Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

North Las Vegas Care Center,
(CCN: 29-5036),

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-16-97

Decision No. CR4997

Date: December 21, 2017

DECISION

In this disturbing case, a registered nurse left one of the facility's "full-code" residents lying, unresponsive, on the shower-room floor.

Petitioner, North Las Vegas Care Center, is a long-term care facility, located in North Las Vegas, Nevada, that participates in the Medicare program. Following a complaint investigation, completed August 12, 2015, the Centers for Medicare and Medicaid Services (CMS) determined that the facility nurse disregarded professional standards of nursing practice and facility policies, and that her actions put the facility out of substantial compliance with Medicare requirements.

CMS has imposed a civil money penalty (CMP) of $750 per day for 51 days of substantial noncompliance.

CMS moves for summary judgment, which Petitioner opposes. For the reasons set forth below, I grant CMS's motion. I find that the facility was not in substantial compliance with Medicare program requirements, and that the penalty imposed is reasonable.

Background

The Social Security Act (Act) sets forth requirements for long-term care facilities to participate 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.[1] To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to survey skilled nursing facilities in order to determine whether they are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. Each facility must be surveyed annually, with no more than fifteen months elapsing between surveys, and must be surveyed 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. The state agency must also investigate all complaints. Act § 1819(g)(4).

Here, the facility reported to the Nevada Department of Health and Human Services (state agency) that one of its residents was neglected when he was observed lying on a floor. CMS Ex. 6. In response, the state agency sent a surveyor to investigate. The surveyor completed the complaint investigation on August 12, 2015, concluding that the facility did not comply substantially with the quality-of-care regulation, 42 C.F.R. § 483.25 (Tag F309) and that, although isolated, the deficiency caused actual harm to a facility resident (scope and severity level G). CMS Ex. 1. CMS agreed. CMS Ex. 3.

After a follow-up survey, completed on October 2, 2015, CMS determined that the facility returned to substantial compliance on October 1, 2015. CMS Ex. 4. It imposed against the facility a $750 per day penalty for 51 days of substantial noncompliance (August 12 through October 1, 2015). CMS Ex. 4.

Petitioner appealed.

CMS moves for summary judgment. With its motion/pre-hearing brief (CMS Br.), CMS submits 14 exhibits (CMS Exs. 1-14). With its response (P. Br.), Petitioner submits one exhibit (P. Ex. 1).

[1] The regulations governing long-term-care facilities have been revised. 81 Fed. Reg. 68688 (Oct. 4, 2016); 82 Fed. Reg. 32256 (July 13, 2017). I apply the regulations in effect at the time of the survey.

Issues

As a threshold matter, I consider whether summary judgment is appropriate.

On the merits, the issues are: 1) from August 12 through October 1, 2015, was the facility in substantial compliance with 42 C.F.R. § 483.25; and 2) if not, is the $750 per-day penalty reasonable.

Discussion

Summary judgment. Summary judgment is appropriate if a case presents no genuine issue of material fact, and the moving party is entitled to judgment as a matter of law. *Bartley Healthcare Nursing & Rehab.*, DAB No. 2539 at 3 (2013), *citing Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986); *Ill. Knights Templar Home*, DAB No. 2274 at 3-4 (2009), and cases cited therein.

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. v. Dep't of Health & Human Servs.*, 388 F.3d 168, 173 (6th Cir. 2004), *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. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 n.11 (1986); s*ee also Vandalia Park*, DAB No. 1939 (2004); *Lebanon Nursing & Rehab. Ctr.*, DAB No. 1918 (2004). The non-moving party may not simply rely on denials, but must furnish admissible evidence of a dispute concerning a material fact. *Ill. Knights Templar*, 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 (2007); *Livingston Care Ctr.*, 388 F.3d at 172; *Guardian Health Care Ctr.*, DAB No. 1943 at 8 (2004); *but see Brightview*, DAB No. 2132 at 10 (entry of summary judgment upheld where inferences and views of non-moving party are not reasonable). 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. *Cf. 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.").

1. CMS is entitled to summary judgment because the undisputed evidence establishes that one of the facility's registered nurses disregarded professional standards of nursing practice and the facility's written policies when she declined to assess or administer CPR to a resident who was "full code." This puts the facility out of substantial compliance with 42 C.F.R. § 483.25.[2]

Program 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 regulation 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. Leavitt*, No. 04-3018 (6th Cir. 2005); *Woodstock Care Ctr.*, DAB No. 1726 at 25-30 (2000), *aff'd*, *Woodstock Care Ctr. v. Thompson*, 363 F.3d 589 (6th Cir. 2003).

Facility policy. The facility had in place a written "Do Not Resuscitate" (DNR) policy. The policy required that each resident's medical record be flagged to identify the resident's status as "DNR" or "FULL CODE" and that staff then follow the resident's advance directive. The policy also emphasized that, absent any DNR order, staff had to respond to medical emergencies with CPR measures and institute a "FULL CODE." CMS Ex. 7 at 1.

The parties agree that facility nurses must follow the American Heart Association (AHA) guidelines regarding coronary pulmonary resuscitation (CPR). CMS Br. at 5; P. Br. at 11; *see* CMS Ex. 11 at 2 (pointing out that "AHA guidelines for CPR provide the standard for the American Red Cross, state EMS agencies, healthcare providers, and the general public."); CMS Ex. 12 at 2 (Gomez Decl. ¶ 10).

The AHA guidelines call for "*immediate*, high-quality CPR" whenever a healthcare provider recognizes that an individual is not breathing or is not breathing normally. CMS Ex. 10 at 6, 7 (emphasis added). "[B]rain damage begins four to six minutes following cardiac arrest if CPR is not administered during that time." CMS Ex. 11 at 2. In a guidance letter, issued January 23, 2015, CMS reiterated that nursing homes *must* provide basic life support, including initiating CPR, "to any resident who experiences cardiac

[2] My findings of fact/conclusions of law are set forth, in italics and bold, in the discussion captions of this decision.

arrest (cessation of respirations and/or pulse) in accordance with that resident's advance directives. . . ." CPR–certified staff must be available at all times. CMS S&C 14-01-NH; CMS Ex. 14 at 1, 3.

The AHA guidelines characterize as "inappropriate" the practice of making delayed or token efforts, such as "slow-codes." In the AHA's view, "[t]his practice compromises the ethical integrity of healthcare providers, uses deception to create a false impression, and may undermine the provider-patient relationship." CMS Ex. 14 at 29.

Staff failure to follow the facility's DNR policy. Resident 1 (R1) was a 61-year-old man, admitted to the facility on September 11, 2014, for physical therapy, occupational therapy, and medical management. CMS Ex. 8 at 1, 5. He suffered from chronic bilateral lower extremity edema (i.e., his legs swelled), cellulitis, and peripheral vascular disease. He had a history of congestive heart failure, lymphedema, hypertension, and bipolar disorder. *He was full code*. CMS Ex. 8 at 4.

Although the facility did not well-document the events of July 23, 2015, those events are not in dispute. At about 8:30 p.m. that evening, R1 was taking a shower, apparently unsupervised.[3] Sometime thereafter, a registered nurse (RN) entered the shower room and found him lying on the floor. CMS Ex. 8 at 3; P. Ex. 1 at 1 (Fleming Decl. ¶ 3). She did not check his vital signs; she did not begin CPR. CMS Ex. 5 at 3; P. Ex. 1 at 1 (Fleming Decl. ¶ 3). Instead, she found a nurse aide and told him that the resident was on the shower room floor. She offered no assistance but left the nurse aide to address the problem. CMS Ex. 5 at 3, 5; P. Ex. 1 at 1.

The nurse aide went to the shower room, found the resident unresponsive, and reported that to a licensed practical nurse (LPN). The LPN went to the nurses station and told the RN, who said that she knew about the resident but that he "was already gone"; the RN said that she had "pronounced" him dead because "he seemed to be dead." CMS Ex. 5 at 5. The LPN checked the resident's medical record and saw that he was "full code." Only then did staff initiate CPR and call "911." CMS Ex. 5 at 3-5; P. Ex. 1 at 1-2 (Fleming Decl. ¶ 3). The paramedics arrived and continued resuscitation efforts for another 25 minutes, but their efforts were unsuccessful. CMS Ex. 8 at 3.

The facility terminated the RN's employment, finding that she did not follow the facility's policy nor professional standards of nursing practice. CMS Ex. 5 at 5; P. Ex. 1 at 2 (Fleming Decl. ¶ 5).

With rare exceptions (e.g. decapitation), medical personnel should not declare a person dead without checking that person's vital signs. Here, the RN did not check R1's vital

[3] But according to R1's assessment, he required supervision when bathing. CMS Ex. 8 at 8.

signs before she effectively pronounced him dead. In any event, under Nevada law, an RN may pronounce death only under limited circumstances: if the resident's physician anticipates that the resident will die because of an illness, infirmity, or disease, he may authorize the facility's RNs to pronounce death. His authorization must be in writing and entered into the resident's chart. It is valid for 120 days. Nev. Rev. Stat. §§ 440.415; 632.474. R1's chart contained no such order. CMS Ex. 12 at 3 (Gomez Dec.¶ 14). Indeed, nothing in this record suggests that R1's physician anticipated R1's imminent death.

Petitioner disputes none of this but argues that failing to perform CPR did not adversely affect R1's ability to attain or maintain his highest practicable physical well-being because CPR is generally ineffective in the elderly nursing home population. P. Br. at 12. Putting aside the fact that R1 was not a typical nursing home resident, I note that the Departmental Appeals Board has rejected such arguments. In the Board's view, this argument "implies that members of the nursing staff could, in an emergency, choose to disregard an advance directive if they determined, on-the-spot, that CPR would not likely save the resident," a position that has no support in the regulations or standards of care. The Board has recognized a "bright-line rule" with respect to treating residents in distress: a patient without a do-not-resuscitate order *must* be administered CPR unless that resident is irreversibly dead. *Woodland Oaks Healthcare Facility*, DAB No. 2355 at 16 (2010). With respect to the futility argument, the Board pointed out that one of CPR's goals is to reverse clinical death, "even though that outcome is achieved in only a minority of cases." *Id*., *quoting John J. Kane Reg'l Ctr.*, DAB No. 2068 at 16 (2007).

Moreover, R1 did not fall into that category of the "elderly nursing home population" for whom CPR is considered generally ineffective. In its guidance, CMS acknowledges the studies that suggest that CPR is ineffective, but points out that a growing number of residents are younger, i.e. *under 65*, and have been admitted because they require medical care or short-term rehabilitation. These residents are more likely to benefit from CPR. S&C 14-01-NH; CMS Ex. 11 at 2-3.[4] R1 was just 61-years old and admitted to the facility for physical and occupational therapies and medical management, making him one of those "more likely" to benefit from CPR.

Thus, even though R1 was full code, the RN on duty declined to check his vital signs or administer CPR. This puts the facility out of substantial compliance with 42 C.F.R. § 483.25 because its staff declined to provide one of its residents with the care and services he needed.

[4] CMS also reports that a shocking 33% of those nursing home residents who requested CPR did not receive it before the EMS team arrived.

2. CMS's determination as to the duration of the substantial noncompliance is consistent with statutory and regulatory requirements.

Petitioner also complains about the duration of the penalty, claiming that the facility brought itself back into substantial compliance by August 14.

Substantial compliance means not only that the facility corrected the specific cited instances of substantial noncompliance, but also that it implemented a plan of corrections *designed to assure that no future incidents would occur*. A facility remains out of substantial compliance until it affirmatively demonstrates that it has achieved substantial compliance once again. *Life Care Ctr. of Elizabethton*, DAB No. 2367 at 16-17 (2011); *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 Center 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. (Emphasis added) 42 C.F.R. § 488.456(e); *Hermina Traeye Mem'l Nursing Home*, DAB No. 1810 at 12 (*citing* 42 C.F.R. §488.456(a) and (e); *Cross Creek Care Ctr.*, DAB No. 1665 (1998).

Here, Petitioner maintains that it re-educated its staff through training sessions and conducted audits in the form of drills, which were completed on August 14. In addition, the facility's quality assurance committee reviewed the CPR issue at its monthly meetings beginning in September 2015 and continuing through January 2016. Petitioner submits the attendance sheets for the training sessions and drills:

- On July 27, twelve nurses attended a one-hour training session that covered multiple topics: documentation, medication passes, skin checks, "team work," attendance, codes, "nurse of the year," and "CPR Drill." P. Ex. 1 at 10;

- On July 28, a different group of nurses and nurse aides, 9 in all, attended a one-hour training session that covered the same topics. P. Ex. 1 at 11;

- Later in the day (July 28), a third group of nurses, again 9 in all, attended a training session that included "CPR Drill," code status, policy, green/red dot indicators. The session began at 2 p.m., but the attendance sheet does not indicate when it ended. P. Ex. 1 at 12;

- On August 4, a group of 14 nurses and aides participated in a "CPR Code status drill." Six of these do not appear to have attended the earlier training sessions. The attendance sheet does not indicate the duration of the drill. P. Ex. 1 at 13;

- On August 14, 2015, more than 30 members of the nursing staff attended a session described as a "drill" and "see agenda." P. Ex. 1 at 14. The agenda includes a list of sixteen items, one of which refers to code status and CPR. P. Ex. 1 at 15-16.

The facility's deficiency is not the type of deficiency (like a leaky roof or a broken dishwasher) that lends itself to a quick fix. An in-service training and a practice drill or two (whatever that entails) are not sufficient to ensure that a quality-of-care deficiency has been corrected and will not recur. If properly implemented, these interventions might help a facility achieve substantial compliance, but introducing them does not, by itself, establish substantial compliance. Until the facility can demonstrate that its training and other interventions were effective, i.e., that staff capably followed the training, that management put effective monitoring tools in place, and that those interventions resolved the problem, the facility has not met its significant burden of demonstrating that it has alleviated the level of threat to resident health and safety. *Oceanside*, DAB No. 2382 at 19; *Premier Living and Rehab. Ctr.*, DAB CR 1602 (2007), *aff'd* DAB No. 2146 (2008).

3. The penalty imposed is reasonable.

Except to argue that its "noncompliance did not warrant remedies" and to complain about the duration of its noncompliance, Petitioner has not challenged the amount of the CMP.

To determine whether a civil money penalty is reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f): (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.

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 section 488.438(f) 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 22 *et seq*. (2002); *Emerald Oaks*, DAB No. 1800 at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1638 at 8 (1999).

Here, CMS imposes a penalty of $750 per day for each day of substantial noncompliance, which is at the low to very low end of the penalty range ($50 to $3,000). 42 C.F.R. §§ 488.408(d)(1)(iii); 488.438(a)(1)(ii).

With respect to the section 488.438(f) factors, I note first that the facility has a history of substantial noncompliance. Based on its prior annual surveys, the facility was not in substantial compliance during the four annual health surveys that immediately preceded this complaint investigation (May 2012, April 2013, April 2014, and May 2015). CMS Ex. 9. And the facility was consistently out of substantial compliance with the quality-of-care regulation (42 C.F.R. § 483.25); in 2012, that deficiency caused actual harm. CMS Ex. 9 at 1. The facility was also consistently out of substantial compliance with life safety code requirements. CMS Ex. 9 at 3. By itself, the facility's history justifies the modest penalty.

Petitioner does not claim that its financial condition affects its ability to pay the penalty.

Applying the remaining factors, a registered nurse deliberately left a resident lying on the shower room floor; she did not even check his vital signs. Her actions show a high degree of neglect, indifference, and disregard for resident care, comfort, or safety, for which the facility is culpable.

For these reasons, I find that the penalty imposed is reasonable.

Conclusion

For the reasons discussed above, I find that the facility was not in substantial compliance with 42 C.F.R. § 483.25 and that the amount of the penalty imposed is reasonable.

/s/
Carolyn Cozad Hughes
Administrative Law Judge