Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Avalon Place Kirbyville
Docket No. A-14-21
Decision No. 2569
April 17, 2014

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Avalon Place Kirbyville (Avalon), a skilled nursing facility (SNF), appeals the September 30, 2013 decision of an administrative law judge (ALJ) upholding the final decision of the Centers for Medicare & Medicaid Services (CMS) to impose two per-instance civil money penalties (CMPs) on Avalon. *Avalon Place Kirbyville*, DAB CR2930 (2013). CMS imposed the CMPs based on its determination that Avalon was not in substantial compliance with two Medicare participation requirements – 42 C.F.R. §§ 483.13(c) and 483.25 – as found during an on-site survey of the facility completed on June 19, 2012. The ALJ granted CMS's motion for summary judgment after concluding that applying the law to the undisputed material facts established Avalon's noncompliance with both requirements. The ALJ also found reasonable the amounts of the per-instance CMPs – $2,750 for the noncompliance with section 483.13(c) and $4,000 for the noncompliance with section 483.25. Avalon asserts on appeal that there are genuine disputes about material facts and that the ALJ, therefore, erred in granting summary judgment for CMS. Avalon does not ask the Board to reverse the ALJ on the merits but asks the Board to remand for an evidentiary hearing. Avalon also does not assert any disagreement with the ALJ's decision that the per-instance CMP amounts are reasonable.

We conclude that the ALJ did not err in granting summary judgment for CMS because Avalon has shown no genuine dispute about any material fact, and application of the law to the undisputed material facts establishes that CMS must prevail on the issue of Avalon's noncompliance with sections 483.13(c) and 483.25. Since Avalon makes before us no argument addressed to the ALJ's determination that the CMP amounts were reasonable, we uphold that determination without further discussion.[1]

[1] We note, however, that the ALJ properly reviewed this issue de novo, applying the applicable regulatory factors in 42 C.F.R. §§ 488.438(f) and 488.404(b), (c). *See* ALJ Decision at 15-16.

Legal Background

To participate in Medicare, a SNF must at all times be in "substantial compliance" with the requirements in 42 C.F.R. Part 483. 42 C.F.R. § 483.1. Under agreements with the Secretary of Health and Human Services (Secretary), state health agencies conduct onsite surveys to verify compliance with those participation requirements. *Id.* §§ 488.10(a), 488.11; *see also* Social Security Act (Act) §§ 1819(g)(1)(A), 1864(a).

A state survey agency reports any "deficiencies" it finds in a document called a Statement of Deficiencies. *See* 42 C.F.R. § 488.331(a). A "deficiency" is any failure to comply with a Medicare participation requirement, and a SNF is not in substantial compliance when it has one or more deficiencies that have the potential for causing more than minimal harm to residents. *Id.* § 488.301 (defining the term "substantial compliance"). The regulatory term "noncompliance" is synonymous with lack of substantial compliance. *Id.* (defining "noncompliance").

Surveyors categorize each instance of noncompliance found by its level of "seriousness," which is a function of: (1) "severity" – that is, whether the deficiency has created a "potential" for "more than minimal" harm, resulted in "actual harm," or placed residents in "immediate jeopardy" (the latter circumstance is the highest degree of severity); and (2) "scope" – that is, whether the noncompliance is "isolated," constitutes a "pattern," or is "widespread." 42 C.F.R. § 488.404(b); State Operations Manual, CMS Pub. 100-07, Appendix P – *Survey Protocol for Long Term Care Facilities,* Part I, Chapter IV ("Deficiency Categorization").[2]

Based on a survey's findings, CMS may impose enforcement "remedies" – including CMPs – for noncompliance with one or more of the Medicare participation requirements. 42 C.F.R. §§ 488.402(b), (c); 488.406. In choosing an appropriate remedy, CMS considers the seriousness of the SNF's noncompliance and other factors specified in the regulations. *Id.* § 488.404(a), (c).

CMS may impose either a per-instance or a per-day CMP. 42 C.F.R. § 488.408(d), (e). When CMS imposes a per-instance CMP, CMS determines an amount within the range of $1,000 to $10,000 per instance of noncompliance. *Id.* § 488.408(d)(1)(iv), (e)(1)(iv). That range applies regardless of the scope and severity of the noncompliance determined by CMS. *Id.*

[2] Appendix P to the State Operations Manual is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_p_ltcf.pdf.

A long-term care facility may appeal a determination of noncompliance that has resulted in the imposition of an enforcement remedy by requesting a hearing before an ALJ. 42 C.F.R. §§ 488.408(g)(1), 498.3(b)(13). In its appeal, the SNF may also contend that the amount of the CMP imposed for the noncompliance is unreasonable. *See Lutheran Home at Trinity Oaks*, DAB No. 2111, at 21 (2007); *Capitol Hill Cmty. Rehab. & Specialty Care Ctr.*, DAB No. 1629, at 5 (1997).

Case Background

The ALJ Decision set out the following undisputed evidence, which includes, but is not limited to, various statements made by Avalon staff. Avalon proffered no testimony from the staff members who made the statements and did not otherwise dispute the accuracy of the statements. As we discuss below, the ALJ made findings of fact based on that evidence that Avalon did not contest.

A. Undisputed evidence regarding Avalon's written policies and procedures

Avalon had a written policy to "ensure a safe environment for residents by prohibiting physical and mental abuse including involuntary seclusion, neglect and misappropriation of resident property." ALJ Decision at 5, citing CMS Ex. 7, at 77. The policy defined "neglect" as "includ[ing] but . . . not limited to the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." *Id*., citing CMS Ex. 7, at 78. Avalon also had an "Emergency Response to Respiratory or Cardiac Arrest" policy (emergency response policy) which required staff to "effectively" perform cardio-pulmonary resuscitation (CPR) for all full code residents "until help arrives."[3] CMS Ex. 8 at 2; ALJ Decision at 5. The facility also gave specific instructions to staff on how to implement this policy. These included the following:

1. When a resident is having a cardiac arrest or respiratory arrest, early intervention is essential.

2. It is critically important for the nearest person(s) to

    - Recognize the need for immediate action
    - Get help
    - Perform the steps of CPR effectively until help arrives.

[3] Avalon's brief refers to this policy as its "CPR policy." RR at 4. However, this policy, as indicated, encompasses substantially more than the performance of CPR. The record contains a separate Avalon policy entitled "Cardio Pulmonary Resuscitation" that addresses the procedures for determining CPR status for each resident, that is for determining whether residents are full code as opposed to DNR (do not resuscitate). CMS Ex. 8, at 1. Since the ALJ did not specifically discuss this policy and the parties do not discuss it on appeal, we find no reason to address it except to state that we find in it nothing that would affect our decision. For clarity's sake, our decision uses the phrase "emergency response policy" except where we refer specifically to performance of CPR.

3. When recognizing an emergency situation in a resident's room,

    a. Call for help by pulling the emergency call light in the bathroom, while verbally calling for help at the same time.
    b. Stay with the resident and initiate CPR until staff arrives.
    c. The responding person goes immediately to nursing station and makes an overhead page "Code Gray and room number or location of resident."
    d. When a code is called, nursing staff on nursing unit respond by CNA retrieving the Emergency Cart, one licensed or registered nurse responding to the room to assist with CPR, and one nurse calling EMS [Emergency Medical Services].
    e. Follow procedure for Emergency Cart – 111 C-13.

ALJ Decision at 5-6, citing CMS Ex. 8, at 2.

B. Undisputed evidence relating to the incident involving Resident 1

Resident 1 was a 48-year-old male quadriplegic diagnosed with hypertension, seizure disorder, peptic ulcer, anxiety, renal and urethral disease, prostatic disorder, muscle disuse atrophy, head injury, insomnia, hypothyroidism, generalized pain, shortness of breath, hypocalcaemia, and urinary tract infection. ALJ Decision at 6, citing P. Exs. 4, 10. The resident was "full code," meaning staff was required to initiate CPR in case of cardiac arrest. *Id*., citing P. Br. at 2-3; CMS Br. at 3-4; CMS Ex. 7, at 14; P. Ex. 4, at 1. Resident 1's plan of care listed approaches designed to ensure staff initiated CPR. *Id*. at 6. These included putting in his medical record a green document reflecting his full code status and putting the same document in the front of his chart under an "ad[vance] dir[ective]" tab. *Id*. The approaches also directed staff to begin "CPR immediately in the event of cardiac arrest," contact "EMS for hospital transfer," contact Resident 1's physician and family and update the resident's code status quarterly during care plan meetings and as needed. *Id*.

Resident 1 died the evening of June 14, 2012. ALJ Decision at 6. Nurse's notes document events preceding his death. *Id*., citing P. Ex. 1; CMS Ex. 7. Around 5:30 p.m., a Licensed Vocational Nurse (LVN) observed that Resident 1 was complaining that his right foot was hurting.[4] *Id*., citing P. Ex. 1, at 3; CMS Ex. 7, at 58. Resident 1 declined

[4] The LVN is identified on the survey report as LVN A. The ALJ referred to the LVN as LVN S, explaining that he was identifying Avalon's employees "by their position titles and the first initials of their last names." ALJ Decision at 6, n.1. It is undisputed that the LVN discussed on the survey report, in the parties' briefs (below and here) and in the ALJ Decision is the same LVN. Accordingly, for simplicity's sake and to avoid confusion, we use "LVN" without any further identifier.

dinner and received fluids and Vicodin for pain. *Id*. The LVN checked on Resident 1 at 7:00 p.m. and again at 8:30 p.m. When she reentered the resident's room at 9:15 p.m., the LVN noted he "'appear[ed] to be unconscious.'" *Id*. The LVN "initiated CPR, but it was 'unsuccessful.'" *Id*. at 7. At 9:30 p.m., the LVN called the on-call nurse, the director of nursing (DON) and "other individuals" to report the resident's condition. *Id*., citing P. Ex. 1, at 3-4; CMS Ex. 7, at 58, 60. "Nurs[ing] notes do not reflect that anyone on staff called EMS." *Id*.

During Avalon's investigation of the incident, the LVN completed written statements on two days, June 16 and June 18, 2012. In the first statement, the LVN stated that she "'was in another [resident's] room when I was approached by CNA [B] that [Resident 1] didn't appear to have a pulse.'"[5] ALJ Decision at 7, citing P. Ex. 12, at 1; CMS Ex. 7, at 90, 101 (brackets in ALJ Decision). The LVN said that she went to the resident's room, where the CNA was not present, and found no pulse and felt no breath. *Id.* The LVN stated that she began chest compressions and completed two full cycles with "'[n]o results'" and then "'got down off [the resident] & left the room'" and "'called the on-call nurse.'" *Id*. (brackets in ALJ Decision). The LVN further stated "'This was my first code. I was very overwhelmed with the situation.'" *Id*. In a written statement two days later, the LVN stated that the CNA told her she believed the resident was dead and that "'[a]t that moment . . . team work went out the window . . . [e]veryone stood back & watched me.'" *Id*., citing P. Ex. 12, at 2; CMS Ex. 7, at 97. The LVN further stated her belief "'that we all were in a state of shock because this was a sudden death [with] no warning to what was about to take place.'" *Id.*

The DON completed a written statement (undated) in which she stated that she had been notified at about 9:50 p.m. on June 14, 2012, by the on-call nurse that Resident 1 "'had passed.'" ALJ Decision at 7, citing P. Ex. 12, at 3; CMS Ex. 7, at 89. The DON further stated that the LVN admitted she knew the resident was "'full code'" and answered "'no'" when the DON asked if she had performed CPR or called 911. *Id*. at 8. When asked "'why not,'" the LVN told the DON "'because he was to[o] far gone.'" *Id*. The on-call nurse provided a written statement that also said the LVN told her the resident was full code. *Id*., citing CMS Ex. 7, at 94. After the DON read the LVN's entry on the chart stating she had done CPR, the DON questioned her, and the LVN stated she had done it but stopped when she got no response because she "'freaked out.'" *Id*., citing P. Ex. 12, at 3; CMS Ex. 7, at 89.

The CNA who found Resident 1 unresponsive and went to find the LVN also made written statements. ALJ Decision at 9. She stated, in relevant part, that around 9:20 p.m. on the night in question, she stopped to talk to Resident 1's roommate when she "'noticed [Resident 1's] color just didn't look right. Went over to his bed and his eyes were closed.

[5] This employee was also identified as "CNA B" on the survey report. Our references to the "CNA" in this decision are to CNA B except where we refer to the presence of additional CNAs.

I felt for pulse on [his] wrist [and] neck and listened for heartbeat on his chest. Heard or felt nothing[.]'"[6] *Id.*, citing CMS Ex. 7, at 98-99. She went to find the LVN and "'informed her . . . couldn't find a pulse or heartbeat on [Resident 1] and she went to his room.'" *Id*. (brackets in ALJ Decision). The CNA stated that when she went to Resident 1's room at 9:26, "'[t]he nurse was standing looking at [Resident 1]. I did not see CPR performed and was not informed of a DNR or full code.'" *Id.* (brackets in ALJ Decision). The CNA also stated that another CNA was with her during this observation. *Id*.

Standard of Review

Whether summary judgment is appropriate is a legal issue the Board addresses de novo. *1866ICPayday.com, L.L.C.*, DAB No. 2289, at 2 (2009), citing *Lebanon Nursing & Rehab. Ctr.*, DAB No. 1918 (2004). Summary judgment is appropriate when the record shows there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. *See 1866ICPayday.com* at 2, citing *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986).

In *Livingston Care Center*, DAB No. 1871, at 5-6 (2003), *aff'd*, *Livingston Care Ctr. v. U.S. Dep't of Health & Human Servs*., 388 F.3d, 168, 172-73 (6th Cir. 2004), the Board described the parties' respective burdens regarding summary judgment as follows:

> The party moving for summary judgment bears the initial burden of demonstrating that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. *Celotex*, 477 U.S. at 323. This burden may be discharged by showing that there is no evidence in the record to support a judgment for the non-moving party. *Id*. at 325. If a moving party carries its initial burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial.'" *Matsushita Elec. Industrial Co. v. Zenith Radio*, 475 U.S. 574, 587 (1986) (quoting FRCP 56(e)). To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact – a fact that, if proven, would affect the outcome of the case under governing law. *Id*. at 586, n.11; *Celotex*, 477 U.S. at 322 (moving party is entitled to summary judgment if the party opposing the motion "fails to make a showing 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").

[6] We note a slight discrepancy in times because while the CNA states she checked on the resident around 9:20 p.m. and then went to find the LVN, the LVN indicated she arrived at the resident's room at 9:15 p.m. However, neither party has made an issue of this, and it is not material to our decision.

> Under the applicable substantive law, CMS has the initial burden of coming forward with evidence that the provider was not in substantial compliance with Medicare participation requirements. However, the provider bears the ultimate burden of persuading the ALJ that it was in substantial compliance with those requirements. *See South Valley Health Care Center*, DAB No. 1691 (1999), *aff'd, South Valley Health Care Center v. HCFA*, 223 F.3d 1221 (10th Cir. 2000).

Summary judgment principles also provide that "[i]n order to demonstrate a genuine issue, the opposing party must do more than show that there is 'some metaphysical doubt as to the material facts . . . . Where the record taken as a whole could not lead a rational trier of fact to find for the non-moving party, there is no "genuine issue for trial."'" *1866ICPayday.com* at 3, quoting *Matsushita*, 474 U.S. at 587. In deciding whether the record taken as a whole could not lead a rational trier of fact to find for the non-moving party, "the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor." *Id*., citing *U.S. v. Diebold, Inc*., 369 U.S. 654, 655 (1962).

The ALJ Decision

The regulation at 42 C.F.R. § 483.13(c) requires long-term care facilities participating in Medicare to "develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property." Another regulation defines "neglect" as a "failure to provide goods and services necessary to avoid physical harm . . . ." 42 C.F.R. § 488.301. The ALJ concluded that the undisputed evidence established that Avalon was not in substantial compliance with section 483.13(c) based on the following specific findings of fact:

1. Contrary to Petitioner's emergency response policy and procedures, [the CNA] did not call for help by pulling the emergency call light in the bathroom while verbally calling for help.
2. Contrary to Petitioner's emergency response policy and procedures, [the CNA] did not stay with Resident 1 and initiate CPR while waiting for other staff to arrive.
3. Contrary to Petitioner's emergency response policy and procedures, no staff member called EMS.
4. Contrary to Petitioner's emergency response policy and procedures, Petitioner's staff did not effectively perform CPR until help arrived.

ALJ Decision at 10. The ALJ also noted that Avalon did not assert that "its staff should not have initiated its CPR emergency policy on Resident 1." *Id.* at 9, 15.

The other Medicare participation requirement found unmet in this case, 42 C.F.R. § 483.25, requires that "[e]ach 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 ALJ concluded that the undisputed evidence establishes that Avalon was not in substantial compliance with section 483.25 because Avalon did not provide necessary care and services to Resident 1 in accordance with his plan of care. *Id.* at 14.

Discussion

A. Summary judgment for CMS was appropriate.

Avalon's request for review does not take specific exception to any of the ALJ's numbered findings of fact. Nor does Avalon claim that the ALJ erred in finding that the facility's emergency response policy and procedures and Resident 1's plan of care for cardiac arrest applied here, when the CNA and then the LVN found Resident 1 unresponsive. Instead, Avalon raises issues of law and, with respect to the ALJ's finding 4, makes arguments in the nature of affirmative defenses.[7]

Avalon asserts that summary judgment was inappropriate because of the following alleged disputed issues of material fact:

- Whether Petitioner and its staff "neglected" Resident #1;
- Whether Petitioner and its staff implemented their applicable policies and procedures;
- Whether Petitioner and its staff provided care and services to Resident #1 to enable this resident to achieve his "highest practicable" physical, mental, and psychosocial well-being in accordance with his written plan of care; and
- Whether termination/cessation of CPR by [the LVN] was justified or whether it constitutes regulatory "neglect."

RR at 3.

We reject Avalon's arguments that these alleged factual disputes preclude summary judgment for CMS under either section 483.13(c) or section 483.25. For the most part, the listed issues are not factual disputes at all but, rather, disputes

[7] Avalon also purports to incorporate by reference all of the arguments in its pre-hearing brief before the ALJ. RR at 3-4. Board guidelines for appeals of ALJ decisions expressly prohibit this, and 42 C.F.R. § 498.82(b) requires appellants to "specify" in the request for review "the issues, the findings of fact or conclusions of law with which the party disagrees, and the basis for contending that the findings and conclusions are incorrect." *Apollo Behavioral Health Hospital, L.L.C.*, DAB No. 2561, at 12 (2014). A copy of the guidelines was enclosed for Avalon with the ALJ Decision. Accordingly, while we have conducted full record review of the facts, our decision addresses only the arguments Avalon raises in its request for review.

about the legal conclusions to be drawn from the undisputed material facts regarding the incident involving Resident 1. To the extent any of the listed issues can be viewed as raising factual disputes, we accept Avalon's evidence and the reasonable inferences from it, but find that the evidence and reasonable inferences are not material and, therefore, do not preclude summary judgment for CMS.

We set forth above the facts the ALJ relied on as material to determining whether Avalon complied with both regulations at issue here. Avalon does not dispute any of these facts or their materiality, and as discussed below, these facts clearly support the ALJ's entry of summary judgment for CMS because they show that as a matter of law Avalon was not in substantial compliance with section 483.13(c) and section 483.25.

1. *The undisputed material facts support the ALJ's conclusion that Avalon did not implement its anti-neglect policy.*

We address in this section why summary judgment for CMS is appropriate on the finding of noncompliance with section 483.13(c). Avalon first questions why, in upholding CMS's finding of noncompliance with section 483.13(c), the ALJ relied on the failure of Avalon staff to follow the facility's emergency response policy when the regulatory citation under that section was for Avalon's failure to implement its anti-neglect policy. RR at 4-5. Referring to the "F tag" identifiers that correspond to the regulatory participation requirements on the Statement of Deficiencies (SOD), Avalon asserts that there is "no specific regulatory requirement under F224, 226, or 309 for a facility to have a certain CPR policy." *Id.* at 5.

This assertion is correct but irrelevant. As stated earlier, section 488.301 – which defines "neglect" for purposes of section 483.13(c) – provides in applicable part that "neglect" includes "failure to provide goods and services necessary to avoid physical harm . . . ." The Board has held that a facility's failure to follow its other policies or procedures can support a finding of noncompliance with section 483.13(c) where, as here, those other policies determine what the facility deems the "goods and services necessary to avoid physical harm . . . ." In *Azalea Court*, DAB No. 2352, at 13-15 (2010), for example, the Board affirmed the ALJ's conclusion that a nursing home failed to implement policies and procedures prohibiting neglect when it failed to follow its elopement protocol and smoking policy when caring for the resident. The Board explained, "The fact that the regulations do not specify that a particular type of care is necessary to meet a requirement does not prevent a finding of noncompliance when the facility itself has determined that type of care is necessary." *Id.* at 15; *see also Liberty Commons Nursing & Rehab. Ctr. – Johnston*, DAB No. 2031 (2006), *aff'd*, *Liberty Commons Nursing & Rehab. Ctr. – Johnston v. Leavitt*, 241 F. App'x 76 (4th Cir. 2007) (upholding ALJ's inference of failure to implement anti-neglect policy where staff failed to take several precautions

required by facility's latex allergy policy for a resident with a known latex allergy); *Hanover Hill Health Care Ctr.*, DAB No. 2507, at 18 (2013) (citing *Liberty Commons* and holding that in determining whether Hanover failed to implement its anti-neglect policy the ALJ could appropriately consider whether Hanover failed to follow its aspiration and nutrition policies). In this case, as Avalon does not dispute, its emergency response policy reflects Avalon's determination as to what "services [were] necessary to avoid physical harm" to Resident 1 and other full code residents experiencing respiratory or cardiac arrest. Thus, the ALJ appropriately relied on staff failure to follow that policy as a basis for concluding that Avalon did not implement its anti-neglect policy.

Avalon also asserts by way of legal argument that CMS cited five cases in its summary judgment motion "for the proposition that if a facility does not perform CPR on a resident, there is an automatic regulatory violation: . . . ." RR at 5 (case citations omitted). Avalon then says that each case is "distinguishable from the present case, and no case cited by CMS pertains to a situation in which the American Heart Association [AHA] guidelines allow for termination of CPR by an out of hospital BLS [basic life support] provider, which is the situation which occurred here." *Id.* at 6. CMS does not cite here any of the cases Avalon identifies as having been cited by CMS in its summary judgment motion or make here the "proposition" for which it allegedly cited those cases below. Nor does the ALJ Decision indicate that the ALJ relied on any of those cases or in any way concluded that any failure to perform CPR automatically violates the regulation. Accordingly, whether CMS cited those cases for such a proposition in its summary judgment brief is irrelevant to our decision.

With respect to Avalon's assertion about the AHA guidelines, Avalon does not cite the guideline on which it is relying.[8] The ALJ discussed affidavit testimony by Avalon's physician expert, Dr. R., that in situations where a person rendering CPR suffers an extreme emotional reaction rendering them incapable of continuing, the AHA guidelines "'allow the traumatized provider to stop CPR and ask for help.'"[9] ALJ Decision at 12, citing CMS [sic] Ex. 15, at 3 (the exhibit containing Dr. R's affidavit is actually P. Ex. 15). The ALJ accepted this testimony as true but found that it did not raise a material dispute of fact. Although we noted in footnote 8 the absence of a situation corresponding

[8] There are AHA guidelines in the record. *See* CMS Ex. 11. They contain a provision that states "BLS rescuers who start BLS should continue until one of the following occurs: . . . " and then lists five situations, but none of these addresses a situation where the BLS provider is incapable of continuing CPR due to an extreme emotional reaction. *See id*. at 17.

[9] We abbreviate the last name to protect the privacy of the witness. Avalon asserts that the ALJ "discounted the opinions" of Dr. R. and its other expert witness, Dr. M., a registered nurse with a Master of Science in Nursing and Doctorate of Education. RR at 4. We disagree. The ALJ discussed the affidavit testimony of these witnesses but concluded that testimony raised no genuine dispute about any material fact. *See* ALJ Decision at 11-13.

to that addressed in Dr. R.'s testimony in the AHA guidelines of record here, we too accept the truth of her statement for purposes of summary judgment but agree with the ALJ that the statement is not material. Dr. R's testimony does not assert that the AHA guidelines allow all staff to not perform CPR in this circumstance. Her statement refers only to the traumatized provider, in this case the LVN, and specifically states that if that person stops CPR, he or she should ask for help. Although the LVN stated she called people, including the on-call nurse and DON, to report the resident's condition after she stopped CPR and left the room, she did not state that she asked for help continuing CPR. Even if one could reasonably infer from the LVN's statements about the absence of team work and everyone standing back and watching her that she did ask for help, those statements also indicate that no employee responded to that request. Avalon does not dispute this. Nor does Avalon dispute that its own emergency response policy provided for the cooperation of more than one person to assure that CPR and its other emergency procedures were followed.

Avalon also argues that it was "reversible error" for the ALJ to determine there were no disputed fact issues remaining for trial while "admit[ing] that Avalon's employees were properly trained regarding the facility's CPR policy, and that the facility had done what was required in terms of educating its staff regarding this policy." RR at 5. We find no error. The ALJ did accept as true Avalon's statements that its staff, including the LVN, were appropriately trained, licensed and in-serviced regarding the facility's CPR policy. ALJ Decision at 12. The ALJ also accepted as true that Avalon's nursing staff understood the facility's CPR policy. *Id*. However, the ALJ properly concluded that this did not change the fact that Avalon had not identified any material factual dispute. *Id*. Whether a facility has provided training on its policies and procedures is a relevant circumstance an ALJ may consider. However, it is not material where, as here, there is undisputed evidence that staff did not act on that education and training to implement those policies and procedures in circumstances where they apply. It is undisputed that with the limited exception of two rounds of chest compressions, Avalon staff failed to implement the multiple emergency response procedures Avalon's policy and Resident 1's care plan required when Resident 1 went into cardiac arrest, and those failures are the critical facts for purposes of the ALJ's conclusion, and ours, that Avalon did not comply with section 483.13(c).

Avalon's reliance on the ALJ Decision in *Heron Pointe Health & Rehab.*, DAB CR1401 (2006), is misplaced and premised on a characterization of the incident involving Resident 1 that is inconsistent with the undisputed facts in this case. Avalon cites *Heron Pointe* for the proposition that one employee's failure to follow a facility policy on one occasion "does not equate to an overall failure by the facility to implement its abuse/neglect policies, particularly when the facility can demonstrate that its employees were properly trained and in-serviced." RR at 5. We need not address either Avalon's

characterization of *Heron Pointe* or the merits of that decision since neither the Board nor other ALJs are bound by an ALJ decision. *Britthaven of Chapel Hill*, DAB No. 2284, at 9-10 (2009). But even assuming *Heron Pointe* constituted binding precedent and Avalon correctly states its holding, the case is inapposite because Avalon did not challenge the ALJ's findings regarding the failure of the CNA, the LVN, and other staff to provide services that Avalon's emergency response policy established were necessary for a resident having cardiac arrest. Most importantly, no staff stepped in to continue CPR on Resident 1 when the LVN "freaked out," and there is no evidence any employee called EMS, even though Avalon's emergency response policy required staff to do so.

Moreover, contrary to Avalon's suggestion, the Board's analysis for determining whether there has been a failure to implement a facility's anti-neglect policy is not merely quantitative. In *Oceanside Nursing & Rehab. Ctr.*, the Board noted its repeated holdings that "'multiple or sufficient examples of neglect may support a reasonable inference that a facility has failed to develop or implement policies and procedures that prohibit neglect.'" DAB No. 2382, at 11 (2011) (citation omitted). The Board then explained, "The focus, thus, is not simply on the number or nature of the instances of neglect (i.e., failure to provide necessary care or services) but on whether the facts found by the ALJ surrounding such instance(s) demonstrate an underlying breakdown in the facility's implementation of the provisions of an anti-neglect policy." *Id.*, citing *Columbus Nursing & Rehab. Ctr.*, DAB No. 2247, at 27 (2009) (question is "whether the circumstances presented, viewed as a whole, demonstrate a systemic problem in implementing policies and procedures"); *Liberty Commons Nursing & Rehab. Ctr. – Johnston*, DAB No. 2031. *See also Hanover Hill*, DAB No. 2507, at 9-10 (reiterating analysis set forth in *Oceanside* and citing examples of circumstances the Board has considered relevant when determining whether an "underlying breakdown" has occurred). Clearly, the undisputed facts surrounding the incident involving Resident 1 demonstrate just such an "underlying breakdown."

For the reasons stated above, we conclude there was no genuine dispute of material fact precluding summary judgment for CMS on the issue of whether Avalon was in substantial compliance with section 483.13(c).

2. The undisputed material facts support the ALJ's conclusion that Avalon did not provide Resident 1 the care and services required by his plan of care.

The quality of care regulation, 42 C.F.R. § 483.25, requires that "[e]ach 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." Applying the undisputed facts in this

case, as set forth in prior sections of this decision, the ALJ concluded that Avalon did not provide the quality of care necessary to comply with that regulation. The ALJ properly focused on the resident's care plan and Avalon's emergency response policy as setting the quality of care standard in this instance. Based on the undisputed facts in this case, we agree with his conclusion that Avalon's failure to provide the emergency services required by its policy and the resident's care plan – including effectively administering CPR until help arrived and calling EMS – was a failure to meet that standard. *See, e.g.*, *Desert Lane Care Ctr.*, DAB No. 2287, at 9-10 (2009) ("facility's failure to fully employ . . . measures as intended in its policies may thus be evidence that the facility failed to provide residents with the services required by specific subsections of section 483.25"); *Cedar Lake Nursing Home*, DAB No. 2288, at 6-7 (2009), *aff'd*, *Cedar Lake Nursing Home v. U.S. Dep't of Health & Human Servs*., 619 F.3d 453 (5th Cir. 2010) (holding that the plan of care developed to prevent a resident from eloping "was, in effect, Cedar Lake's policy for preventing her from eloping," and that Cedar Lake failed to comply substantially with section 483.25(h) where, among other things, it "did not follow [that] plan of care . . ."); *Spring Meadows Health Care Ctr.*, DAB No. 1966, at 17 (2005) ("the clearest case of failure to meet [section 483.25] is failure to provide one of the specific services outlined in the subsections or failure otherwise to follow the plan of care based on the comprehensive resident assessment").

The rationale in those cases applies here. Avalon determined that Resident 1 was full code and that in the event he suffered respiratory or cardiac arrest, the "necessary care and services" Resident 1 needed "to attain or maintain the highest practicable physical . . . well-being in accordance with [his] comprehensive assessment and plan of care" included the emergency care services set forth in its emergency response policy adopted for full code residents. Since it is undisputed that staff did not provide those services to Resident 1, who was experiencing cardiac arrest, the ALJ properly determined that the facility was not in compliance with section 483.25.

Avalon tries to avoid this conclusion by asserting "that CPR for Resident #1 would have been futile [because] [he] died of cardiac arrest . . . prior to the time [the LVN] was called to assess the resident." RR at 7. For these assertions, Avalon cites a written statement by the DON that the Justice of the Peace told her the death certificate listed "myocardial infarction" as Resident 1's cause of death (P. Ex. 11) and affidavit testimony by Dr. R. (P. Ex. 15).[10] Avalon also relies on the LVN's inability to detect breathing or find a pulse on Resident 1 and her observation of a change in coloration and on the CNA's report of similar findings when she first found Resident 1 unresponsive. RR at 7-8. Avalon made

[10] We note Avalon overstates the testimony of Dr. R., who did not testify definitively that continuing CPR and calling EMS would have been "futile" but only that "based on reasonable medical probability, the end-result would have been the same." P. Ex. 15, at 4-5 (emphasis added).

essentially the same argument to the ALJ, albeit in more detail there. The ALJ considered these arguments and for purposes of summary judgment, accepted these factual allegations as true. However, he concluded they were not material to his determination of noncompliance. ALJ Decision at 12-13. We agree they are not material.

The ALJ stated, and Avalon does not dispute, that "no one responding knew whether CPR might revive the resident and neither [the LVN] nor [the CNAs] had the authority to declare death." ALJ Decision at 13. But even assuming Resident 1 was exhibiting signs of possible death, as the Board stated in *John J. Kane Regional Ctr. – Glen Hazel*, DAB No. 2068, at 17 (2007), cited in the ALJ Decision at 14,

> The fact that a person may exhibit signs of death does not necessarily obviate the caregiver's duty to provide CPR because one of CPR's goals, according to the AHA Guidelines, is the reversal of clinical death, even though that outcome is achieved in only a minority of cases.

Accord Ross Health Care Ctr., DAB No. 1896, at 8-9 (2003) (agreeing with ALJ that it "is immaterial whether it could be determined with hindsight that [the resident] would have benefitted from CPR . . ."). As the ALJ recognized, the quoted statement leaves open the possibility that there may be circumstances in which the caregiver's duty to provide CPR does not arise. Avalon, however, proffered no evidence that, even viewed in the light most favorable to Avalon, would establish that its staff had no duty to provide CPR to Resident 1. Avalon's own emergency response policy and Resident 1's care plan specifically provided that "CPR . . . be initiated in case of cardiac arrest . . . ," and the approaches listed included a reiteration of the requirement that staff "initiate CPR immediately in the event of cardiac arrest" and further provided that they "call EMS for hospital transfer [and] contact MD . . . ." CMS Ex. 7, at 12-13. It is undisputed that this was a case of cardiac arrest requiring, according to Avalon's policy and Resident 1's care plan, that staff initiate and continue CPR as well as other emergency procedures. It is also undisputed that staff did not continue CPR or follow the other emergency procedures. We agree with the ALJ that by not following the specific requirements of its emergency care policy and Resident 1's care plan, Avalon failed to provide the quality of care required by section 483.25.

Conclusion

For the reasons discussed above, the Board affirms the ALJ Decision in its entirety.

/s/
Leslie A. Sussan

/s/
Judith A. Ballard

/s/
Sheila Ann Hegy
Presiding Board Member