Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Avalon Place Kirbyville,
(CCN: 675220),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-12-1235

Decision No. CR2930

Date: September 30, 2013

DECISION

Petitioner, Avalon Place Kirbyville (Petitioner or facility), is a long-term care facility located in Kirbyville, Texas, that participates in the Medicare program. Following a complaint survey completed on June 19, 2012, the Centers for Medicare & Medicaid Services (CMS) determined that Petitioner was not in substantial compliance with Medicare participation requirements. Based on this determination, CMS imposed against Petitioner a per-instance civil money penalty (PICMP) of $2,750 for noncompliance with 42 C.F.R. § 483.13(c) and a PICMP of $4,000 for noncompliance with 42 C.F.R. § 483.25. Petitioner appealed and CMS moves for summary judgment. After considering the undisputed material facts, I grant CMS summary judgment and sustain its determinations.

I. Background

The Social Security Act (Act) sets forth requirements for skilled nursing facility and nursing facility participation in the Medicare program. The Act authorizes the Secretary of the U.S. Department of Health and Human Services (Secretary) to promulgate

regulations implementing those statutory provisions. Act § 1819 (42 U.S.C. § 1395i-3). The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the program, a facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a) (42 U.S.C. § 1395aa(a)); 42 C.F.R. §§ 488.10; 488.20. The Act and regulations require that facilities be surveyed on average every 12 months, and more often if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A) (42 U.S.C. § 1395i-3(g)(2)(A)); 42 C.F.R. §§ 488.20(a), 488.308. Here, surveyors from the Texas Department of Aging and Disability Services (state agency) completed a complaint survey of Petitioner on June 19, 2012. Based on their findings, CMS determined that the facility was not in substantial compliance with participation requirements at 42 C.F.R. §§ 483.13(c) and 483.25 and that the noncompliance constituted immediate jeopardy.

On August 28, 2012, Petitioner timely requested a hearing to review CMS's determinations. The case was assigned to me for hearing and decision. On September 13, 2012, I issued an Acknowledgment and Initial Prehearing Order establishing a briefing schedule (September 13 Order). In accordance with that schedule, CMS filed a Motion for Summary Judgment and Pre-Hearing Brief (CMS Br.) accompanied by CMS Exhibits (CMS Exs.) 1 – 11. Petitioner filed its Pre-Hearing Brief (P. Br.), accompanied by Petitioner's Exhibits (P. Exs.) 1 – 16 and a response to CMS's Motion for Summary Judgment (P. Response). CMS filed a reply to Petitioner's response to CMS's Motion for Summary Judgment (CMS Reply). In the absence of objection, I admit CMS Exs. 1 – 11 and P. Exs. 1 – 16 into the record.

II. Issues

The issues presented here are whether undisputed material facts establish that:

A. Petitioner was in substantial compliance with the participation requirements at 42 C.F.R. § 483.13(c) and 42 C.F.R. § 483.25 for an incident involving Resident 1; and

B. The PICMPs CMS imposed are reasonable.

At the conclusion of the survey, CMS also cited Petitioner as out of compliance with other participation requirements for which it did not impose a remedy. On October 23, 2012, CMS filed a motion to dismiss these alleged deficiencies arguing that Petitioner had no right to contest them because CMS imposed no remedy based upon them. Petitioner agreed that the case is limited to the two deficiencies for which a remedy was

imposed, stating that the issues in the case are whether it "substantially complied with the regulations forming the basis of the F224 and F309 citations. . . ." P. Br. at 1-2. As Petitioner did not object to CMS's motion, and because CMS imposed no remedies based on those other deficiencies, Petitioner has no right to an administrative law judge (ALJ) hearing with regard to the deficiencies. Therefore, I grant CMS's motion and dismiss them from my consideration here. 42 C.F.R. § 498.70(b).

CMS's October 23, 2012 motion to dismiss also seeks to bar Petitioner from appealing the scope and severity of the alleged deficiencies because the scope and severity of a PICMP is not reviewable where a successful challenge to the PICMP does not affect the range of monetary penalties CMS is able to collect. Petitioner recognizes that the case involves PICMPs, and that because Petitioner does not operate a nurse aide training program, Petitioner cannot directly challenge the scope and severity of the deficiencies. P. Br. at 2. 42 C.F.R. §§ 498.3(b)(14), (d)(10)(i); 498.60(c). I also then grant CMS's motion to dismiss on this issue because I agree the scope and severity determinations are not directly reviewable, although I may consider them as a factor in reviewing the reasonableness of the penalties.

III. Findings of Fact and Conclusions of Law

A. Summary judgment is appropriate.

CMS alleges in its motion that it is undisputed that Petitioner's staff did not provide cardiopulmonary resuscitation (CPR) to Resident 1 as required by Petitioner's policy and Resident 1's plan of care. As a result, CMS alleges it is simply a matter of law as to whether Petitioner violated the relevant Medicare requirements. Board members of the Appellate Division of the Departmental Appeals Board (the Board) stated the standard for summary judgment as follows:

> Summary judgment is appropriate when the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. . . . The party moving for summary judgment bears the initial burden of showing that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. . . . 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. . . . In determining whether there are genuine issues of material fact for trial, 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.

Senior Rehab. & Skilled Nursing Ctr., DAB No. 2300, at 3 (2010) (citations omitted). The role of an ALJ in deciding a summary judgment motion differs from the ALJ's role in resolving a case after hearing. The ALJ should not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Vill. at Notre Dame, Inc.*, DAB No. 2291, at 4-5 (2009). 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.*, DAB No. 1871 (2003), *aff'd, Livingston Care Ctr.*, 388 F.3d at 169, 172 (6th Cir. 2004); *Guardian Health Care Ctr.*, DAB No. 1943, at 8 (2004); *but see*, *Cedar Lake Nursing Home*, DAB No. 2344, at 7 (2010); *Brightview Care Ctr.*, DAB No. 2132, at 10 (upholding entry of summary judgment when inferences and views of non-moving party are not reasonable).

Drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions. *Cedar Lake Nursing Home*, DAB CR1967, at 4 (2009), *aff'd*, DAB No. 2288 (2009), *aff'd, Cedar Lake Nursing Home v. DHHS*, 619 F.3d 453 (5th Cir. 2010), citing *Guardian Health Care Ctr.*, DAB No. 1943, at 11 (2004) ("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.").

Rule 56(e) of the Federal Rules of Civil procedure govern summary judgment motions in these appeals of CMS actions, and Petitioner argues the rule requires a motion for summary judgment to be supported by affidavits made on personal knowledge. P. Response at 8. Petitioner argues that CMS's motion contains unsworn declarations from two surveyors and other unauthenticated correspondence, notes, and other documents which do not constitute proper summary judgment evidence. P. Response at 8. Petitioner's argument is unavailing.

The declarations of Surveyors Deena Gill, RN (CMS Ex. 9) and Una Darlene Williams, RN (CMS Ex. 10) are signed by the witnesses, although it is true that they are not signed "under penalties of perjury." However, a party moving for summary judgment need not offer supporting affidavits or exhibits. *See* September 13 Order; *Cedar Lake Nursing Home*, DAB CR1967, at 4 (2009), *aff'd* DAB No. 2288 (2009), *aff'd Cedar Lake Nursing Home v. DHHS*, 619 F.3d 453 (5th Cir. 2010) (noting that either party may move for summary judgment under Rule 56(a) and (b) "with or without supporting affidavits."). With regard to other exhibits CMS submitted, Petitioner does not identify which of them

Petitioner does not consider "proper summary judgment evidence," and thus I do not address its general argument.

B. The undisputed evidence establishes Petitioner was not in substantial compliance with 42 C.F.R. § 483.13(c) because Petitioner did not implement its emergency response policies and procedures prohibiting neglect when providing Resident 1 with CPR.

A facility participating in Medicare must "develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property." 42 C.F.R. § 483.13(c). The regulatory definition of "neglect" includes failing to provide services necessary to avoid physical harm. *See* 42 C.F.R. § 488.301.

The following facts are undisputed unless otherwise noted. Petitioner's 2007 Abuse Policy & Procedure provides that Petitioner "will ensure a safe environment for residents by prohibiting physical and mental abuse including involuntary seclusion, neglect and misappropriation of resident property." CMS Ex. 7, at 77. The policy provides that neglect "includes but i[s] not limited to the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." CMS Ex. 7, at 78.

Petitioner's undated policy titled "Emergency Response to Respiratory or Cardiac Arrest" provides that its staff will perform CPR for all "Full code" residents until "appropriate help arrives." This policy addresses the prohibition of neglect because it requires staff to provide services to avoid physical harm, in this case, death. The facility's procedural guidelines specifically state:

> 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. 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.

CMS Ex. 8, at 2.

Resident 1 was a 48-year-old quadriplegic man. His diagnoses included hypertension, seizure disorder, peptic ulcer disease, anxiety, renal and urethral disease, prostatic disorder, muscle disuse atrophy, head injury, insomnia, hypothyroidism, generalized pain, shortness of breath, hypocalcemia, and urinary tract infection. P. Exs. 4, 10. Resident 1 was on a "full code" status, meaning that Resident 1's care plan required that Petitioner's staff initiate CPR in case of cardiac arrest. P. Br. at 2-3; CMS Br. at 3-4; CMS Ex. 7, at 14, 75; P. Ex. 4, at 1.

Petitioner planned approaches to ensure that its staff initiated CPR for Resident 1 if he suffered a cardiac arrest. These approaches included: placing a green colored document in his medical record to reflect his "full code status"; placing this document in the front of his chart under an "adv[ance] dir[ective] tab"; initiating "CPR immediately in the event of cardiac arrest"; calling "EMS for hospital transfer"; contacting the resident's physician and family; and updating his code status quarterly during care plan meetings and as needed. P. Ex. 4; CMS Ex. 7, at 14.

Nurse notes contained in the record describe events occurring on the evening Resident 1 died. On June 14, 2012, at 5:30 p.m., Licensed Vocational Nurse (LVN) S[1] documented Resident 1's complaint that his right foot was hurting. P. Ex. 1, at 3; CMS Ex. 7, at 58. LVN S advised a certified nursing assistant (CNA) caring for Resident 1 to give him pain medication. P. Ex. 1, at 3; CMS Ex. 7, at 58. Resident 1 declined dinner because of his foot pain. P. Ex. 1, at 3; CMS Ex. 7, at 58. Resident 1 received fluids. P. Ex. 1, at 3; CMS Ex. 7, at 58. At 5:45 p.m., the CNA gave Resident 1 Vicodin for pain. P. Ex. 1, at 3; CMS Ex. 7, at 58. At 7:00 p.m., LVN S checked Resident 1. P. Ex. 1, at 3: CMS Ex. 7, at 58. She reported he did not want to eat anything but stated that, while he had no pain in his right foot, he felt "bad." P. Ex. 1, at 3; CMS Ex. 7, at 58. LVN S took his vital signs and determined he was afebrile. P. Ex. 1, at 3; CMS Ex. 7, at 58. At 8:30 p.m., LVN S again entered the room. P. Ex. 1, at 3; CMS Ex. 7, at 58. Resident 1 stated he wanted water and LVN S gave him some. P. Ex. 1, at 3; CMS Ex. 7, at 58. At 9:15 p.m., LVN S entered Resident 1's room, and saw that he "appear[ed] to be unconscious."

[1] I identify Petitioner's employees in this decision by their position titles and the first initials of their last names.

P. Ex. 1, at 3; CMS Ex. 7, at 58. LVN S initiated CPR, but it was "unsuccessful." P. Ex. 1, at 3; CMS Ex. 7, at 58. At 9:30 p.m., LVN S called the on-call nurse (RN Z) and the Director of Nursing (DON R) and other individuals to report Resident 1's condition. P. Ex. 1, at 3-4; CMS Ex. 7, at 58, 60. Nurse notes do not reflect that anyone on staff called EMS.

During Petitioner's investigation of the incident, LVN S provided two written statements. On June 16, 2012, LVN S stated:

> I, [LVN S] was in another [resident's] room when I was approached by CNA [B] that [Resident 1] didn't appear to have a pulse. She said "I think [Resident 1] is dead." I ran to [Resident 1's] room, called his name, grabbed his hand to check for pulse. No pulse found. I put my ear to his mouth to feel his breath. He had none. CNA was not present. I began chest compressions. Full cycle completed. Approx. 2 times. No results. I got down off [the resident] & left the room. I called the on-call nurse, [RN Z] was informed of [the resident's] status. On call nurse informed me that she would call DON & Adm. I went into [Resident 1's] room & CNA was performing post mortem care. Call received from [DON R] who informed me to call the JP & family. This was my first code. I was very overwhelmed with the situation.

P. Ex. 12, at 1; CMS Ex. 7, at 90, 101. On June 18, 2002, LVN S also stated:

> I, [LVN S], was alerted from another resident[']s room into the hallway by CNA [B]. She said "I believe [Resident 1] is dead.["] At that moment is when I believe team work went out the window. No teamwork! Everyone stood back & watched me. I do believe however 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. I do know without a shadow of a doubt that I did the very best that I knew to do.

P. Ex. 12, at 2; CMS Ex. 7, at 97. DON R provided an undated written statement regarding the incident. She stated:

> On 06/14/12 at about 9:50 pm on call nurse [RN Z] called me to tell me that [Resident 1] had passed. I then hung up the phone and called the nursing home. [LVN G] the 10/6 LVN was in the building and answered the phone. Then I spoke with [LVN S] the LVN on duty for hall two. I ask[ed] [LVN

> S] what happened and she told me that [Resident 1] had passed[.] I said when and she said about 9:15 p.[m.]. I said he was a full code and she stated I know and [I] ask[ed] her if she did cpr [or] called 911 and she stated no[.] I ask[ed] her why not and she told me because he was to[o] far gone. I ask[ed] her if she had called the Dr. and she said no[.] I then ask[ed] her if she had called the family and she said yes. I ask[ed] her what they said he she [sic] said[.] Kathy said she couldn't come up here to call the Newton funeral home. I said to call the coroner to see if he could come to pronounce him and if he couldn't to call me back. At 10:00 pm I called [GD] the administrator and informed him. I called back and she said that [M] had came and pronounced him. I told [LVN S] that if she ever had another that if it ever happened again to do cpr until the ambulance people got here to relieve her and she said I know. The next morning when I got to work I read the chart and it said that she had done cpr on [the] resident. I called her in to talk to her about it and she told me that she had done cpr but she had gotten no response so she stopped. She stated she stopped because she freaked out and because he was dead, to[o] far gone. [O]n 06/16/12 I spoke with [LVN S] again [and] she stated that the resident was like coming up of the bed to get her when she was doing cpr on him and she freaked out and that's why she stopped the cpr. On 06/17/12 I called [LVN S] again to get her to come in for her termination and I ask[ed] her why she didn't call for help and she stated they saw I needed help and did nothing to help me they knew I was in a bind and did nothing to help.

P. Ex. 12, at 3; CMS Ex. 7, at 89. RN Z provided an undated written statement regarding the call LVN S made to her. RN Z stated:

> On June 14, 2012 @ 9:49 p, (looked @ on-call phone to see the time), received a call from [LVN S]. She stated "[Resident 1] is Dead." I immediately called [DON R] & reported death. [DON R] called [LVN S] to see what happened. I waited about 15 min[utes] to 20 min[utes] then called back to [LVN S] to see what happened. I asked if he was DNR or Full Code. [LVN S] stated "Full Code." I asked if she did CPR. [LVN S] stated "But, He was dead & blue." That was the end of our conversation.

CMS Ex. 7, at 94. CNA B also made written statements concerning the incident. She stated in one undated statement that:

> On June 14, 2012, I reported to my charge [LVN S] a resident had passed on our hall. She went down to the room to check on him, I was not in there at the time she entered the room. Arrived in the room after speaking to a co-worker [CNA E] in the hallway who had spoke to me as to what was going on. Me and [CNA E] entered the room at the same time.

CMS Ex. 7, at 96, 106. On June 18, 2012, CNA B stated:

> At 9:00 pm Thursday, June 14, 2012, I started my last round with [Resident 1]. [Resident 1] assisted me in his repositioning to left side towards window. Completed all care on hall 2 around 9:20 pm. Started back down the hall going out to go smoke and see co-worker CNA E. Passed by [Resident 1's] room and [his roommate] was up in his [wheelchair]. I stopped and spoke to him asked him was he ok. He said yes and I noticed [Resident 1's] color just didn't look right. Went over to his bed and his eyes were closed. I felt for pulse on wrist neck and listened for heartbeat on his chest. Heard or felt nothing[.] Tried to page [CNA M] co-worker on Hall and couldn't get a quick response. So I immediately left the room to locate the charge nurse [LVN S] whose cart was on our hall and she was in the room with [another resident] at the front of the Hall 2. [I] asked [LVN S] to please come out [of another resident's room] I needed to talk to her. She said ok, just a minute. I said I need you now without alerting [the other resident] anything was wrong. She came to the door, informed her of couldn't find a pulse or heartbeat on [Resident 1] and she went to his room. I started to his room and met co-worker [CNA E] in the hall. I must have had a strange look on my face and she stopped me and said what's wrong. I told her and she pushed her linen cart aside and came back down the hall with me to [Resident 1's] room after about a time frame of 2 minutes. Went in the room. The nurse was standing looking at [Resident 1]. I did not see CPR performed and was not informed of a DNR or full code at this time was 9:26 p.m.

CMS Ex. 7, at 98-99. Nowhere does Petitioner dispute that its staff should not have initiated its CPR emergency response policy on Resident 1.

1. Contrary to Petitioner's emergency response policy and procedures, CNA B did not call for help by pulling the emergency call light in the bathroom while verbally calling for help.

CNA B found Resident 1 unconscious. She noted that upon entering his room he "didn't look right." CNA B checked his pulse and heartbeat but "felt nothing." Although she states she "tried to page" CNA M, she didn't get a "quick response" and left the room to locate LVN S. CNA B did not pull the emergency call light in the bathroom or verbally call out for help, contrary to Petitioner's emergency response policy and procedures. CMS Ex. 7, at 96, 98-99, 101, 106; CMS Ex. 8, at 2.

2. Contrary to Petitioner's emergency response policy and procedures, CNA B did not stay with Resident 1 and initiate CPR while waiting for other staff to arrive.

Instead of remaining with Resident 1 after alerting other staff with the emergency call light in the bathroom and initiating CPR while waiting for help, CNA B left the room to look for "the charge nurse," contrary to Petitioner's emergency response policy and procedures. CMS Ex. 7, at 98-99; CMS Ex. 8, at 2. During this critical period, Resident 1 was left unattended and received no CPR.

3. Contrary to Petitioner's emergency response policy and procedures, no staff member called EMS.

It is undisputed that no one called EMS, contrary to Petitioner's emergency response policy and procedures. P. Ex. 12, at 1- 3; CMS Ex. 7, at 89, 90, 94, 96, 97, 98-99, 101, 106; CMS Ex. 8, at 2. This is consistent with the written statements of LVN S, CNA B, and DON R. Instead, CNAs B and E entered Resident 1's room and simply watched LVN S administer CPR. As LVN S stated, there was no "teamwork." The other staff just "stood back & watched." P. Ex. 12, at 1-3; CMS Ex. 7, at 89, 90, 94, 96, 97, 98-99, 101, 106; CMS Ex. 8, at 2.

4. Contrary to Petitioner's emergency response policy and procedures, Petitioner's staff did not effectively perform CPR until help arrived.

It is further undisputed that no one relieved LVN S and continued administering CPR once LVN S ceased her revival efforts. LVN S recognized that there was "no teamwork." P. Ex. 12, at 2; CMS Ex. 7, at 97. DON R states that LVN S "freaked out" when she thought Resident 1 was "coming up [out] of the bed to get her . . . and that's why she stopped the cpr." P. Ex. 12, at 3; CMS Ex. 7, at 89. However, neither CNA in the room intervened to continue providing CPR to Resident 1 as Petitioner's policy required.

5. CMS provided Petitioner with proper notice of the deficiencies.

Petitioner argues that the state surveyors did not properly cite the facility because they used "Tag F 224," which does not cover a facility's implementation of its abuse and neglect policies. Petitioner asserts, instead, Tag F 226 covers policy implementation deficiencies. Petitioner thus argues that the plain reading of the regulation does not apply the citation to the incident at issue. P. Br. at 4-6.

Petitioner's argument is unavailing, as it claims an incorrect reference to an F Tag designation precludes enforcement of a regulatory requirement. The State Operations Manual (SOM) includes guidance to surveyors on how to complete a statement of deficiencies (SOD). Each deficiency is listed under a separate F Tag which corresponds to a separate regulatory violation. F Tags, however, have no legal significance. Their use does not even rise to the level of survey guidance provided by the SOM, which itself does not have the force and effect of law. *Cedar Lake Nursing Home,* DAB CR1967, at 9, *citing Aase Haugen Homes, Inc.,* DAB No. 2013, at 15 (2006), *citing Beverly Health & Rehab. Servs., Inc. v. Thompson,* 223 F. Supp 2d 73, 99, 100 (D.D.C. 2002) and *Cmty. Nurition Inst. v. Young,* 818 F. 2d 943, 949 (D.C.Cir. 1987). Here, the text of the regulation at issue is set forth in the SOD, as is the surveyors' explanation of how Petitioner's conduct contravened the regulation. CMS Ex. 4, at 1-2. Further, during this appeal process, CMS notified Petitioner of the nature and legal authority relating to the cited deficiency. Petitioner thus had adequate notice of, and opportunity to respond to, the basis for the deficiency citation which related to non-implementation of its policy. *See, e.g., Alden Town Manor Rehab. & HCC,* DAB No. 2054, at 17-19 (2006).

6. Petitioner's arguments do not constitute legal grounds for exceptions to the implementation of Petitioner's emergency response policy.

Petitioner argues it could not foresee that LVN S would suffer an extreme emotional reaction to performing CPR. P. Br. at 6-7. Moreover, Petitioner argues that Resident 1 suffered his cardiac arrest before LVN S or CNA B entered the room, and thus performance of CPR would not have likely prevented physical harm for Resident 1. Accordingly, Petitioner argues it did not fail to provide goods and services to Resident 1 causing him to suffer physical harm, nor did any failure to do so make a difference as to whether Resident 1 lived or died. P. Br. at 8-10. In support, Petitioner references the testimony of R. Lynn Rea, M.D. (P. Ex. 15) and Pearl Merritt, Ed.D, MS, MSN, RN (P. Ex. 13).

Dr. Rea declared that performing CPR on Resident 1 would have been futile because cardiac arrest occurred prior to the time that LVN S was called to assess the resident. P. Ex. 15. Dr. Rea is familiar with the American Heart Association (AHA) guidelines for performing CPR and for terminating CPR by basic life support responders outside a hospital. Dr. Rea explains that AHA guidelines for out of hospital CPR provide that CPR should continue until there are signs of irreversible death or until the provider is no longer able to continue. Although Dr. Rea recognizes that LVN S was CPR certified as a basic life support provider, health care providers such as LVN S sometimes "suffer an extreme emotional reaction during their first code which renders them physically and emotionally unable to continue performing CPR. When this occurs, it is not at all foreseeable, and there is no way it can be anticipated by the facility . . . ." CMS Ex. 15, at 3. In such a situation, which Dr. Rea believes happened here, the AHA guidelines allow the traumatized provider to stop CPR and ask for help. Dr. Rea opined that Petitioner could not have reasonably foreseen that LVN S would suffer the type of severe emotional reaction she did, as she was licensed by the State of Texas, the facility conducted proper inservices regarding CPR and other life support measures, and the facility verified her CPR/basic life support certification was current. P. Ex. 15, at 3-4. Moreover, when the surveyor questioned nurses and aides at the facility about Petitioner's CPR protocol, including LVN S, all could recite and articulate the protocol. P. Ex. 15, at 4; CMS Ex. 4, at 31.

Dr. Merritt echoes Dr. Rea's affidavit in declaring that there was "no way the nursing home could have known or foreseen that [LVN S] would suffer the type of severe emotional reaction she did to her first code" given that LVN S was properly licensed, certified in CPR and basic life support, and inserviced by Petitioner. P. Ex. 13, at 5. Dr. Merritt notes that Resident 1 suffered no physical harm because he had already suffered his cardiac arrest and it is "more likely than not that Resident #1 was already dead when [LVN S] entered the room." Furthermore, according to Dr. Merritt, Petitioner's nurses and CNAs understood the facility's CPR protocol. P. Ex. 13, at 5-7.

For purposes of summary judgment, I accept Petitioner's statements that LVN S was appropriately trained, licensed, and inserviced on Petitioner's CPR policy. P. Br. at 6-7. Moreover, I accept that, when the surveyors asked Petitioner's nurses and aides about the facility's CPR policy, the employees were able to correctly recite the policy with respect to residents with full codes and residents with DNR orders. I accept that Petitioner's employees correctly stated their understanding that, if they initiated CPR, it was to continue until help arrived. P. Br. at 8; CMS Ex. 4, at 31. However, Petitioner still identifies no factual dispute that is material here. Regardless of a flawless understanding, licensing and training, Medicare requirements still obligate staff to correctly implement Petitioner's policy and procedures for administering CPR to a full code resident.

For purposes of summary judgment, I also accept that performing CPR on this resident may ultimately have proved futile, and that, as Dr. Rea noted, when CNA B initially found Resident 1 unresponsive, the resident had stopped breathing, he had no pulse and his color had changed. P. Ex. 15, at 3. Dr. Merritt acknowledges, however, that LVN S is not "qualified to pronounce death . . ." (P. Ex. 13, at 7), and the Texas Board of Nursing has determined that LVNs do not have that authority. CMS Ex. 11, at 24. At the time of Resident 1's cardiac arrest, it remains undisputed that no one responding knew whether CPR might revive the resident and neither LVN S nor CNAs B and E had the authority to declare death. Regardless of whether a resident may eventually die, Medicare requirements still obligate staff to appropriately implement Petitioner's policy and procedures with regard to administering CPR for a full code resident.

Having a full code cardiac arrest overwhelm Petitioner's staff was also something that the implementation of Petitioner's CPR policy and procedures protects against by requiring the cooperation of more than one person. So I also do not find a material fact in dispute if I assume it was unforeseeable that a trained nurse may become overwhelmed while performing CPR.

Finally, Petitioner argues that the Texas Supreme Court has held that when the withdrawal of life-saving measures is at issue, if the patient, in reasonable medical probability, would not survive due to a prior event that precedes an allegedly neglectful act (i.e., the patient had less than a 50% chance of survival before the alleged neglect occurs), then the health care provider cannot be liable, citing *Park Place Hosp. v. Estate of Milo*, 909 S.W.2nd 508 (Tex. 1995). Petitioner's analogy to this case is inapposite. Petitioner acknowledges that this is a federal, not a state, forum, but urges me to apply Texas law here and find that federal regulations do not require facilities to undertake treatment that is futile or that in reasonable probability would make no difference. P. Response at 7-8. Petitioner's argument is unavailing. *Park Place Hosp. v. Estate of Milo* involves issues relating to whether an estate can collect damages; it does not concern whether a facility is in substantial compliance with federal regulatory requirements, which would not excuse the non-compliance here even if I were to assume Resident 1's chances of survival were less than 50%.

C. The undisputed evidence establishes Petitioner was not in substantial compliance with 42 C.F.R. § 483.25 because Petitioner did not provide necessary care and services to Resident 1 in accordance with his plan of care.

A facility participating in the Medicare program ensures 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." 42 C.F.R. § 483.25.

Resident 1's plan of care, as noted above, provided for several approaches to ensure that staff would initiate CPR for Resident 1 in the event of cardiac arrest, including making sure that his medical record reflected his full code status, initiating CPR immediately, alerting other staff, and calling EMS for hospital transfer. P. Ex. 4; CMS Ex. 7, at 14. Petitioner failed to provide the necessary care and services to Resident 1 under 42 C.F.R. § 483.25 when its staff failed to provide him with CPR in accordance with his care plan and the facility's policy and procedures for emergency response, when Petitioner's staff failed to immediately administer CPR, contact EMS, and continue to administer CPR to Resident 1 until other staff or EMS arrived.

Petitioner argues that Resident 1 died of cardiac arrest and this event had already occurred prior to the time CNA B asked LVN S to assess the resident. P. Br. at 11-12; P. Response at 6-8. Petitioner contends specifically that when CNA B checked on the resident, shortly before summoning LVN S, Resident 1 had stopped breathing, had no pulse, and his color had changed. LVN S's assessment was the same. P. Br. at 12; P. Response at 6-7. Despite this, LVN S performed two rounds of CPR, to which Resident 1 did not respond. P. Br. at 12; P. Response at 7. Petitioner recognizes that LVN S is not qualified to pronounce death. However, referring to Drs. Rea's and Merritt's testimony, Petitioner argues that under the AHA's guidelines, discussed above, LVN S was legally authorized to stop CPR. Therefore, Petitioner did not fail to provide necessary services. P. Br. at 12.

However, providing care pursuant to section 483.25 is not "outcome determinative." The fact of a negative outcome (here Resident 1's demise) does not absolve Petitioner of responsibility. The Board previously explained in a case involving a resident in cardiac arrest, when the facility failed to call emergency services and stopped CPR after two or three rounds:

> 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.

John J. Kane Regional Ctr. – Glen Hazel, DAB No. 2068, at 17 (2007). The Board explained that the AHA guidelines recommend that, for out of hospital situations, healthcare workers provide basic life support and call for advanced cardiovascular life support as part of their professional duty to respond, except in situations where a person has obvious clinical signs of death (rigor mortis, decapitation, or dependent lividity), when an attempt to perform CPR would place the rescuer at risk of personal injury, or when a patient or surrogate has indicated resuscitation is not desired. Petitioner has not come forward with any evidence showing the aforementioned obvious clinical signs of death. As Surveyor C testified, "other than not having any pulse and heartbeat, the review of the nurses notes by LVN [S] did not contain documentation of the presence of any other presumptive or conclusive signs of death," and Petitioner has not reasonably evinced any. CMS Ex. 11, at 7; *see* CMS Ex. 11, at 14.

Clearly no one here disputes that Petitioner's staff should have initiated the CPR policy for Resident 1. By Petitioner's own timeline, it was a matter of minutes from when he was last seen conscious to when staff found him non-responsive. Had Petitioner's staff started immediately performing CPR on Resident 1, contacted EMS, and continued CPR after LVN S became overwhelmed, there may have been a different outcome here. No one knows with certainty whether the difference in care would have saved Resident 1's life if staff followed the policy and the care plan. But regardless of potential or actual outcomes, I find the undisputed evidence establishes that Resident 1 should have been afforded the requisite administration of CPR in accordance with his full code status.

D. The PICMPs that CMS imposed are reasonable.

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

The Board has repeatedly held that "an ALJ or the Board properly presumes that CMS considered the regulatory factors and that those factors support the amount imposed." *See, e.g., Pinecrest Nursing & Rehab. Ctr.*, DAB No. 2446, at 23 (2012). Thus, CMS did not need to present evidence regarding each regulatory factor. Instead, the burden was on Petitioner "to demonstrate, through argument and the submission of evidence addressing the regulatory factors, that a reduction is necessary to make the CMP amount reasonable." *Id.* (quoting *Oaks of Mid City Nursing & Rehab. Ctr.*, DAB No. 2375, at 26-27 (2011)).

Petitioner challenges the seriousness of the penalty by alleging through an expert witness that the alleged violation was isolated and only affected Resident 1 and one staff member. P. Br. at 13; P. Ex. 13, at 7. CMS argues multiple staff members were involved in the failure of the implementation of the policies, and thus the breach had the potential to place all 52 facility residents who were designated "full code" at risk of death. CMS Ex. 4, at 25-26. For purposes of summary judgment, I will assume Petitioner's proposed limited scope. The noncompliance here remains serious, given Petitioner's staff's failure to adhere to requirements to appropriately administer CPR in a life-threatening situation. Staff's failure to even, at a minimum, simply call EMS is concerning given its professed understanding of the facility's emergency response policy and procedures. Petitioner did not otherwise come forward with any evidence challenging the reasonableness of the PICMPs with respect to any of the other regulatory factors that would affect my consideration of the amount of the penalty. 42 C.F.R. § 488.438(f). The PICMPs imposed, $2,750 for the instance of noncompliance at 42 C.F.R. § 483.13(c) and $4,000 for the instance of noncompliance at 42 C.F.R. § 483.25, are in the lower half of the allowable PICMP range, which is $1,000 to $10,000 per instance. 42 C.F.R. § 488.438(a)(2). I find them to be eminently reasonable from the perspective of the Petitioner considering CMS would have been able to justify a much a higher CMP due to Petitioner's substantial culpability with respect to both violations.

IV. Conclusion

For the reasons set forth above, I grant summary judgment and sustain CMS's determinations. I find that the undisputed evidence establishes Petitioner was not in substantial compliance with the participation requirements at 42 C.F.R. §§ 483.13(c) and 483.25 and that the PICMPs imposed, $2,750 for the instance of noncompliance at section 483.13(c) and $4,000 for the instance of noncompliance at section 483.25, are reasonable.

/s/
Joseph Grow
Administrative Law Judge