Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Lakeridge Villa Healthcare Center
Docket No. A-11-30
Decision No. 2396
June 30, 2011

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Lakeridge Villa Healthcare Center (Lakeridge), an Ohio skilled nursing facility (SNF), appeals the September 23, 2010 decision of Administrative Law Judge (ALJ) Richard J. Smith, *Lakeridge Villa Healthcare Center*, DAB CR2249 (2010) (ALJ Decision). The ALJ determined that Lakeridge was not in substantial compliance with two Medicare participation requirements: 42 C.F.R. § 483.13(b), which states that residents have the right to be free from physical and other abuse; and 42 C.F.R. § 483.25, which establishes a quality of care standard that a SNF must meet for each resident. The ALJ also sustained two civil money penalties that the Centers for Medicare & Medicaid Services (CMS) had imposed on Lakeridge for its alleged noncompliance with those requirements.

For the reasons discussed below, we affirm the ALJ Decision.

Legal Background

In order to participate in Medicare, a SNF must comply with the participation requirements in 42 C.F.R. §§ 483.1-483.75. Compliance with these requirements is verified by nursing home surveys conducted by state health agencies. 42 C.F.R. Part 488, subpart E. Survey findings are reported in a document called a Statement of Deficiencies. *See, e.g.*, CMS Ex. 9. A "deficiency" is "any failure to meet a participation requirement." 42 C.F.R. § 488.301.

CMS may impose enforcement "remedies" on a SNF if it determines, on the basis of survey findings, that the SNF is not in "substantial compliance" with one or more participation requirements. 42 C.F.R. §§ 488.400, 488.402(b), (c). A SNF is not in substantial compliance when it has a deficiency that creates the potential for more than minimal harm to one or more residents. *Id.* § 488.301 (defining "substantial compliance" to mean the "level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm"). Under the regulations, the term "noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." *Id.*

The remedies available to CMS include a civil money penalty (CMP) "for either the number of days a facility is not in substantial compliance with one or more participation requirements or for each instance that a facility is not in substantial compliance[.]" 42 C.F.R. § 488.430(a). If CMS chooses to impose a per-instance CMP, the CMP must be imposed within the range of $1,000 to $10,000. *Id.* § 488.438(a)(2).

A SNF may challenge a finding of noncompliance that has resulted in the imposition of a CMP or other remedy by requesting a hearing before an ALJ. *See* 42 C.F.R. §§ 488.408(g)(1), 498.3(b)(13), 498.5(b). The SNF may also contend in that proceeding that the amount of a CMP imposed by CMS is unreasonable. *Capitol Hill Community Rehabilitation and Specialty Care Center*, DAB No. 1629, at 5 (1997).

Case Background[1]

On November 19, 2008, the Ohio Department of Health (ODH or "State survey agency") completed a compliance survey of Lakeridge ("November 2008 survey"). *See* CMS Ex. 1, at 1. As a result of that survey, ODH cited Lakeridge for two immediate jeopardy-level deficiencies: a violation of section 483.13(b) involving Resident 46; and a violation of section 483.25 involving Resident 100. CMS Exs. 1, 9, 10. CMS concurred with both deficiency citations and imposed a per-instance CMP for each violation: $5,100 for the noncompliance involving Resident 46; and $4,900 for the noncompliance involving Resident 100. CMS Ex. 1, at 2-3.

Lakeridge requested a hearing to contest the findings of noncompliance, and the case was initially assigned to ALJ Alfonso Montano. On September 25, 2009, Judge Montano issued a ruling that granted summary judgment for CMS on the compliance issue involving Resident 46 but ruled that genuine disputes of material fact precluded summary judgment on the compliance issue involving Resident 100. On the latter issue, Judge Montano conducted an evidentiary hearing over two days (January 12 and April 8, 2010), receiving testimony from seven witnesses: Laura McClure and Alice Cox, R.N., ODH surveyors; Bernard Moskowitz, Lakeridge's Assistant Administrator and President; Syed Moqeeth, M.D., Resident 100's attending physician and Lakeridge's Medical Director; Dinah Lynn Studt, R.N., Lakeridge's Director of Nursing; Debbie Ohl, R.N., an expert witness called by Lakeridge; and Roberta Ann Kaplow, R.N., Ph.D., an expert witness called by CMS.

[1] The information in this section is drawn from the ALJ Decision and the record before the ALJ, and is presented to provide a context for the discussion of the issues raised on appeal. Nothing in this section is intended to replace, modify, or supplement the ALJ's findings of fact or conclusions of law.

After the hearing, Judge Montano left his position as an ALJ, and the case was re-assigned to ALJ Smith, who issued the decision that Lakeridge now appeals. Based on the evidence before him, the ALJ concluded that Lakeridge was, as CMS had determined, noncompliant with section 483.13(b) in its care of Resident 46 and noncompliant with section 483.25 in its care of Resident 100. The ALJ also concluded that the amounts of the per-instance CMPs were reasonable.

Lakeridge then filed this appeal, contesting these key conclusions.

Standards of Review

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. *Kingsville Nursing and Rehabilitation Center*, DAB No. 2234, at 3 (2009) (*citing Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986)). 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. *Id*. 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 the governing law. *Id.*; *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). Whether summary judgment is appropriate is a legal issue that we address de novo. *Lebanon Nursing and Rehabilitation Center*, DAB No. 1918, at 7 (2004).

In an appeal of an ALJ decision based on evidence developed in an evidentiary hearing, the Board's standard of review on a disputed finding of fact is whether the decision is supported by substantial evidence on the record as a whole. *Appellate Review* of *Decisions* of *Administrative Law Judges Affecting* a *Provider's Participation in the Medicare and Medicaid Programs ("Guidelines")*, http://www.hhs.gov/dab/divisions/appellate/guidelines/index.html. The Board's standard of review on a disputed conclusion of law is whether the ALJ's decision is erroneous. *Id.* Substantial evidence is "more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971), quoting *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938). Under the substantial evidence standard, the reviewer must examine the record as a whole and take into account whatever in the record fairly detracts from the weight of the evidence relied on in the decision below. *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 488 (1951).

Discussion

1. *Lakeridge was noncompliant with 42 C.F.R. § 483.13(b) in its care of Resident 46.*

Title 42 C.F.R. § 483.13(b) states that a "resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion." For purposes of this requirement, the regulations define the term "abuse" to mean "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish." 42 C.F.R. § 488.301; *see also Beverly Health and Rehabilitation Center*, DAB No. 1748, at 6 (2000).

Granting summary judgment to CMS, the ALJ concluded that Lakeridge was noncompliant with section 483.13(b) because it failed to ensure that Resident 46 remained free from physical abuse. ALJ Decision at 5-6. That conclusion, as we indicated earlier, was based on the factual findings and legal analysis in Judge Montano's September 25, 2009 summary judgment ruling. In that ruling, Judge Montano found the following facts to be undisputed:

- On September 23, 2008, a Lakeridge employee known here as Housekeeper #9 (H9) "pulled [Resident 46] across a corridor in the behavior unit on the second floor of the facility, then pushed her into a wall, grabbed her neck, and struck her at least once in the left eye and on her face."

- Lakeridge admitted that H9 injured Resident 46 during this incident.

- Immediately after the incident, "H9 was left alone with [Resident 46] and another resident while Laundry Aide #7 (LA7) . . . went to find the Director of Nursing[.]"

- LA7 reported that H9 had hit Resident 46 two or three times during the incident.

- Activity Aide #2 saw Resident 46 after the incident and reported that Resident 46's eye was bloodshot, red and swollen.

Sept. 25, 2009 Ruling on CMS's Motion for Summary Judgment at 1-2. In addition, Judge Montano ruled that Lakeridge did not create a genuine dispute of material fact with its contention that it "could not have known" that H9 "would react as he did." *Id.*; Pet.'s Reply to Motion for Summary Judgment (dated Aug. 21, 2009) at 4. "What Petitioner knew or did not know relative to what its employee would do does not negate well settled case law [that a SNF is liable for the actions of its employee acting within the scope of his employment] and the undisputed fact that the resident was hit by Petitioner's employee and Petitioner is responsible for the conduct of its employee." *Id.*

While not disputing that H9's treatment of Resident 46 on September 23, 2008 constituted "abuse," Lakeridge contends in this appeal that the facts found by the ALJ were insufficient to prove noncompliance with section 483.13(b).[2] RR at 6-9. According to Lakeridge, CMS must do more than prove the occurrence of an abusive act by a facility employee. In these circumstances, says Lakeridge, a showing of noncompliance with section 483.13(b) requires evidence that the SNF "failed to protect residents from reasonably foreseeable risks of abuse." RR at 7 (emphasis added).

Lakeridge further contends that H9's misconduct was not, in fact, foreseeable. RR at 9 (asserting that it provided "sufficient evidence to demonstrate . . . the impossibility of predicting H9's behavior"). According to Lakeridge, "[n]othing in H9's employment file, background check, work history, training or prior conduct gave the facility any reason to expect H9 to become upset and strike a resident." Reply Br. at 3 (citing P. Exs. 2 and 12). Lakeridge asserts that declarations by its Assistant Administrator and Director of Nursing either verify that H9's abusive conduct was unforeseeable, or create a genuine dispute of material fact about that issue. *Id.* In addition, Lakeridge asserts that CMS did not allege or "demonstrate that [the facility] failed to take reasonably necessary precautions to prevent the abuse from occurring." *Id.*; *see also* RR at 9.

Because we find that the undisputed evidence clearly demonstrates that the staff-on-resident abuse in this case was reasonably foreseeable, we need not discuss further Lakeridge's argument that a showing of noncompliance with section 483.13(b) requires evidence that the SNF "failed to protect residents from reasonably foreseeable risks of abuse." RR at 7. CMS submitted evidence that, prior to the September 23, 2008 incident involving Resident 46, Lakeridge possessed – but failed to act upon or evaluate – information indicating that H9 had anger-control problems. The Statement of Deficiencies contains the following report of the state survey agency's interview of Housekeeping Manager 8 (HM8):

> [HM8] was interviewed . . . . [He] stated he was [H9's] direct supervisor and was responsible for scheduling. HM8 stated [that] on 09/23/08, H9 returned to work after three weeks off. HM8 stated [that] H9 had been hospitalized and was under quite a bit of stress. He stated [that] he knew H9 had court ordered anger management classes and had known this for quite some time as he was not able to schedule H9 to work on Tuesdays. He identified Tuesday as the day H9 met weekly with his probation officer and had anger management classes. HM8 stated [that] he allowed H9 to work on 09/23/08 because he thought it was good for him to get away from

[2] Lakeridge contends that the ALJ failed to make "detailed findings" supporting his summary judgment ruling concerning Resident 46. RR at 5-6. Any such error is harmless because our consideration of the summary judgment issue and our related findings are de novo.

> all of his problems. H9's employee record was silent for evaluation of the employee's performance and scheduling for weekly visits to a probation officer or attendance at anger management sessions.

CMS Ex. 9, at 7 (emphasis added).

Assistant Administrator Bernard Moskowitz and Director of Nursing Dinah Studt, R.N. responded to this survey finding in their declarations. While both claimed that H9 "never showed violent or aggressive tendencies before the incident," neither denied that H9 had been ordered to participate in anger management classes or that HM8 was in possession of that information prior to the incident involving Resident 46. *See* P. Exs. 12-13. And neither claimed that HM8 shared the information with other employees.

In short, the undisputed facts, viewed in the context of the entire record, demonstrate that prior to September 23, 2008, HM8 knew that H9 was attending court-ordered anger management classes and failed to share that information with the nursing staff or facility management before allowing H9 to work on September 23, 2008. The information was plainly relevant to H9's fitness to work around residents, particularly those (like Resident 46) who had dementia.

The testimony proffered by Lakeridge – contained in the declarations of the Assistant Administrator and Director of Nursing – does not make a difference in this case. The Assistant Administrator and Director of Nursing suggested that Lakeridge was not responsible for the information in HM8's possession because HM8 was not a "management" employee and did not report what he knew to management. P. Ex. 12 ¶ 14; CMS Ex. 13 ¶ 3 (stating that "no one in facility management had any knowledge" of H9's court-ordered anger management classes). However, Lakeridge cannot disown HM8's reporting failure because a SNF is accountable for the acts or omissions of <u>any</u> employee, supervisory or otherwise. *Royal Manor*, DAB No. 1990, at 12 (2005) (stating that a SNF "acts through its staff and is correspondingly responsible for their actions as employees"); *North Carolina State Veterans Nursing Home, Salisbury*, DAB No. 2256, at 12 (2009) (stating that "[t]he rationale for holding a facility accountable for the actions of its staff applies equally to all staff members"). Moreover, neither the Assistant Administrator nor the Director of Nursing excused HM8's reporting failure or suggested that the information about H9's court-ordered classes would not have caused them to take precautions, such as inquiring about the circumstances that led the classes, changing H9's work duties, monitoring his conduct in the facility, or suspending or terminating his employment.

We further note that, in connection with its claim that H9's conduct was unforeseeable, Lakeridge fails to address the significance of undisputed information in the record about H9's criminal background. In support of its motion for summary judgment, CMS submitted a document, reportedly obtained from Lakeridge's files, that appears to be a

2007 criminal background check of H9. CMS Ex. 19; CMS Ex. 31 ¶ 6. The document reveals a troubling history, including prior misdemeanors for intoxication (2000), menacing by stalking (1999), DUI (1993), and assault and battery (1973), as well as a felony conviction for carrying a concealed weapon (1985). CMS Ex. 19. Lakeridge does not challenge a declaration by one of the surveyors that this document was obtained from its files (CMS Ex. 31, ¶ 6), nor does Lakeridge deny that such information, in combination with the information about H9's court-ordered classes, would have led it to take precautions to protect its residents.

Characterizing H9's court-ordered anger management classes as having "result[ed] from a personal matter" that "did not involve work," the Assistant Administrator and Director of Nursing claimed in their declarations that "[t]he only way Lakeridge could have learned about [the] domestic issue was if it conducted ongoing criminal background checks on staff, which is neither required nor feasible." P. Ex. 12 ¶ 14; P. 13 ¶ 3 (emphasis added). This contention is unconvincing because a facility employee (HM8) had actual knowledge of the court-ordered classes, and Lakeridge is charged with that knowledge – knowledge that, at minimum, should have prompted Lakeridge to inquire about the circumstances that led to the underlying court order. Moreover, the fact that the order resulted from a "personal" and not an employment situation is immaterial. Lakeridge's own analysis focuses on whether a SNF has taken appropriate precautions to protect residents from potential abuse. For purposes of that analysis, the material issue presented by CMS's evidence is whether Lakeridge acted to assess the potential that H9's "personal" problems or "domestic" behavior might affect – or be indicative of – his ability to work safely around residents. There is, as indicated, no allegation, much less evidence, that Lakeridge performed such an assessment prior to September 23, 2008.

For the reasons discussed above, we affirm the ALJ's conclusion that Lakeridge was not in substantial compliance with section 483.13(b) in its care of Resident 46 on September 23, 2008.

2. *The ALJ's conclusion that Lakeridge was noncompliant with 42 C.F.R. § 483.25 in its care of Resident 100 is supported by substantial evidence and free of legal error.*

Title 42 C.F.R. § 483.25 states 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" of the resident "in accordance with [the resident's] comprehensive assessment and plan of care." The Board has held that section 483.25 "requires long-term care facilities to furnish the care and services set forth in a resident's care plan; to monitor and document the resident's condition; and to implement physician orders." *Embassy Health Care Center*, DAB No. 2327, at 6 (2010) (citing cases). Section 483.25 also "implicitly imposes on facilities a duty to provide care and services that, at a minimum, meet accepted professional standards of quality 'since the

regulations elsewhere require that the services provided or arranged by the facility must meet such standards.'" *Sheridan Health Care Center*, DAB No. 2178, at 15 (2006) (quoting *Spring Meadows Health Care Center*, DAB No. 1966, at 17 (2005)).

The ALJ concluded that Lakeridge was noncompliant with section 483.25 when its nursing staff failed to administer CPR to Resident 100 on July 19, 2008. ALJ Decision at 9, 13. The facts found by the ALJ in support of that conclusion include the following:

- On July 19, 2008, Resident 100 was a "full-code" resident, a status reflected on a "Full Measures" form found in Lakeridge's records. ALJ Decision at 7; *see also* CMS Ex. 24, at 3; CMS Ex. 38 ¶ 4. "On the facility's Full Measures form, [Resident 100] had requested that, in the event that she required emergency medical treatment, facility staff would provide her with 'resuscitative, life sustaining and/or life-support measures.'" ALJ Decision at 7 (citing CMS Ex. 24, at 3). "The Full Measures form [also] specifies that [Resident 100] did not have a 'Do Not Resuscitate' (DNR) order." *Id*. Resident 100's "full measures" or full code status was communicated to the nursing staff in a physician order. *Id.*

- At 1:45 a.m. on July 19, 2008, Resident 100 was transported to the hospital because of low oxygen saturation levels. ALJ Decision at 7. She returned to Lakeridge at 4:00 a.m. that same day with oxygen saturation levels at 97 percent. *Id.*

- Sometime between 3:35 and 3:55 p.m. on July 19, 2008, Resident 100 was taken to the bathroom by Licensed Practical Nurse 30 (LPN-30). ALJ Decision at 7 & n.2. LPN-30's notes for that encounter state that Resident 100 was resting comfortably with stable vital signs and oxygen saturation at 93-94 percent. *Id.*

- The next entry in LPN-30's treatment notes for Resident 100 is at 4:10 or 4:15 p.m. (the same day). ALJ Decision at 7. That entry states that LPN-30 found Resident 100 unresponsive and stiff and with closed eyes, cool skin, and absent vital signs. *Id.* LPN-30 notified her supervisor, Registered Nurse 20 (RN-20), of this discovery. *Id.* at 8. RN-20 later recalled, during a survey interview, that LPN-30 had told her that Resident 100 had died. *Id.*

- At approximately 4:30 p.m., RN-20 phoned Dr. Moqeeth, Lakeridge's Medical Director. ALJ Decision at 8. Dr. Moqeeth testified that RN-20 informed him during this telephone call that the "patient was found dead, you know, cold, clammy, can we release the body." *Id.* at 10 (quoting Jan. 12, 2010 Tr. at 129). CPR was not discussed during the call. *Id.*

- RN-20 informed surveyors that when LPN-30 told her that Resident 100 had died, she called the resident's physician, notified the resident's family, and left a

message with the Director of Nursing. ALJ Decision at 8. The Director of Nursing returned RN-20's call at 5:00 p.m. *Id.* Afterward, RN-20 observed Resident 100's body. *Id.* She recalled that the body was then not cold or stiff. *Id.*

- LPN-30 "failed to initiate CPR when she discovered [Resident 100] unresponsive at 4:10 p.m," and "[t]here is no evidence that LPN-30 consulted with or was advised by a physician at 4:10 p.m. that she should not initiate CPR." ALJ Decision at 7-8, 10. In addition, RN-20 "failed to initiate CPR when she was informed of [Resident 100's] condition." *Id.* at 8. Also, neither LPN-30 nor RN-20 checked Resident 100's code status until 5:00 p.m., 50 minutes after Resident 100 was first discovered to be unresponsive. *Id.*

- Lakeridge fired LPN-30 for failing to perform CPR on Resident 100, and suspended RN-20 for three days for failing to properly supervise LPN-30. ALJ Decision at 8.

In addition to these facts, the ALJ found that Lakeridge's failure to administer CPR to Resident 100 in these circumstances violated or disregarded professional nursing standards, American Heart Association (AHA) guidelines, the facility's own CPR policy, physician orders, and Resident 100's wishes as expressed in her advance directive. ALJ Decision at 10, 13.

Substantial evidence supports the ALJ's conclusion that on July 19, 2008, Lakeridge was noncompliant with section 483.25 in its care of Resident 100. As indicated, the "necessary care and services" required by section 483.25 include care and services called for by accepted professional standards of nursing practice. *Oaks of Mid City Nursing and Rehabilitation Center*, DAB No. 2375, at 6 (2010); *John J. Kane Regional Center – Glen Hazel*, DAB No. 2068, at 11 (2006). The record here contains ample undisputed evidence of an applicable and accepted nursing practice standard.[3] *See* ALJ Decision at 8-9; CMS Ex. 26. That standard, enunciated by CMS's expert Roberta Ann Kaplow and reflected in Lakeridge's own CPR policy, required the nursing staff, upon discovering Resident 100 without clinical life signs (e.g., lack of pulse and respiration), to immediately: (1) verify the resident's code status; (2) summon paramedics (call 911) or the facility's emergency response team; and (3) initiate and continue administering CPR until the resident's death was pronounced by a physician or other competent medical professional. *See* CMS Exs. 26, 37 (at 14), 38 (¶¶ 4-10), and 40; April 8, 2010 Tr. at 23-33.

[3] That evidence includes: Lakeridge's post-incident report (CMS Ex. 25, at 6); LPN-30's termination report (*id.* at 2); RN-20's disciplinary form (*id.* at 4); a July 22, 2008 written statement by Lakeridge's Director of Nursing (*id.* at 1); CPR guidelines published by the AHA (CMS Ex. 37); testimony by CMS expert Roberta Ann Kaplow, R.N., Ph.D. (CMS Ex. 40 and April 8, 2010 Tr. at 23-33); testimony by State surveyors Laura McClure and Alice Cox (CMS Ex. 38 and Jan. 12, 2010 Tr. at 26); and, finally, testimony by Lakeridge's medical director, Dr. Moqeeth, who conceded that LPN-30 should have performed CPR on Resident 100 (Jan. 12, 2010 Tr. at 100, 131).

The record further confirms the ALJ's finding that the nursing staff failed to comply with the applicable nursing practice standard. There is no dispute that on July 19, 2008, Resident 100 was a full code (or "full measures") resident, having requested "resuscitative, life sustaining and/or life-support measures." P. Ex. 13 ¶ 6. Also undisputed is that although Resident 100 was found without clinical life signs at 4:10 or 4:15 p.m. that day, no one at Lakeridge initiated CPR, called 911, or sought or received a pronouncement of death from a physician. *See* CMS Ex. 38; P. Exs. 12-13. Lakeridge also does not dispute the ALJ's finding that staff made no attempt to verify Resident 100's code status until 50 minutes after she was discovered unresponsive. *See* RR at 6-9. Roberta Ann Kaplow gave uncontradicted testimony that LPN-30 deviated from the standard nursing practices when: (1) "she failed to contact 911 or activate an emergency response team upon finding that [Resident 100] was unresponsive, apneic (not breathing) and pulseless"; (2) "failed to initiate cardiopulmonary resuscitation (CPR) upon finding [Resident 100] in this condition"; and (3) "failed to rescue [Resident 100] during a life-threatening emergency." CMS Ex. 40; April 8, 2010 Tr. at 23. Surveyor Cox (a registered nurse) gave similar testimony. *See* CMS Ex. 38 ¶¶ 4-16. Even Lakeridge's Medical Director and Director of Nursing admitted (at the hearing or to surveyors) that LPN-30 should have initiated CPR under these circumstances. Jan. 12, 2010 Tr. at 100, 131; CMS Ex. 38 ¶ 20.

AHA guidelines on CPR state that CPR should be provided unless: (1) there is a Do Not Resuscitate (DNR) order; (2) there are signs of irreversible death, such as rigor mortis, decapitation, decomposition, or dependent lividity; or (3) no physiological benefit can be expected because vital signs have deteriorated despite maximal therapy (e.g., progressive septic or cardiogenic shock). CMS Ex. 37, at 14. The ALJ found that "[n]one of the AHA exceptions to providing CPR are present in the case of [Resident 100]," ALJ Decision at 9, and Lakeridge does not dispute that finding. Moreover, none of the contemporaneous nursing records indicate that LPN-30 or RN-20 assessed Resident 100 for the signs of irreversible death specified in the AHA guidelines (to the extent they were trained or authorized to do so).[4]

In an undated memorandum, the Director of Nursing wrote that when she asked LPN-30 why she had not initiated CPR at 4:10 or 4:15 p.m., LPN-30 reported that Resident 100's body was stiff, dusky, and very cold and that the resident "was dead obviously for some

[4] Rigor mortis was the only "sign of irreversible death" that Lakeridge even hints was present at 4:10 or 4:15 p.m. CMS's expert witness testified that rigor mortis – defined as "stiffening of a dead body, accompanying the depletion of adenosine triphosphate in the muscle fibers" (Dorland's Illustrated Medical Dictionary, 28th ed.) – ordinarily does not set in until three or four hours after clinical death. April 8, 2010 Tr. at 31. In view of this uncontested testimony, the suggestion that rigor mortis was present at 4:10 or 4:15 p.m. is, as CMS's expert witness noted, inconsistent with LPN-30's report that Resident 100 was alive 20 to 30 minutes earlier. *Id.* Moreover, a surveyor and CMS's expert on CPR testified that nurses are not authorized or trained to assess whether a patient has rigor mortis. Jan. 12, 2010 Tr. at 81-82, 83-84; April 8, 2010 Tr. at 29, 31.

time." CMS Ex. 25, at 3. Even if LPN-30's report is truthful, it does not justify her failure under the applicable nursing standard to administer CPR until a physician or a paramedic pronounced the resident's death. The report implies that Resident 100 had signs of irreversible death, but, as we indicated earlier, there is no persuasive evidence (e.g., contemporaneous nursing notes) that LPN-30 actually assessed Resident 100 for those signs. And, as the ALJ found, CPR "is designed to be given when an individual shows no signs of life." ALJ Decision at 9. The ALJ had other good reasons to discount LPN-30's report. Surveyor Laura McClure testified that RN-20 had told her in an interview that when RN-20 went to see Resident 100 at around 5:00 p.m. (45 minutes after LPN-30 discovered the resident in an unresponsive state), Resident 100's body was not cold or stiff. Tr. at 25; *see also* CMS Ex. 12, at 9. RN-20's statement to the surveyor is inconsistent with the statement in LPN-30's report, and Lakeridge did not put on any testimony by LPN-30 or RN-20 to resolve the inconsistency.

Lakeridge's appeal briefs fail to address many, if not all, of the ALJ's key factual and credibility findings. Most notably, Lakeridge does not question the ALJ's acceptance of the testimony by CMS's expert witness (Roberta Ann Kaplow) concerning the applicable standard of care or suggest that the nursing staff's failure to initiate CPR was consistent with that standard. Nor does Lakeridge contend that the facts found by the ALJ were insufficient to support the conclusion that the facility was noncompliant with section 483.25. Instead, Lakeridge principally argues, as it did before the ALJ, that the nursing staff's inaction was justified because CPR was a medically futile exercise given Resident 100's age, fragile medical condition, and short life expectancy. RR at 9-10. According to Lakeridge, the ALJ's findings are "nothing more than a hindsight determination that Lakeridge should have initiated CPR on a frail, terminally ill resident, who not only did not have a chance of surviving CPR, but, more importantly, had been biologically dead for several minutes before CPR could have been initiated." *Id.* Lakeridge asserts that LPN-30 was Resident 100's "regular caregiver," familiar with her medical history and prognosis, "thoroughly trained" in CPR, and thus was in a good position to know whether CPR would be efficacious. *See* Reply Br. at 4. Lakeridge also points to testimony by Dr. Mosqeeth that Resident 100 would not have survived even if CPR had been started immediately. Reply Br. at 6 (citing Tr. at 125-31 and P. Ex. 17 ¶ 4).

Lakreidge's argument is based upon the faulty premise that a nurse may disregard a resident's advance directive to administer CPR if, in his or her clinical judgment, CPR would be medically futile. The ALJ rejected that argument (ALJ Decision at 11), and his reasons for doing so (and for giving more weight to the testimony of CMS's expert witness, Roberta Ann Kaplow, than to the testimony of Lakeridge's expert, Deborah Ohl) are sound, supported by the record, and require no additional elaboration or discussion. Moreover, we have independently reviewed the entire record and see nothing that materially detracts from the ALJ's findings. As the ALJ noted, Lakeridge's own witnesses conceded that, in these circumstances, LPN-30 should have initiated CPR on Resident 100 and that the authority or professional discretion to withhold that procedure

properly rested in the physician's hands, not the nurse's. *See* ALJ Decision at 12-13 (discussing Debbie Ohl's testimony); *id.* at 10 (accurately noting that Lakeridge's Director of Nursing testified that only a physician may make the decision to stop CPR or not to begin it); *id.* at 11 (accurately noting that Dr. Moqeeth admitted on cross-examination that LPN-30 was not authorized to decide whether to withhold CPR).

None of Lakeridge's other contentions undermine the ALJ's conclusion that its nursing staff breached the applicable standard of care. For example, Lakeridge challenges the ALJ's finding (ALJ Decision at 9) that the nursing staff failed to follow its own resident care policy. Reply Br. at 4. According to Lakeridge, LPN-30 "made a clinical decision not to commence CPR because [Resident 100] was beyond the need for the 'emergency medical services' called for by the facility's full measures policy." Reply Br. at 4. The contention mistakenly assumes that the facility's CPR policy permits a nurse to decide whether or not to perform CPR based on an evaluation of the procedure's efficacy or likely consequences. In fact, the policy does not permit a nurse to conduct or act upon such an evaluation but, rather, directs the nurse to act in accordance with the nursing practice standard described above. *See* CMS Ex. 26.

Lakeridge further contends that the ALJ could not have made a sound decision because he did not have the benefit of personally observing the demeanor of employees – namely, LPN-30 and RN-20 – who were involved in the incident, making the "already difficult process of applying the law to the grey areas of medicine . . . almost impossible[.]" RR at 11. This contention is legally baseless because an ALJ is permitted to make credibility findings concerning statements made outside the hearing. *Woodland Oaks Healthcare Center*, DAB No. 2355, at 7 (2010) (holding that Board "deference is warranted for credibility findings [by an ALJ] concerning unsworn written statements of facility employees who, for whatever reason, do not testify in-person"). The contention is also factually baseless because neither LPN-30 nor RN-20 testified. Moreover, Lakeridge does not indicate what they would have said or how their testimony would have materially altered the ALJ's understanding of the relevant circumstances, nor does Lakeridge allege that it was precluded from producing or compelling their testimony.[5]

In addition, Lakeridge asserts that nurses in Ohio "are authorized [under state law] to assess whether a patient is deceased and phone the patient's death in to a physician who, upon reliance of the nurse's assessment, pronounces death without personally examining the body." RR at 12 (emphasis added) (citing P. Ex. 19, at 1); *see also* Reply Br. at 4-5. According to Lakeridge, "nothing different happened in this case": "LPN-30 discovered [Resident 100]f obviously dead, assessed to make sure, and contacted her physician and

[5] Because CMS made a prima facie showing of noncompliance with section 483.25, the burden was on Lakeridge to demonstrate, by a preponderance of evidence, that it was in substantial compliance with section 483.25 on July 19, 2008. *Evergreen Nursing Care Center*, DAB No. 2069, at 7-8 (2008).

the coroner." Reply Br. at 6. "It borders on hypocrisy," says Lakeridge, to accept that a nurse can telephone a physician and be relied upon in her assessment of the patient's death to an extent where the physician is not required to even look at the patient, yet that same nurse is allegedly not capable of assessing a patient, for which she was the primary caregiver, for the purpose of initialing [sic] CPR and determine that this patient was obviously dead." RR at 12.

This contention misrepresents the law and the evidence. Contrary to Lakeridge's assertion, the Ohio regulation in question, Ohio Administrative Code § 4731-14-01, entitled "Pronouncement of Death," does not permit a nurse to "assess" whether a patient has died. The regulation merely states that a nurse may "recite the facts of" the patient's "present medical condition" to enable the off-site physician to determine whether death has, in fact, occurred. In any event, the ALJ found that the evidence before him did not support Lakeridge's claim that its staff followed (or even attempted to follow) the procedure described in the state regulation, *see* ALJ Decision at 11, and we see nothing in the record that undermines that finding.[6] Even if RN-20's 4:30 p.m. telephone call to Dr. Moqueeth constitutes evidence of compliance with the state regulation, the call does not, as the ALJ correctly held, excuse the staff's failure to perform CPR on Resident 100 between 4:10 or 4:15 p.m. and 4:30 p.m. *See* ALJ Decision at 11.

Moreover, regardless of the role that state law carves out for nurses in the pronouncement of death, "[f]ederal law, not State law, governs what constitutes substantial compliance (or noncompliance) with the requirements for long-term care facilities participating in the Medicare program." *Cedar Lake Nursing Home*, DAB No. 2344, at 10 (2010). As we have explained, the applicable federal law obligated the nursing staff to initiate CPR for Resident 100 during the afternoon of July 19, 2008.

Finally, Lakeridge asserts that "[a]t some point, clinical judgment and common sense must override rote procedure" in deciding whether any particular patient should receive CPR or other life-saving or life-sustaining treatment. Reply Br. at 6. Such a broad, general proposition cannot override clear professional standards in determining compliance with federal regulations. Those professional standards required the performance of CPR under the circumstances presented and also dictated that a resident and her physician – not the nurse – make the judgment about the medical necessity, expected benefit, and desirability of a life-saving measure. *Cf.* CMS Ex. 38 ¶ 20 (testimony by Surveyor Cox that "[i]f nursing home staff do not think that resuscitative measures are appropriate for a particular resident this should be discussed by the physician with the resident and the resident's family, the discussion documented in the resident's medical record, and changes (if any) to the resident's code status should be indicated in the resident's care plan and physician orders"). But even if Lakeridge's

[6] As the ALJ found, Dr. Moqeeth did not at any point state or testify that he pronounced Resident 100's death during his 4:30 p.m. telephone call with RN-20. ALJ Decision at 10.

proposition concerning "clinical judgment and common sense" had some arguable relevance, there is no evidence that Lakeridge's staff did an assessment of Resident 100 that was a sufficient basis for making a sound clinical judgment about the necessity to administer CPR.

3. *The per-instance CMPs imposed by CMS for Lakeridge's noncompliance with 42 C.F.R. §§ 483.13(b) and 483.25 were reasonable.*

In choosing an appropriate remedy for a SNF's noncompliance, CMS must consider the "seriousness" of the noncompliance (and may consider other factors, such as the SNF's history of noncompliance). 42 C.F.R. § 488.404. The seriousness of a SNF's noncompliance is a function of its "severity" (whether the noncompliance has created a "potential" for harm, resulted in "actual harm," or placed residents in "immediate jeopardy") and "scope" (whether the noncompliance is "isolated," constitutes a "pattern," or is "widespread"). *Id.* § 488.404(b); State Operations Manual (SOM), CMS Pub. 100-07, App. P, sec. IV. "Immediate jeopardy" is the highest level of severity.[7] *See* 42 C.F.R. §§ 488.404 (setting out the levels of scope and severity that CMS considers when selecting remedies), 488.438(a) (authorizing the highest civil money penalties for immediate jeopardy); SOM § 7400.5.1.

When CMS elects, as it did here, to impose a per-instance CMP, the penalty amount must be in the range of $1,000 to $10,000. 42 C.F.R. §§ 488.438(a)(2), 488.408(d)(1)(iv). In deciding whether the chosen CMP amount is reasonable, an ALJ (or the Board) may consider only those factors specified in section 488.438 of CMS's regulations. *See* 42 C.F.R. § 488.438(e), (f); *Senior Rehabilitation and Skilled Nursing Center*, DAB No. 2300, at 19-20 (2010). Those factors are: (1) the SNF's history of noncompliance; (2) the SNF's financial condition; (3) factors specified in 42 C.F.R. § 488.404 (i.e., the severity and scope of the noncompliance, and "the relationship of the one deficiency to other deficiencies resulting in noncompliance"); and (4) the SNF'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. An ALJ (or the Board) reviews the reasonableness of the CMP de novo, based on the facts and evidence contained in the appeal record. *Cedar Lake Nursing Home*, DAB No. 2288, at 14 (2009); *Emerald Oaks*, DAB No. 1800, at 13 (2001); *CarePlex of Silver Spring*, DAB No. 1683, at 17-18 (1999).

The ALJ concluded that the following factors supported imposition of the $5,100 and $4,900 per-instance CMPs (for the deficiencies involving Resident 46 and Resident 100, respectively):

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[7] Immediate jeopardy is defined as a situation in which the noncompliance "has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301.

> The deficiencies are extremely serious. Physical abuse of a resident is very serious and H9 was a possible threat to other residents. Petitioner does not deny that [Resident 46] was injured by H9. As to the deficiency based on failure to perform CPR, Petitioner in essence maintains that a dead person cannot suffer harm. However, failure to perform CPR on a resident who had the full expectation that she would receive CPR based on her code status, her physician's order, and the facility's own policies, deprived her of her only chance to be resuscitated. Petitioner's failure to provide CPR to [Resident 100] revealed a similar threat to other full code residents. *Both* deficiencies demonstrate a complete disregard for the safety of its residents and thus a high degree of culpability. In light of the potential for harm, the [per-instance CMPs] imposed are reasonable.

ALJ Decision at 15 (emphasis added).

Lakeridge contends that the ALJ "incorrectly evaluated" the seriousness of the deficiencies by failing to recognize that they stemmed from "isolated incidents" on July 19 and September 23, 2008. RR at 13. Lakeridge further asserts that neither deficiency posed a potential of harm to residents other than Residents 46 and 100, as evidenced by the fact that the state of Ohio did not investigate the incidents until four months after they occurred. *Id*. Lakeridge also contends that it was not culpable for the noncompliance because it "took every reasonable step to prevent resident abuse prior to September 23, 2008" and took immediate steps to prevent repetition of the deficiencies. RR at 14. Finally, Lakeridge asserts that, contrary to the ALJ's finding, it "did not deprive [Resident 100] of her only chance to be resuscitated" because "such a chance no longer existed by the time LPN-30 discovered the resident." *Id.*

We agree with the ALJ that the amount of each per-instance CMP was reasonable given the totality of the relevant circumstances. CMS found that both deficiencies placed residents in immediate jeopardy, the highest level of severity. CMS Ex. 9, at 1-2; CMS Ex. 10, at 1-2 (citing the deficiencies at scope and severity level J, which denotes "isolated" immediate-jeopardy noncompliance); *see also* ALJ Decision at 5 n.1 (discussing CMS's scope-and-severity designations). We reject Lakeridge's assertion that the deficiencies posed no risk to residents other than Residents 46 and 100. The failure to report or assess H9's participation in court-ordered anger management classes placed any resident with whom H9 came in contact at risk for serious harm. Similarly, any full-code resident who may have required CPR or other life-saving procedures on July 19 was at risk of harm (or even death) from the nursing staff's disregard of proper nursing standards and the facility's own emergency procedures. In any event, the immediate jeopardy findings here justify CMPs substantially higher than the regulatory minimum of $1,000 per instance because the deficiencies are serious enough to support

the amount of the CMP regardless of whether other residents were harmed.[8] *Cedar Lake Nursing Home*, DAB No. 2390, at 18 (2011).

We also agree with the ALJ that Lakeridge was culpable in some degree for the noncompliance. The undisputed failure of a Lakeridge employee to report information relating to H9's participation in court-ordered anger management shows, at minimum, careless disregard for resident safety. That failure is also evidence that Lakeridge did not take "every reasonable step" to prevent the September 23, 2008 incident involving Resident 46. Similarly, the nursing staff's apparently complete failure to handle Resident 100's July 19, 2008 medical emergency in accordance with accepted standards of nursing practice (and with its own resident care policies) shows careless or negligent disregard for resident care at best, and deliberate indifference at worst. Other than to suggest that LPN-30 and RN-20 made a reasonable clinical judgment about the futility of CPR – a claim not supported by the contemporaneous nursing records – Lakeridge offered no plausible or legitimate excuse for its nursing staff's failure to adhere to the applicable nursing practice standard.

Finally, the fact that Lakeridge took immediate measures to prevent a repetition of the noncompliance is irrelevant in judging the reasonableness of the per-instance CMP amounts. "Although a facility's prompt institution of corrective measures is certainly desirable, the Secretary of Health and Human Services has not made doing so a basis for reducing a CMP amount." *Brian Center Health and Rehabilitation/Goldsboro*, DAB No. 2336, at 13 (2010) (citing 42 C.F.R. § 488.438(f)).

Given the seriousness of the noncompliance and Lakeridge's culpability, we affirm the ALJ's conclusion that the $5,000 and $4,900 per-instance CMPs – squarely in the middle of the applicable penalty range – were reasonable. *Cf. Brian Center Health and Rehabilitation/Goldsboro* at (2010) (upholding a $4,550 per-day CMP for immediate jeopardy-level noncompliance involving a failure to perform CPR). Lakeridge has identified no permissible basis for reducing the penalties sought by CMS.

[8] The ALJ held that CMS's immediate jeopardy findings were not appealable in these circumstances, ALJ Decision at 4, and Lakeridge does not challenge that holding. The ALJ properly applied the law on this issue in any event. *See Cedar Lake Nursing Home*, DAB No. 2390, at 4.

Conclusion

For the reasons outlined above, we affirm the ALJ Decision in its entirety.

_____/s/_____
Judith A. Ballard

_____/s/_____
Sheila Ann Hegy

_____/s/_____
Stephen M. Godek
Presiding Board Member