Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Evergreen Commons
(CCN: 33-5110),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-324

Decision No. CR2372

Date: May 20, 2011

DECISION

Petitioner, Evergreen Commons (Petitioner or facility), is a long-term care facility, located in East Greenbush, New York, that participates in the Medicare program. Based on a survey completed October 22, 2009, the Centers for Medicare and Medicaid Services (CMS) determined that the facility was not in substantial compliance with Medicare program requirements and that some of its deficiencies posed immediate jeopardy to resident health and safety. Among other problems, CMS found that the facility did not have in place an effective system for identifying its residents' advance directives. In CMS's view, the absence of a coherent system put facility residents at risk, because staff would not necessarily know whether to resuscitate a resident in respiratory or coronary distress.

Based on its deficiencies, CMS imposed against the facility a per instance civil money penalty (CMP) of $10,000.

Petitioner challenges four deficiencies that were cited at the immediate jeopardy level (42 C.F.R. §§ 483.25, 483.75, 483.75(d) and 483.75(o)(1)), as well as the immediate jeopardy determination itself.

For the reasons set forth below, I find that the facility was not in substantial compliance with the challenged program requirements. Petitioner has not challenged the amount of the penalty, and I have no authority to review the immediate jeopardy finding.

I. Background

The Social Security Act (Act) sets forth requirements for nursing facility participation in the Medicare program and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act § 1819. The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. The regulations require that each facility be surveyed once every twelve months and more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a), 488.308.

Here, following a recertification survey completed October 22, 2009, CMS determined that the facility was not in substantial compliance with multiple Medicare participation requirements, specifically:

- 42 C.F.R. § 483.10(b)(11) (Tag F157 – resident rights, notification of changes) at a D level of scope and severity (isolated instance of noncompliance that causes no actual harm with the potential for more than minimal harm);

- 42 C.F.R. § 483.15(a) (Tag F241 – dignity and respect of individuality) at an E level of scope and severity (pattern of noncompliance that causes no actual harm with the potential for more than minimal harm);

- 483.20(k)(3)(i) (Tag F 281 – comprehensive care plans – professional standards) at an E level of scope and severity;

- 42 C.F.R. § 483.25 (Tag F309 – quality of care) at an L level of scope and severity (widespread noncompliance that poses immediate jeopardy to resident health and safety);

- 42 C.F.R. § 483.25(j) (Tag F327 – hydration) at a D level of scope and severity;

- 42 C.F.R. § 483.25(m)(1) (Tag F332 – medication errors) at an E level of scope and severity;

- 42 C.F.R. § 483.25(m)(2) (Tag F333 – medication errors) at a D level of scope and severity;

- 42 C.F.R. § 483.75 (Tag F490 – administration) at an L level of scope and severity;

- 42 C.F.R. § 483.75(d) (Tag F493 – governing body) at an L level of scope and severity;

- 42 C.F.R. § 483.75(l)(1) (Tag F514 – administration, clinical records) at an E level of scope and severity; and

- 42 C.F.R. § 483.75(o)(1) (Tag F520 – quality assessment and assurance) at an L level of scope and severity.

CMS Exhibit (Ex.) 1.

CMS has also determined that, prior to completion of the survey, the facility's deficiencies no longer posed immediate jeopardy and that the facility returned to substantial compliance on December 4, 2009. CMS Exs. 2, 3.

CMS has imposed against the facility a per instance CMP of $ 10,000. CMS Exs. 3, 5, 54.

Petitioner timely requested a hearing to challenge four deficiencies that were cited at the immediate jeopardy level: 42 C.F.R. § 483.25 (Tag F309 – quality of care); 42 C.F.R. § 483.75 (Tag F490 – administration); 42 C.F.R. § 483.75(d) (Tag F493 – governing body); and 42 C.F.R. § 483.75(o)(1) (Tag F520 – quality assessment and assurance). Petitioner also challenged CMS's determinations as to the scope and severity of those deficiencies.

The parties agree that this matter may be decided based on the written record, without need for an in-person hearing.

I admit into evidence CMS Exhibits (CMS Exs.) 1-18 and Petitioner's Exhibits (P. Exs.) 1-22. The parties have filed written briefs (CMS Br.; P. Br.).

II. Issue

Petitioner did not appeal seven deficiencies that were cited at scope and severity levels that constitute substantial noncompliance. Based on these un-appealed deficiencies, the facility was not in substantial compliance with Medicare program requirements. 42 C.F.R. § 498.20(b). The only issue before me is whether, at the time of the survey, the facility was in substantial compliance with 42 C.F.R. §§ 483.25 (quality of care), 483.75 (administration), 483.75(d) (governing body), and 483.75(o)(1) (quality assessment and assurance).

Petitioner's hearing request did not explicitly challenge the reasonableness of the CMP.[1] Its brief does not address the issue. Without objection from either party, I left open the possibility that Petitioner could nevertheless pursue the issue. Order Summarizing Prehearing Conference (August 25, 2010) at 2. Thereafter, however, Petitioner opted to rest its case on its initial submissions and presented no argument challenging the amount of the CMP. The issue is therefore not before me.

I discuss below why I lack authority to review CMS's finding of immediate jeopardy.

Finally, Petitioner complains about the conduct of the survey. Survey performance does not relieve the facility of its obligation to meet all requirements for program participation nor does it invalidate adequately documented deficiencies. 42 C.F.R. § 488.318(b).[2]

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[1] With respect to this issue, Petitioner complained that the penalty imposed "is not attached to any particular noncompliance" and argued "CMS should not be entitled, through this vagueness, to frustrate any challenge to any aspect of the findings." Hearing Request at 6. Nothing precludes CMS from imposing one per-instance penalty for all of the cited deficiencies, and the agency's choice of remedy is not reviewable. 42 C.F.R. § 488.408(g)(2).

[2] Moreover, as the Departmental Appeals Board (Board) recently noted with approval, the Administrative Law Judge's "de novo evaluation of the evidence 'insulates a facility from the effect of any perceived disparate treatment or bias on the part of the state survey agency or CMS.'" *Jewish Home of E. Pa.*, DAB No. 2380 at 7 n.3 (2011) (*quoting* DAB CR 2242 (2010)).

III. Discussion

A. CMS's scope and severity finding is not reviewable in this forum.[3]

Petitioner bitterly disputes CMS's determination that the facility's deficiencies posed immediate jeopardy to resident health and safety, arguing that the deficiencies should have been cited (if at all) at a lower level of scope and severity. I have no authority to review the immediate jeopardy finding in this case. An Administrative Law Judge (ALJ) may review CMS's scope and severity findings (which include a finding of immediate jeopardy) only if a successful challenge would affect the range of the CMP, or if CMS has made a finding of substandard quality of care that results in the loss of approval of a facility's nurse aide training program. 42 C.F.R. § 498.3(b)(14), (d)(10); *Cedar Lake Nursing Home*, DAB 2344 at 9 (2010), *appeal dismissed*, *Cedar Lake Nursing Home v. Dep't of Health & Human Servs.*, No. 10-60112 (5th Cir. Filed Sept. 13, 2010) (finding ALJ and Board decisions not arbitrary and capricious); *Evergreen Commons*, DAB No. 2175 (2008); *Aase Haugen Homes*, DAB No. 2013 (2006). Here, the penalty imposed is a per instance CMP, for which the regulations provide only one range ($1,000 to $10,000), so the level of noncompliance does not affect the range of the CMP. 42 C.F.R. § 488.438(a)(2).

Nor does CMS's scope and severity finding affect approval of the facility's nurse aide training program. At the time of the October survey, the facility did not have in place a nurse aide training program. The facility had apparently proposed one, but, for reasons unrelated to the survey findings, the state agency did not process the application.[4] Moreover, because CMS has imposed a $10,000 CMP here, the state agency could not approve the facility's nurse aide training program. Without regard to CMS's finding of substandard quality of care (*see* CMS Ex. 4), a state may not approve a facility's program if that facility has been assessed a CMP of $5,000 or more. Act § 1819(f)(2)(B); 42 C.F.R. § 483.151(b)(2)(iv).

Petitioner also argues that the Constitution's due process clause entitles it to review of CMS's scope and severity determination. I have no authority to address constitutional issues. *Hermina Traeye Mem'l Nursing Home*, DAB No. 1810 at 20-22 (2002).

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

[4] In a letter dated October 15, 2009, the state agency listed necessary revisions to the facility's proposed program. P. Ex. 15.

B. The facility was not in substantial compliance with Medicare requirements governing quality of care and administration because it did not have in place a reliable system for identifying a resident's advance directive.

Program requirements. Under the statute and "quality of care" regulation, each resident must receive, and the facility must provide, necessary care and services to attain or maintain for each resident the highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. Act § 1819(b); 42 C.F.R. § 483.25. The regulation imposes on facilities an affirmative duty designed to achieve favorable outcomes "to the highest practicable degree." *Windsor Health Care Ctr.*, DAB No. 1902 at 16-17 (2003), *aff'd, Windsor Health Care Ctr. v. Leavitt*, No. 04-3018 (6th Cir. 2005); *Woodstock Care Ctr.*, DAB No. 1726 at 25-30 (2000), *aff'd, Woodstock Care Ctr. v. Thompson*, 363 F.3d 589 (6th Cir. 2003).

The facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. 42 C.F.R. § 483.75. To this end, the facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility. 42 C.F.R. § 483.75(d). The governing body appoints an administrator who is responsible for the facility's management. 42 C.F.R. § 483.75(d)(2).

The facility must also have in place a quality assessment and assurance committee made up of the director of nursing (DON), a physician, and at least three other staff members. The committee must meet at least quarterly to identify issues for which quality assessment and assurance activities are necessary. It develops and implements appropriate plans of action to correct identified quality deficiencies. The committee is not required to disclose its records to CMS or the state agency "except in so far as such disclosure is related to" the committee's compliance with the requirements of 42 C.F.R. § 483.75. The committee's good faith attempts to identify and correct quality deficiencies cannot be used as a basis for sanctions. 42 C.F.R. § 483.75(o).

The facility's policies and procedures for identifying and following residents' advance directives. CMS charges that the facility was not providing the level of care and services required by 42 C.F.R. § 483.25 and that it was not administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable well-being of each resident, as required by 42 C.F.R. § 483.75, because it had no effective system in place to ensure that staff identified and followed the residents' advance directives. An "advance directive" is a written instrument (*e.g.*, living will,

durable power of attorney for health care), recognized under state law, relating to the provision of health care when the individual is incapacitated. 42 C.F.R. § 489.100. Petitioner agrees that "it is crucially important that nursing homes have in place policies and procedures designed to ensure that the wishes of their residents, both for DNR [do not resuscitate] and CPR [cardio-pulmonary resuscitation], are accurately recorded, made accessible, and implemented as desired by the residents." P. Ex. 2 at 3 (Dolamore Decl. ¶ 14). A facility's written policies and procedures evidence the practices the facility considers necessary to ensure the health and safety of its residents. *See Woodland Oaks Healthcare Facility*, CR 2175 at 5 n.3 (2010), *aff'd*, DAB No. 2355 (2010).

Here, CMS has produced two documents, both dated February 2000 and identified as the facility's policies and procedures for ensuring that CPR be administered to all residents in distress except those designated DNR. CMS Ex. 5 at 1-2, 3-5. The policies are similar. Both say that only a registered or licensed practical nurse is authorized to perform CPR; in addition, both designate the DON as the person "responsible to ensure full compliance of the policy and procedure." CMS Ex. 5 at 1, 3. Both include procedures that call for color-coded wristbands, and, according to both, a blue wristband means that the person should be resuscitated. Both say that, if the resident refuses to wear a wristband, staff must immediately check the resident's medical record and that staff must immediately administer CPR to any resident without a DNR order who suffers cardiac and/or pulmonary arrest. CMS Ex. 5 at 2, 4.

The policies differ in their instructions for identifying residents with DNR orders. One says that a white wristband means that the resident has a current DNR order and that a white dot on the binder of the resident's medical record also indicates a DNR order. CMS Ex. 5 at 2. In contrast, the other policy says nothing about wristbands (of any color) for residents designated DNR and says that a *red* dot on the resident's medical record indicates that the resident has a current DNR order. CMS Ex. 5 at 4.

Petitioner does not comment on either of the written policies, but the policy it claims to have implemented combines an element of each. According to the facility's chief executive officer (CEO), Anthony Scalera, and its (then) DON, Serena Hamel, a white wristband signified DNR. P. Ex. 1 at 3 (Hamel Decl. ¶ 13); P. Ex. 3 at 2 (Scalera Decl. ¶ 8). They also say that a red dot on the spine of the resident's chart meant that the resident was DNR, and that the absence of a dot meant that the resident should be resuscitated. P. Ex. 1 at 3 (Hamel Decl. ¶ 12); P. Ex. 3 at 2 (Scalera Decl. ¶ 6). Further, the medical orders for life-sustaining treatment were in the resident charts on hot pink forms so that staff could find them quickly. P. Ex. 1 at 3 (Hamel Decl. ¶ 11); P. Ex. 3 at 2 (Scalera Decl. ¶ 7); *see* CMS Ex. 6. Both DON Hamel and CEO Scalera claim that errors regarding a resident's wristband or the dot on his/her chart were of minor significance

because: 1) the nurses knew the residents well enough to know their advance directives;[5] and 2) nurses were always expected to check the chart before deciding whether to administer CPR. P. Ex. 1 at 2-3 (Hamel Decl. ¶¶ 9, 12, 16); P. Ex. 3 at 2-3 (Scalera Decl. ¶¶ 5, 7, 13).

But these claims are not consistent with either version of the facility's written policy. Neither written policy tells staff to check the resident's medical record in all cases of emergency. Instead, they direct staff to *check the resident's identification band*. CMS Ex. 5 at 2, 4. Checking the medical record is limited to instances in which "the resident refuses to wear an identification band." CMS Ex. 5 at 2, 4.[6]

Although not mentioned in either written policy, the surveyors also observed an advance directive list posted on the bulletin board at the nurses' station. CMS Ex. 14 at 7, 8 (Hale Decl. ¶ ¶ 25, 33). The facility administrator, Richard Sents, confirmed that facility staff used these lists to determine a resident's advance directive. He told Surveyors Vicki Nash, John DeBellis, and Lynne Robbins that each unit made up its own list, so they were not uniform. CMS Ex. 15 at 8-9 (Nash Decl. ¶ 29).

The residents' wristbands. In light of the above, it is not surprising that the surveyors observed a confusing and inconsistent use of colored wristbands:

Resident 130 (R130). R130 was "full code," which means that staff were to provide her full CPR, without limitation. CMS Ex. 7 at 54-58. On October 15, 2009, Surveyors Amy Hale and Vicki Nash observed both a white wristband and a blue wristband on the side of R130's wheelchair. They saw a third wristband – white with a red dot -- on the back of

[5] In an emergency, relying on a nurse's memory is not sufficient to assure that staff accurately determine the resident's wishes. Memories fail, and advance directives change. Even DON Hamel concedes that "some nurses float" and "don't necessarily know the wishes of each of their charges," so "it is important" that the nurse confirm the resident's wishes when an emergency occurs. P. Ex. 1 at 2 (Hamel Decl. ¶ 10).

[6] Again, however, the two policies diverge. One simply says to check the medical record if the resident refuses to wear an identification band. CMS Ex. 5 at 4. The other instructs staff that the resident's "medical record must be checked immediately and care planned" if the resident in distress has no wristband. I assume that this provision means that, when a resident refuses to wear a wristband, his care plan should address that problem, and, presumably, the plan should be developed at some time other than during a medical emergency.

the wheelchair. R130 had no wristband on her body. CMS Ex. 1 at 21-22; CMS Ex. 14 at 5 (Hale Decl. ¶ 16); CMS Ex. 15 at 7 (Nash Decl. ¶ 23).[7]

Resident 123 (R123). Surveyor Hale observed that R123 had a blue wristband on her wrist. An undated advanced directive list on the nurses' station bulletin board identified her as full code. CMS Ex. 14 at 7 (Hale Decl. ¶ 24-25). Her chart, however, included DNR orders dated December 1, 2008. CMS Ex. 8 at 15-23.

Resident 147 (R147). Surveyor Hale saw that R147 had both a blue wristband and a white wristband with a red dot on the side of his walker. CMS Ex. 14 at 8 (Hale Decl. ¶ 29). According to his medical chart, he was DNR. CMS Ex. 9 at 17-24; CMS Ex. 14 at 8 (Hale Decl. ¶ 28).

Resident 124 (R124). Resident 124's medical record indicated that he was full code, and he had a blue wristband on his wrist. But he was not included among the full code residents on the advance directive list kept at the nurses' station. CMS Ex. 11 at 5-9; CMS Ex. 14 at 8 (Hale Decl. ¶¶ 32, 33).

With respect to the advance directive list's failure to include R124 as full code, Petitioner suggests that it is unaware of the advance directive lists and argues, disingenuously, that the surveyors "apparently consulted some other document, which is not included in their submission and is not used by the staff to make clinical decisions and were concerned about its contents." P. Br. at 15. Not so. CMS specifically identified the document to which it refers – the advance directive list kept at the nurses' station. Surveyor Hale testified that the surveyors asked Facility Administrator Sents about those lists, and he confirmed that staff used them to determine a resident's advance directive. CMS Ex. 15 at 8-9 (Hale Decl. ¶ 29). Neither Administrator Sents (who offered no testimony) nor any of Petitioner's witnesses denies the existence of the advance directives lists, and no evidence challenges Administrator Sents's statement that staff used the lists to identify the residents' CPR status. If the assertion were untrue, I would expect DON Hamel or some other member of the nursing or administrative staff to have challenged it, but no one did. *See* P. Ex. 1 (Hamel Decl.); P. Ex. 2 (Dolamore Decl.); P. Ex. 3 (Scalera Decl.); P. Ex. 4 (Locke Decl.).

I agree with CMS that the existence of such lists, not incorporated into any articulated facility policy, is likely to cause confusion, especially where, as with R124, the list inaccurately reflects the resident's code status.

[7] Although apparently a common practice at the facility, neither version of the facility's written policy suggests that a resident's CPR status be designated by attaching a colored wristband to the resident's wheelchair or walker.

Resident 96 (R96). R96's chart included a physician DNR order. CMS Ex. 10 at 89; CMS Ex. 15 at 5 (Nash Decl. ¶ 16). On October 16, Surveyor Nash saw that R96 had no wristband in place. She asked Certified Nursing Assistant (CNA) Arlene Waters about the missing wristband, but CNA Waters said that she did not know where it was. CMS Ex. 15 at 6 (Nash Decl. ¶ 19). The following day, Surveyor Nash again saw R96 without a wristband. She asked staff about it, and a CNA said that R96 did not usually wear a band, but was supposed to have it replaced that day. CMS Ex. 15 at 6 (Nash Decl. ¶ 21).

On October 20, another employee, RN Manager Darla Starson, told Surveyor Nash that, on October 16, she put a wristband on R96, and she did not know why it was missing because R96 was not someone who removed her wristband. CMS Ex. 13 at 49; CMS Ex. 15 at 6-7 (Nash Decl. ¶ 22). R96's care plan did not indicate that she would not wear a wristband, and it did not call for any alternative placement. CMS Ex. 15 at 6-7 (Nash Decl. ¶ 22). *See* CMS Ex. 10 at 6-58, 127-81.

Resident 159 (R159). According to her medical record, R159 was full code. CMS Ex. 12 at 7, 25; CMS Ex. 14 at 9 (Hale Decl. ¶ 36). Her care plan also said that she tended to remove her wrist bracelet. Among other interventions, the plan directed staff to put a bracelet on her wheelchair. CMS Ex. 12 at 5. Surveyor Hale observed R159 without a wristband. The resident told staff that she left it on her washstand. She had no bracelet on her wheelchair. CMS Ex. 13 at 1, 27; CMS Ex. 14 at 9 (Hale Decl. ¶ 35).

Petitioner points out that ensuring the accuracy of the residents' armbands is not a simple matter. Residents are able to remove them, and some did so frequently. P. Br. at 4. For those residents, the facility placed the band on the resident's wheelchair. According to Petitioner, this solution may have created an additional problem, because the wheelchair could also have on it a clear tag, identifying the wheelchair's owner. P. Ex. 3 at 4 (Scalera Decl. ¶ 20). Petitioner speculates that the surveyors may have mistaken these clear tags for white DNR tags. But Petitioner offers no support for this theory. The surveyors specifically and unambiguously described the tags they saw and said exactly where they were located. No facility employee or other witness disputes those surveyor observations. Indeed, Surveyors Hale and Nash say that they showed (then) Assistant DON (ADON) Nora Locke the multiple, inconsistent wristbands affixed to R130's wheelchair, that she explained the significance of each tag, and that she conceded that there would be confusion if the resident went into cardiac arrest. CMS Ex. 14 at 6 (Hale Decl. ¶ 20); CMS Ex. 15 at 7 (Nash Decl. ¶ 24). ADON Locke does not deny that surveyors showed her R130's three wristbands affixed to the wheelchair (a blue, a white,

and a white with a red dot). She challenges only the claim that she said the situation would be confusing. P. Ex. 4 at 3 (Locke Decl. ¶¶ 12, 13).[8]

Petitioner points to some additional steps the facility took to insure that its residents' wristbands were in place. In administering medications, nursing staff were supposed to identify the resident by reading his/her wristband. P. Ex. 14 at 2. Staff checked weekly to insure that accurate wristbands were in place and that they accurately reflected the residents' advance directives, as evidenced by weekly checklists. P. Ex. 3 at 3 (Scalera Decl. ¶¶ 9, 10); P. Ex. 10. It seems that these procedures were not particularly effective, at least with respect to the residents discussed above. For example, according to the weekly checklist, R159's wristband was always in place. P. Ex. 10 at 1-17. Staff had to replace it only once (on October 30, 2009 – after the time of the survey), because the resident's room number changed, not because the resident had removed it. P. Ex. 10 at 18. Similarly, according to the weekly audit documents, R130's wristband was always in place. P. Ex. 10 at 1-18. Yet, she was observed without a wristband on her body, but had multiple bands on her wheelchair.

Staff understanding of the facility policies. The surveyors also questioned staff about the facility procedures for determining a resident's advance directive. Some staff were able to describe the facility's policies and procedures (at least as articulated by DON Hamel and CEO Scalera). However, others were sufficiently confused to present the potential for more than minimal harm.

ADON Locke told Surveyors Hale and Nash that a white wristband meant DNR and a blue wristband meant provide CPR. She also explained that the white band with the red dot was from an older system, no longer in use, that identified the resident as DNR. CMS Ex. 13 at 3; CMS Ex. 14 at 6 (Hale Decl. ¶ 20); CMS Ex. 15 at 7 (Nash Decl. ¶ 24).

An RN Manager, identified as "Annette" or "RNM #3," told surveyor Hale that residents with blue wrist bands were full code, which meant that staff should perform CPR and that the charts of DNR residents had a red dot on the spine. Initially, she said that a white wristband meant that the resident was DNR. CMS Ex. 14 at 5-6 (Hale Decl. ¶ 18). But she later corrected herself and told surveyor Hale that a white wristband with a red dot affixed to a wheelchair meant that the resident was DNR, and that the white wristband on the wheelchair just meant that the wheelchair belonged to the resident. CMS Ex. 14 at 6 (Hale Decl. ¶ 18).

[8] According to ADON Locke, "the surveyors [put] words in my mouth. . . . In fact, what I explained to them was that in these circumstances, the nurses are trained to check the patient's medical record. There would not be confusion, but instead, an appropriate response." P. Ex 4 (Locke Decl. ¶¶ 12, 13).

RN Manager Starson told Surveyor Nash that the facility used a dot system to distinguish residents with DNR orders from residents wishing to be resuscitated. A red dot on the wristband and spine of the medical record meant that the resident had a DNR order; a green dot on the wristband and spine of the chart indicated resuscitate. CMS Ex. 13 at 25; CMS Ex. 15 at 5 (Nash Decl. ¶ 17). RN Manager Starson also told Surveyor Nash that, if a resident did not wear a wristband, the band should be placed on the resident's wheelchair, walker, or other chair, and that information should be recorded in the resident's care plan. CMS Ex. 15 at 6-7 (Nash Decl. ¶ 22).

Petitioner did not offer RN Manager Starson as a witness but submits an undated, unauthenticated written statement, in which she claims that she initially told surveyors that a red band indicated DNR, but she "immediately corrected herself and stated a white band." She also claims to have told the surveyors that a blue band indicates full code. P. Ex. 9.

An LPN, identified as "Tori" or "LPN #2," told Surveyor Hale that either a blue wristband or a white wristband with a red dot meant that the resident was DNR. CMS Ex. 14 at 6, 8 (Hale Decl. ¶¶ 19, 30); CMS Ex. 13 at 3. Petitioner challenges this, claiming that the surveyor notes establish that LPN #2 told the surveyors that, in an emergency, she would check the resident's binder. P. Br. at 17. In fact, the surveyor notes are generally consistent with the surveyor's declaration. They identify "LPN Tori" as the speaker and indicate that she was interviewed at noon. According to the notes, she said that she "would *check the name band* if resident was not breathing" and that she would also look for a red dot on the chart. She said that: a white wristband with a red dot means DNR; a red dot on the spine of the chart means DNR; and blue band also means DNR. CMS Ex. 13 at 3. The notes do not mention checking any portion of the chart other than the outside binder. Petitioner has not presented a denial from LPN #2 or any other evidence indicating that her answer differed from that represented by the surveyors and their notes.

Another LPN, identified as "Chie Ner" or "LPN #6," told surveyor Hale that a red dot on the resident wristband meant that the resident was full code. He said he was unsure whether a resident's DNR status had a color code or was otherwise reflected on the resident's wristband. He said that he would consult the resident chart. CMS Ex. 14 at 6-7 (Hale Decl. ¶ 21); CMS Ex. 13 at 2.

CNA Randy Ford told Surveyor Nash that the facility had trained her in CPR some years before and that, if she found an unresponsive resident, she would call the nurse and start CPR. She said that a blue wristband meant that the resident was DNR, and a red wristband meant that the resident should be resuscitated. CMS Ex. 13 at 26, 72; CMS Ex. 15 at 5-6 (Nash Decl. ¶ 18).

CNA Desiree Bekalaze told Surveyor Nash that, if she found an unresponsive resident, she would start CPR, call a nurse, or scream and have another CNA stay with the resident. She would ask the nurse whether the resident was DNR, because she was not sure about the meanings of the colored dots on the resident wristbands. CMS Ex. 13 at 25; CMS Ex. 15 at 6 (Nash Decl. ¶ 20).

According to Surveyors Hale and Nash, DON Hamel also told them that CNAs were allowed to perform CPR if they were certified. CMS Ex. 14 at 7 (Hale Decl. ¶ 27). DON Hamel denies saying this. She claims that the surveyors misunderstood her when she told them that the facility offers its CNAs access to the CPR training that it provides to the licensed staff. P. Ex. 1 at 6 (Hamel Decl. ¶¶ 32, 33).

According to the surveyors, Administrator Sents understood that only licensed nurses could perform CPR and said that he expected that they would know how to do so. He was unsure about staff training and could not say that drills had been conducted to evaluate staff response to a cardiopulmonary event. He dismissed the surveyors' concerns about his staff's errors in describing the facility policy and procedures, claiming that the surveyors made them nervous. He expressed confidence that staff would respond correctly, even if a resident wore the wrong wristband, because they would know the resident. CMS Ex. 15 at 8-9 (Nash Decl. ¶ 29, 30).

Notwithstanding these staff responses, Petitioner claims that it made "significant efforts" to ensure that its staff knew the meaning of the color-coding. According to Erin Marro, RN, the facility's in-service coordinator, new employees are told, as part of their general orientation, that a blue wristband means full code, a white wristband means DNR, and a red dot on the resident's binder means DNR. P. Ex. 5 at 2 (Marro Decl. ¶¶ 5, 6). She then repeats the information during the employees' annual reviews. She gives staff a written test that includes a question about the significance of the colored wristbands. P. Ex. 5 at 2 (Marro Decl. ¶¶ 10, 11, 12). She concedes that some staff did not answer the question correctly, but maintains that the vast majority did. P. Ex. 5 at 3 (Marro Decl. ¶ 13).

Quality of Care. As the above discussion shows, the facility lacked a coherent and consistent policy for identifying, and thus honoring, its residents' advance directives. Instead, it had in place two inconsistent written policies, neither of which accurately reflected what Petitioner claims were the facility's actual practices. In practice, resident preferences were not consistently and accurately designated. Staff were not uniformly familiar with the procedures they were supposed to be following. The facility was thus unable to assure that advance directives would be followed. Since the facility lacked the capacity to provide the necessary care and services called for in it residents' assessments and plans of care, it was not in substantial compliance with 42 C.F.R. § 483.25.

Petitioner suggests that its shortcomings with respect to identifying advance directives presented the potential for no significant harm, because administering CPR to a nursing home resident is generally futile. I reject Petitioner's argument. In *Woodland Oaks*, the Board recognized a "bright-line rule" with respect to treating its residents in distress: a patient without a do-not-resuscitate order *must* be administered CPR, unless that resident is irreversibly dead. *Woodland Oaks Healthcare Facility*, DAB No. 2355 at 16 (2010).

Petitioner also argues that CMS wrongly cited the quality of care regulation, because no full code resident was, in fact, denied the requested treatment. According to Petitioner, the portion of the State Operations Manual (SOM) relating to surveyor review of 42 C.F.R. § 483.25 (Tag F309) "makes no mention at all of advance directives," but directs the surveyors to the "more detailed requirements of other sections. . . ." P. Br. at 7. From this, Petitioner argues that a deficiency can be cited under this tag number only if someone makes "an actual improper care decision." *Id.* at 10. Short of that, issues regarding advance directives should be reviewed only under tags F155 (42 C.F.R. § 483.10(b)(4)) and F156 (42 C.F.R. § 483.10(b)(1)). Petitioner's arguments fail for multiple reasons.

First, the SOM provides useful guidance as to CMS's interpretations of applicable law, but its provisions do not constitute enforceable, substantive rules. *Beverly Health and Rehab. Servs. v. Thompson*, 223 F. Supp. 2d 73, 99-106 (D.D.C. 2002); *Oakwood Cmty. Ctr.*, DAB No. 2214 at 16 (2008); *Aase Haugen Homes, Inc.*, DAB No. 2013 at 15.

Second, Petitioner is simply wrong in claiming that the SOM does not mention advance directives under its discussion of the quality-of-care regulation. The manual specifically recommends that surveyors "use guidance at F309 (of the SOM) for review of quality of care not specifically covered by 42 C.F.R. § 483.25(a)-(m). Tag F309 includes, but is not limited to, care such as end-of-life. . . ." SOM, Appendix PP at 146. The facility's ability to recognize and follow a resident's advance directive is a critical aspect of end-of-life care.

Finally, although other regulations specifically address the resident's right to refuse treatment (including end-of-life treatment) and, to this end, require that the facility have in place written policies and procedures to assure that residents are afforded those rights, it does not follow that the facility's failure to have such policies in place implicates only that one regulation. To the contrary, if a facility lacks the capacity to honor a resident's advance directive, it is not providing the care and services the resident needs to maintain his/her highest practicable well-being in accordance with his/her comprehensive assessment and plan of care. This puts the facility out of substantial compliance with 42 C.F.R. § 483.25. CMS need not wait until a resident is improperly treated before citing that deficiency.

Administration. The facility's governing body, its administrator, and its quality assessment (QA) committee were responsible for insuring that the facility had in place the necessary policies and procedures for assuring that residents' advance directives would be honored. Because these institutions did not meet their responsibilities, the facility was not in substantial compliance with 42 C.F.R. §§ 483.75, 483.75(d), and 483.75(o)(1); *Jewish Home*, DAB No. 2380 at 10-11 (holding that the facility was not in substantial compliance with section 483.75(o) because its QA committee was not doing what the regulation requires), *accord, Alexandria Place*, DAB No. 2245 at 22 (2009); *see also Woodland Oaks Healthcare Facility*, DAB No. 2355 at 17; *Stone County Nursing and Rehab. Ctr.*, DAB No. 2276 at 15-16 (2009) (holding that a deficiency citation alleging noncompliance with section 483.75 may be derived from findings of noncompliance with other participation requirements).

IV. Conclusion

The parties agree that the facility was not in substantial compliance with the following Medicare program requirements: 42 C.F.R. §§ 483.10(b)(11); 483.15(a); 483.20(k)(3)(i); 483.25(j); 483.25(m)(1); 483.25(2); and 483.75(l)(1). On that basis alone, CMS could appropriately impose a penalty.

With respect to the cited deficiencies that Petitioner challenges, I find that, based on the evidence discussed above, the facility was not in substantial compliance with 42 C.F.R. §§ 483.25, 483.75, 483.75(d), and 483.75(o)(1).

/s/
Carolyn Cozad Hughes
Administrative Law Judge