Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Wisconsin Veterans Home, Olson Hall,
(CCN: 52-5718),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-764

Decision No. CR4856

Date: May 26, 2017

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose civil money penalties against Petitioner, Wisconsin Veterans Home, Olson Hall, consisting of the following:

- $4000 for each day of a period that began on February 7, 2016 and that ran through February 24, 2016; and
- $100 for each day of a period that began on February 25, 2016 and that ran through April 13, 2016.

I sustain also Petitioner's loss of authority to conduct nurse aide training (NATCEP) for a period of two years.

I. Background

Petitioner is a skilled nursing facility in Wisconsin. It requested a hearing to challenge CMS's determination that Petitioner failed to comply with Medicare participation requirements governing skilled nursing facilities and also to challenge CMS's remedy determinations. At my direction the parties filed pre-hearing exchanges, including briefs

and proposed exhibits. CMS filed 34 proposed exhibits, identified as CMS Ex. 1-CMS Ex. 34. Petitioner filed 10 proposed exhibits, identified as P. Ex. 1-P.Ex. 10. Neither party objected to my receiving the proposed exhibits into evidence.

I scheduled an in-person hearing. The parties waived the hearing and advised me that they were submitting their cases based on their written exchanges. Therefore, I receive the parties' exhibits into evidence and decide this case based on the written record.

In its final brief Petitioner asserts more than once that I ruled that no disputed issues of material fact exist in this case and that, effectively, summary judgment is appropriate. That mischaracterizes what I advised the parties. I suggested to them that there did not seem to be relevant disputed issues of fact that would be resolved by disputed *testimony*, and questioned whether a hearing would be needed for the purpose of cross-examining a witness or witnesses. I did not preclude an in-person hearing however, and in fact, I scheduled one. Subsequently, the parties agreed that a hearing was unnecessary. Indeed, and as I discuss below, nothing in this decision rests on disputed *testimony*.

II. Issues, Findings of Fact and Conclusions of Law

A. Issues

The issues are whether:

- Petitioner failed to comply substantially with a Medicare participation requirement;
- CMS's determination of immediate jeopardy level noncompliance is clearly erroneous;
- CMS's remedy determinations are reasonable.

B. Findings of Fact and Conclusions of Law

CMS alleges that Petitioner failed to comply substantially with the Medicare participation requirement stated at 42 C.F.R. § 483.25. This regulation requires a skilled nursing facility to provide to each of its residents the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with each resident's comprehensive assessment and plan of care. CMS asserts that Petitioner contravened this regulation when it failed to provide cardiopulmonary resuscitation (CPR) to a non-responsive resident. It contends also that Petitioner's alleged noncompliance created a likelihood of serious injury, harm, or death to all of the residents in Petitioner's facility who might at some point be in need of CPR and who had requested that CPR be administered in the event of cessation of pulse and respiration.

CMS's noncompliance allegations center around the care Petitioner's staff gave to a resident identified as Member # 1. Upon admission to the facility in 2014 the resident and his physician signed a CPR form that stated that the resident desired that Petitioner's staff attempt to resuscitate him in the event of cardiac arrest and/or cessation of respiration. CMS Ex. 20.

In the early morning hours of February 7, 2016, a nurse discovered that the resident was not breathing and had no pulse. CMS Ex. 24 at 2. The nurse did not attempt to perform CPR on the resident. Rather, he concluded that the resident was dead. *Id.* at 1.

Petitioner had a written policy governing when to attempt CPR. The policy orders the staff to:

> activate the EMS system [call 911] and initiate CPR for a member [a resident] who suffers a cardiopulmonary arrest, unless the member has a "No CPR/DNR" order properly recorded in the chart or the member is wearing an approved DNR bracelet.

CMS Ex. 26 at 1. Petitioner's CPR policy provides no exceptions to this rule. It neither states nor suggests that a nurse has the authority to determine that CPR is inutile when he or she discovers a resident to be without pulse and respiration.

CMS argues, and I agree with CMS, that Petitioner's staff's failure to comply with Petitioner's written policy concerning administration of CPR violated 42 C.F.R. § 483.25.[1] The regulation provides a facility with some leeway as to how it will provide necessary care to its residents. But, once a facility establishes a written policy, it is bound to comply with it. A written policy governing nursing care accomplishes at least two objectives. First, it assures that a facility's staff will treat each resident uniformly in a manner consistent with the facility's determination of what is necessary care. Second, and certainly as important, it is a facility's written guarantee to each of its residents concerning what care and the level of care that it will provide to him or her.

By adopting its CPR policy Petitioner assured each of its residents, including Member # 1, that it would provide him or her with CPR if the resident requested that it be attempted in the event of cardiopulmonary arrest. Member # 1 requested that care and had a right to receive it. *See* 42 C.F.R. § 483.10. Petitioner made a promise and it was bound to keep it. There was nothing in Petitioner's guarantee that suggested that Petitioner empowered

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[1] Petitioner also violated its written policy concerning use of an Automatic External Defibrillator (AED) during episodes of cardiac arrest. Petitioner's guidelines state that the AED will be used on "unresponsive victims with no breathing and no pulse." CMS Ex. 26 at 6. As with the more general policy governing CPR, Petitioner's AED policy states no exceptions. *Id.*

its staff to make ad hoc determinations as to whether a nonresponsive resident actually would benefit from attempted CPR and to withhold attempted CPR if the staff concluded that the resident wouldn't benefit from it.

The Departmental Appeals Board's appellate panels have concluded on several occasions that a skilled nursing facility's failure to attempt CPR with a nonresponsive resident who requested it is noncompliance with the requirements of 42 C.F.R. § 483.25. *Avalon Place Kirbyville,* DAB No. 2569 (2014); *Lakeridge Villa Healthcare Ctr.,* DAB No. 2396 (2011); *Woodland Oaks Healthcare Facility,* DAB No. 2355 (2010); *John J. Kane Regional Ctr. – Glen Hazel*, DAB No. 2068 (2007). A facility may establish a general policy governing when CPR is appropriate. If it does so it must follow that policy explicitly in providing CPR to residents who become nonresponsive. *Ross Healthcare Ctr.*, DAB No. 1896, at 9 (2003).

Petitioner raises several arguments as excuse for its staff's failure to attempt CPR with Member # 1. I find them to be without merit.

Petitioner's central argument is that its CPR policy did not rigidly bind its staff to attempt CPR for every nonresponsive resident. It asserts that its nursing staff had discretion, bounded by applicable standards of care and external guidelines, to determine on a case by case basis whether or not to attempt CPR in the case of a nonresponsive resident. It asserts that CMS's insistence that Petitioner was required to apply its CPR policy as written ignores both the flexibility built into the policy and applicable standards of care and external guidelines that Petitioner contends were inherent, if unwritten, elements of its CPR policy.

This argument fails because it ignores the plain and unvarnished language of Petitioner's CPR policy. There is absolutely nothing in that policy that states or implies that Petitioner's staff has discretion to make ad hoc judgments as to whether attempting CPR will benefit an individual resident. Moreover, and as I have stated, Petitioner's residents have the right to rely on the explicit terms of Petitioner's CPR policy because that policy is a guarantee to each resident of what will happen in the event that he or she goes into cardiopulmonary arrest.

Petitioner contends that the policy incorporates guidelines published by the American Heart Association (AHA) that allegedly give discretion to health care professionals to determine when attempted CPR will or will not benefit a resident. According to Petitioner, its guidelines incorporate a CMS memorandum (characterized by Petitioner as the "S & C" memo) that in turn incorporates the AHA guidelines that allegedly give flexibility to health care professionals to make CPR utility determinations. *See* CMS Ex. 10 at 42-45.

I find nothing in Petitioner's policy that refers to the S & C memo or to AHA guidelines in defining when Petitioner's staff will attempt CPR. The operative policy language that I quote above refers to neither of these documents and there is not a word elsewhere in Petitioner's CPR policy that suggests that the policy incorporates these documents.

Moreover, neither the AHA policy on CPR nor the S & C memo provides Petitioner with justification for its staff's decision not to attempt CPR with Member # 1. Both of these documents direct staff to attempt CPR with a nonresponsive individual. CMS Ex. 10 at 42-45; CMS Ex. 28. There is nothing in either document to suggest that a nurse has discretionary authority to decide to withhold an attempt at CPR from a nonresponsive individual premised on his or her judgment that administration of CPR would be inutile.

Petitioner makes additional arguments, but they do not gainsay the fact that Petitioner's policy explicitly requires attempting CPR with each resident who requests such an attempt in the event that he or she is found to be nonresponsive. I find these additional arguments to be irrelevant for that reason alone. There are additional reasons for finding these arguments to be without merit.

For example, Petitioner argues that applicable standards of nursing care authorize a nurse to make a discretionary determination to withhold attempted CPR where the nurse determines that a resident is irreversibly dead. This argument fails first, because Petitioner's explicit policy on CPR trumps whatever professional standards of care may exist. Nothing in that policy gives any member of Petitioner's staff authority to make an ad hoc determination to ignore it.

Moreover, Petitioner effectively concedes that the generally accepted nursing standard of care requires attempted CPR when a resident is found to be nonresponsive. Petitioner's argument is that there is an exception to this rule, both in the AHA guidelines and in general standards of nursing care, allowing skilled nursing facility staff to withhold CPR in the presence of "obvious clinical signs of irreversible death." Petitioner's responsive brief at 4. Petitioner argues that Member # 1 displayed these allegedly obvious signs of irreversible death thus justifying withholding of CPR. It argues further that the nurse who decided to withhold CPR from Member # 1 did so because he made a finding that obvious signs of irreversible death were present.

Petitioner asserts that the "obvious signs of irreversible death" that were present include the following: no carotid pulse or respirations, fixed and dilated pupils, blue lips, eyelids that were difficult to open, and skin that was pale gray in color and cool to the touch despite being covered with blankets. Petitioner contends also that Member # 1's left arm was stiff (although Petitioner does not contend that rigor mortis had set in).

The AHA guidelines cite none of these findings as signs of irreversible death. Indeed, some of the findings – no carotid pulse or respirations – are cited universally as grounds for *attempting* CPR. As Petitioner concedes, the findings cited explicitly by the AHA guidelines are signs that no one would dispute as establishing irreversible death. These include rigor mortis, dependent lividity (blood pooled in a body part), decomposition, and decapitation. Petitioner's responsive brief at 14. Petitioner attempts to get around this distinction between what the AHA guidelines cite and what Petitioner contends are additional signs of obvious irreversible death by arguing that the signs cited in the AHA guidelines are mere examples and not inclusive.

I am not persuaded by this argument. I am sure that there are other examples of obvious irreversible death that might justify withholding CPR in a specific case. But, none of the signs cited by Petitioner as exhibited by Member # 1 remotely resemble the signs cited in the AHA guidelines. There simply exists no justification for liberalizing the signs as Petitioner contends.

Petitioner offered expert testimony that the signs exhibited by Member # 1 were indeed signs of irreversible death. P. Ex. 9 at ¶ 11. It is unnecessary that I make a finding as to whether this testimony is credible. Petitioner's staff should not have made an ad hoc determination of irreversible death even if the expert's testimony is correct. Not only did Petitioner's policy prohibit staff from making such findings but Petitioner offered no evidence to prove that the nurse who made the determination to withhold CPR from Member # 1 has the skills and training to interpret the signs exhibited by the resident as establishing irreversible death. Thus, the expert's testimony is irrelevant even if it is accurate.

It is also irrelevant that attempts at CPR might have provided no benefit to Member # 1. The entire point of attempting CPR on a nonresponsive individual is to give him or her a *chance* at resuscitation. I take notice that most attempts at CPR fail. CPR should have been attempted for Member # 1 both as a matter of facility policy and even if the odds of resuscitation approached zero.

CMS determined that Petitioner's noncompliance put residents of Petitioner's facility at immediate jeopardy. Regulations define immediate jeopardy to be noncompliance that causes or likely is to cause serious injury, harm, or death to a resident. 42 C.F.R. § 488.301.

CMS's determination is not clearly erroneous. Indeed, the facts strongly support an immediate jeopardy determination. Withholding attempted CPR from Member # 1 eliminated all possibility – even if highly remote – that he would be resuscitated. But,

more than that, the fact that the staff was either unaware of Petitioner's CPR policy or chose to disregard it put in immediate jeopardy every resident of the facility who requested CPR in the event of cardiopulmonary arrest. Petitioner's CPR policy was effectively meaningless, given that the staff was at liberty to make ad hoc determinations whether residents in arrest would benefit from CPR.

Petitioner argues that there was no immediate jeopardy because the nurse's determination to withhold CPR from Member # 1 was at worst, a judgment error based solely on the facts at hand. I disagree with that characterization. The evidence satisfies me that either the nurse was unaware of Petitioner's CPR policy or that he deliberately chose to ignore it. If the nurse's decision emanated from his ignorance that put residents in jeopardy because it meant that in future instances the nurse would not understand his duty to the residents. If, on the other hand, the nurse decided to ignore Petitioner's policy that would also put residents in jeopardy because it meant that no resident enjoyed the assurance that Petitioner's guarantee would apply to him or her.

Petitioner argues that there is no way to prove that withholding CPR from Member # 1 caused him to die. It argues further that withholding CPR in this case was meaningless because the resident was in fact dead. According to Petitioner, the fact that CPR would not have benefitted the resident is sufficient to establish that whatever judgment error its staff made could not possibly have caused the resident harm. Consequently, according to Petitioner, no immediate jeopardy existed.

As I have discussed, the issue of immediate jeopardy in this case isn't bounded by the harm that Petitioner's staff may or may not have caused Member # 1 to experience. It is, of course, impossible to establish that withholding CPR caused the resident to suffer or to die. The immediate jeopardy in this case does not result from the harm or injury that Petitioner's staff may have caused Member # 1 to experience. Rather, it emanates from the obvious failure of the staff to understand its duty, not just to Member # 1, but to all residents of Petitioner's facility who might at some point experience cardiopulmonary arrest. Every resident of the facility who requested attempted CPR in the event of an arrest was left in a state of limbo as to whether CPR actually would be attempted. That posed immediate jeopardy because there is a foreseeable likelihood that some residents who would benefit from CPR might not receive it.

Petitioner did not challenge the dollar amount of CMS's penalty determinations and I find them to be reasonable given the seriousness of the noncompliance. The immediate jeopardy level penalty amount of $4000 per day is close to the minimum amount for

immediate jeopardy level noncompliance in effect when this noncompliance occurred. The $100 daily penalty that addresses the non-immediate jeopardy level noncompliance that persisted at Petitioner's facility after Petitioner abated its immediate jeopardy is minimal. Petitioner did not challenge the duration of its noncompliance.[2]

/s/
Steven T. Kessel
Administrative Law Judge

[2] Petitioner's loss of authority to NATCEP results directly from the finding of immediate jeopardy level noncompliance. Petitioner does not dispute that such loss will result if immediate jeopardy is established.