (7:00 a.m. vs. 7:15 a.m.), this statement is consistent with her earlier note. But then she adds that the resident was "cold to touch, yellow skin, black colored lips," and she omits any mention of respiration. She says that she went to the nurses' station to check the resident's code status and to "get other nurse to assess [and] assist." The nurse aide took a crash cart to the room. According to the note, someone, presumably LPN Shamblin, "called 911 and notified family." The note also says that, before LPN Shamblin returned to R8's room (she does not specify the time), the nurses and aides were leaving with the crash cart, saying that "resident had been gone for a half hour or so." P. Ex. 1 at 22.

Two other LPNs, Julie Hall and Katie Washburn, wrote short notes, dated January 6, 2009. They both say that LPN Shamblin asked them to check on R8. They went into the room and saw the crash cart by the door. The resident was cold to the touch, joints stiff, no palpable pulse, no respirations noted, heart rate absent. P. Ex. 1 at 23, 24.

In a statement dated January 22, 2009, ten days after the survey and a month after the incident, LPN Michelle Monroe wrote that an aide summoned LPN Shamblin to R8's room. LPN Shamblin came out of the resident's room and said that the resident was not breathing. LPN Monroe then went to R8's room. The resident was not breathing; her skin was pale and cool; her head and neck were "in a flexed fixed position." LPN Monroe then could not detect a pulse. She instructed the aide to get the crash cart. But, as she was rolling down the bed, "Julie and Katie" came in. "After Julie's assessment, she stated there was no reason to start chest compressions, performing CPR would cause more trauma to the body than necessary." P. Ex. 1 at 25.

I note first that none of these nurses testified. Three of them, LPNs Monroe, Hall, and Washburn, are currently employed by the facility. At Petitioner's request, I issued subpoenas compelling them to appear at the hearing.[5] They appeared with their own counsel but, citing the Fifth Amendment, declined to answer any questions relating to the incident of December 24, 2008. Tr. at 105, 106, 108, 109. So, no witness has sworn to the accuracy of these statements nor been subject to cross-examination.

Second, I find it suspicious that no one mentioned any signs of irreversible death until *after* the surveyors raised their concerns. I consider more reliable the contemporaneous notes. *See Jennifer Matthew*, DAB No. 2192, at 10-11 (2008) (According more weight to eyewitness contemporaneous statements is "perfectly reasonable," especially where no eyewitness testified and contemporaneous statements are corroborated by other evidence.); *Bergen Reg'l Med. Ctr.*, DAB No. 1832 (2002). Because the December 24 note describes R8's breathing and does not mention any signs of lividity, rigor mortis, or algo mortis, I find it far more likely that R8 displayed no signs of irreversible death when the nurses declined to administer CPR. Clinical records are supposed to be complete and accurate. 42 C.F.R. § 483.75(l)(1).[6] If such significant findings had been present, someone would have documented them at the time. Indeed, the facility's medical director, Dr. John Bond, testified that he would expect the nurse's note to reflect "signs of rigor, patient was cold, patient had no corneal reflex." Tr. at 166-67;[7] *accord Claiborne-Hughes Health Ctr.*, No. 09-3239 at 9 ([I]f staff had observed extreme symptoms, they would have recorded them).

Third, although the record does not definitively establish how long it would take for the signs of irreversible death to occur, it seems highly unlikely that R8 had stopped breathing long enough to have exhibited the signs of irreversible death described in the Monroe, Hall, Washburn, and Shamblin after-the-fact statements. The more reliable evidence establishes that R8 was awake, alert, and talking at 6:00 a.m. She was in distress but breathing at 7:00 a.m. and still exhibited signs of breathing when LPN Shamblin entered her room, probably just minutes before the 7:09 a.m. call to EMS. I do not accept that R8 developed signs of irreversible death between then and 7:13 a.m., when the facility cancelled the EMS call.

---

[5] Although Petitioner listed her on its initial witness list, it neither requested a subpoena for, nor provided any testimony from, LPN Shamblin.

[6] Petitioner's claim that inadequate documentation cannot formulate the basis for citation or imposition of CMP is thus simply wrong. P. Reply at 5. I note also that CMS cited a clinical records deficiency, which Petitioner did not appeal. Since I do not find credible the nurses' after-the-fact descriptions of irreversible death, I find it appropriate that the survey report form does not mention R8 under its discussion of 42 C.F.R. § 483.75(l)(1).

[7] No evidence suggests that anyone checked for corneal reflex.

Surveyor Combs, himself a registered nurse, testified that it is very difficult to determine that someone has been dead to the point that resuscitation is futile, particularly if that determination is based on rigor mortis and algo mortis, because multiple factors determine the speed at which those phenomena occur. Tr. at 64. He opined that not enough time elapsed following the observation of "shallow breathing" (as described in the nurse's note) to make plausible the determination that resuscitation would be futile. Tr. at 65.

Petitioner offers no evidence as to how long it takes for an individual to exhibit signs of irreversible death. Dr. Bond instead focused on when it would be futile to initiate CPR, but his answers were equivocal. He opined generally that nursing home residents would almost never benefit from resuscitation efforts. Tr. at 176-77. When pressed for specific examples of when it would not be necessary to initiate CPR, he referred to someone having "passed away within probably an hour or two or longer. . .." Tr. at 151. But he later said that it is futile to perform CPR on someone who has been without blood pressure or pulse for eight minutes. Tr. at 184. On the other hand, he agreed that if someone thought she observed a full-code resident breathing within the last few minutes, "they need to start CPR." Tr. at 162-63. Based solely on the information contained in the nurse's note (without considering the statements drafted by the nurses during and after the survey), he conceded that it would "probably" have been "not inappropriate" to begin CPR. Tr. at 180.

Finally, I note that the nurses' after-the-fact statements are not consistent with the observations of others who handled the body after R8 had been pronounced dead. Nursing Assistant Shannon provided post-mortem care. She told the surveyors that R8's body seemed normal, except for the "pasty" color. She observed no blue or dark discoloration to the resident's back (signs of lividity). CMS Ex. 1 at 8-9. Petitioner did not produce Ms. Shannon nor anyone else to refute this evidence.

Even more significant, the funeral home picked up the body at 8:55 a.m. CMS Ex. 5 at 60; CMS Ex. 1 at 9; Tr. at 171. The attendant who picked up the body told the surveyors that it takes 25-30 minutes to drive from the facility to the funeral home. Based on this, the surveyors reasonably estimated that at least 2.5 hours elapsed between the discovery of the resident in distress and the arrival of her body at the funeral home. But the mortician who embalmed the body told the surveyors that even then R8 had "no pooling of blood or dark discoloration to [her] back. . .. [T]here was slight rigor mortis to the large joint, suggesting the resident had only been dead for a short while." CMS Ex. 1 at 9. That the LPNs described more significant signs of irreversible death than the mortician found at least two hours later seriously undermines the credibility of their statements. CMS Ex. 1 at 9.

Failure to investigate. DON Evans agreed that failing to provide CPR to a full-code resident constitutes neglect. Tr. 79. As discussed above, the regulations and the facility's written policy required staff to report immediately any suspicions of neglect. The report had to be given to the employee's supervisor and to the facility administrator or her designee. The policy promised that the incident would be reported to the appropriate state agency and that an in-house investigation would be conducted and completed within five working days. 42 C.F.R. § 483.13(c)(3), (4); P. Ex. 1 at 12.

None of that happened here. Until the surveyors raised questions, the facility conducted no investigation at all. Administrator Kimberly Tice testified that she did not learn of the incident until the time of the survey. Tr. at 93-94.

DON Evans testified that she reviewed R8's chart shortly after the resident's death and did not note anything amiss. Tr. at 84. I find this surprising, since, according to the chart, this full-code resident went from breathing to "pronounced dead" in no more than fifteen minutes, without any suggestion that staff honored her advance directive.

And the facility's eventual "investigation" was far from adequate. The investigators took no statements from LPN Meadows, Nursing Assistant Shannon, or the employee/family member who saw R8 active and alert at about 6:00 a.m. DON Evans knew that "a statement was given" that R8 was awake and alert and talking to family members at 6:00 a.m. on December 24. She was also aware that a nurse's aide said she noticed labored breathing at 7:00 a.m. and fetched LPN Shamblin. Yet, remarkably, she testified that she did not talk to that nurse's aide. Tr. at 85. Administrator Tice "could not recall" ever having spoken to the nurse's aide. Tr. at 99. It strains credulity that administrative staff charged with investigating an allegation of neglect would not even question the people who apparently last observed R8 alive. This is particularly baffling in light of: 1) the inconsistencies between what Nursing Assistant Shannon told the surveyors and what the LPNs claimed in their statements; and 2) the fact that, unlike the LPNs who opted not to provide CPR, neither Nursing Assistant Shannon nor LPN Meadows had any apparent incentive to be less than forthcoming.

Thus, the facility was not in substantial compliance with **42 C.F.R. § 483.25**. When R8 stopped breathing, her only hope for survival rested with staff providing her CPR during the first critical minutes, as her care plan called for. Since they failed to do so, and she died, I can only conclude that the facility failed to provide her the care and services she needed to maintain her highest practicable physical well-being, in accordance with her comprehensive assessment and plan of care.

I recognize that R8 was seriously ill and likely not looking forward to a much longer life. In *John J. Kane Regional Center – Glen Hazel*, DAB No. 2068 (2007), the Departmental Appeals Board (Board) acknowledged that CPR's goal of reversing clinical death is "achieved in only a minority of cases," but the Board also pointed out that no clear

criteria accurately predict the futility of CPR. *Kane,* DAB No. 2068, at 17. For a resident who stops breathing or goes into cardiac arrest, staff *must* initiate CPR and call the EMS, unless the resident has a valid DNR in place. *Kane,* DAB No. 2068, at 16.

Next, the facility was not in substantial compliance with **42 C.F.R. § 483.20(k)(3)(ii)**. Inasmuch as R8's comprehensive care plan instructed the staff to honor R8's full code advance directive, and the nurses failed to do so, they failed to provide care and services "in accordance with" R8's written plan of care, as that regulation required.

Third, the facility was not in substantial compliance with **42 C.F.R. § 483.13(c)**. Although the facility may have had in place acceptable written policies designed to prevent neglect, and to assure that each resident's advance directive would be honored, it did not implement those policies, as 42 C.F.R. § 483.13(c) requires. Facility nurses neglected to provide R8 the services she needed when she stopped breathing on the morning of December 24, 2008. According to the nurse's note, the facility's DON "was notified" within minutes of LPN Shamblin's assessment, before the resident was pronounced dead. CMS Ex. 5 at 31. But the evidence, or lack of evidence, suggests that she remained uninvolved. DON Evans admitted that she reviewed the resident's chart but took no action. Until the time of the survey, the incident was neither reported nor investigated, even though the regulation and the facility's anti-neglect policy required that the incident be reported immediately to the administrator and to the appropriate state agency and that an in-house investigation be completed and its results reported to the administrator (or her designee) and to the state officials within five working days. P. Ex. 1 at 12. To this day, the facility has not thoroughly investigated the incident, since it has never questioned some key witnesses.[8]

Finally, the facility was not in substantial compliance with **42 C.F.R. § 483.75**. A finding of substantial 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 is 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 Ctr. at Johnson City, DAB No. 1815 at 11 (2002); *Odd Fellow and Rebekah Health Care Facility*, DAB No. 1839 at 7 (2002).

---

[8] By not investigating, the facility loses an opportunity to analyze and correct its problems. *Century Care of Crystal Coast*, DAB No. 2076 at 21 (2007), *aff'd* No. 07-1491, 2008 WL 2385505 (4th Cir. 2008).

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.

Moreover, the failings here are not attributable to a single individual. Four nurses are immediately implicated in the failure to honor R8's advance directive. Management is implicated, because of the DON's failure to act, to report, or to investigate. The administrator is also implicated for failing to investigate adequately, when the incident was finally reported to her. The facility was therefore not administered in a manner that used its resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of its residents.

B. CMS's determination that the facility's deficiencies posed immediate jeopardy to resident health and safety is not clearly erroneous.

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. 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; Florence Park Care Ctr., DAB No. 1931 at 27-28 (2004) (*citing Koester Pavilion*, DAB No. 1750 (2000); *Daughters of Miriam Ctr.*, DAB No. 2067 at 7, 9 (2007)).

Here, four nurses failed to provide CPR to a resident who had stopped breathing, and have not provided any credible explanation for their actions. Failing to provide CPR to a full-code resident who has stopped breathing all but guarantees that resident's death and, thus, poses immediate jeopardy to resident health and safety.[9]

[9] I note also that 29 of 104 facility residents were classified as full code. CMS Ex. 13 at 2 (Combs Decl.); CMS Ex. 1 at 5. Until the facility instituted procedures and training to assure that all full-code directives would be honored, any one of these individuals was at risk.

C. CMS's determinations as to the duration of the periods of noncompliance and immediate jeopardy are consistent with statutory and regulatory requirements.

Substantial compliance means not only that the facility corrected the specific cited instances of substantial noncompliance but also that it implemented a plan of correction *designed to assure that no additional incidents would occur* in the future. Once a facility has been found to be out of substantial compliance (as Petitioner was here), it remains so until it affirmatively demonstrates that it has achieved substantial compliance once again. *Premier Living and Rehab. Ctr.*, DAB No. 2146 at 23 (2008); *Lake City Extended Care*, DAB 1658 at 12-15 (1998). The burden is on the facility to prove that it has resumed complying with program requirements, not on CMS to prove that deficiencies continued to exist after they were discovered. *Asbury Ctr. at Johnson City*, DAB No. 1815 at 19-20 (2002). A facility's return to substantial compliance usually must be established through a resurvey. 42 C.F.R. § 488.454(a). To be found in substantial compliance earlier than the date of the resurvey, the facility must supply documentation "acceptable to CMS" showing that it "was in substantial compliance and *was capable of remaining in substantial compliance*" on an earlier date. 42 C.F.R. § 488.456(e) (emphasis added); *Hermina Traeye Mem'l Nursing Home*, DAB No. 1810 at 12 (2002) (*citing* 42 C.F.R. §488.456(a), (e); *Cross Creek Care Ctr.*, DAB No. 1665 (1998).

Here, Petitioner complains about the duration of the periods of substantial noncompliance and immediate jeopardy, claiming that all deficiencies were corrected by January 6, 2009, when it trained its nurses on implementing advance directives and on CPR. P. Cl. Br. at 20-21. But, by itself, one in-service training session does not establish that the facility has corrected its problems and assured that they will not recur. After all, a serious error occurred here, involving multiple staff members, even though the facility believed that they had been trained adequately. So the facility must not only make sure that its staff is adequately trained, it must thereafter monitor to make sure that the training has resolved the problem.

Moreover, the facility's promised corrective actions were not limited to one in-service training session. The facility conducted additional training on January 15, 2009. CMS Ex. 1 at 17-18. The facility promised that every death would be "immediately" reported to the DON and/or quality assurance nurse, who would review and forward her conclusions to the Administrator. CMS Ex. 1 at 6-7. Any deviation from facility policy would be followed-up with additional training. CMS Ex. 1 at 7. Medical records would be audited monthly. CMS Ex. 1 at 9. The facility promised enhanced oversight by the administrator. CMS Ex. 1 at 10-11. The *facility* repeatedly set January 16, 2009, as the completion date for its corrections. CMS Ex. 1 at 11, 19, 27, 40, 51.

Because Petitioner has not established that an effective plan of correction was implemented any earlier than that determined by CMS, I sustain CMS's determinations as to the duration of the periods of substantial noncompliance and immediate jeopardy.

D. The penalty imposed is reasonable.

I next consider whether the CMPs are reasonable by applying the factors listed in 42 C.F.R. § 488.438(f), which are: 1) the facility's history of noncompliance; 2) the facility's financial condition; 3) factors specified in 42 C.F.R. § 488.404; and 4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort, or safety. The absence of culpability is not a mitigating factor. The factors in 42 C.F.R. § 488.404 include: 1) the scope and severity of the deficiency; 2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and 3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

In reaching a decision on the reasonableness of the CMP, I consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found, and in light of the above factors. I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Ctr.*, DAB No. 1848 at 21 (2002); *Cmty. Nursing Home*, DAB No. 1807, at 21-22. (2002); *Emerald Oaks*, DAB No. 1800 at 9-11 (2001); *CarePlex of Silver Spring*, DAB No. 1683 at 8 (1999).

CMS has imposed a penalty of $4,550 per day, which is at low end of the penalty range for situations of immediate jeopardy ($3,050-$10,000). 42 C.F.R. § 488.438(a)(1).

CMS does not cite facility history as a factor that justifies a higher CMP. Petitioner has not argued that its financial condition affects its ability to pay the penalty.

With respect to the remaining factors, I consider *all* of the facility's deficiencies. In addition to those discussed above, the facility was not in substantial compliance with 42 C.F.R. §§ 483.10(b)(11), 483.20(d), and 483.10(k)(2) at a D level of scope and severity. It was not in substantial compliance with 42 C.F.R. § 483.75(l)(1) at an E level of scope and severity. Any one of these, by itself, would have justified a penalty of at least $50 (and potentially up to $3,000) per day, so they alone justify increasing the CMP above the minimum. 42 C.F.R. § 488.438(a)(1)(ii).

Moreover, the facility here is culpable, because four nurses neglected their direct responsibilities to the resident. Then, when the DON learned of the situation, she dismissed it as insignificant and failed to investigate. Adding to the culpability, when the Administrator finally learned of the incident, the facility conducted a half-hearted and wholly inadequate investigation.

Based on all of these significant deficiencies, I do not find the penalties imposed unreasonable.

IV. Conclusion

For the reasons discussed above, I find that the facility was not in substantial compliance with the Medicare requirements, its deficiencies posed immediate jeopardy to resident health and safety, and I affirm as reasonable the penalty imposed.

/s/
Carolyn Cozad Hughes
Administrative Law Judge