Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	
John J. Kane Regional Center – Glen Hazel,	DATE: February 9, 2007
Petitioner,	Civil Remedies CR1394 App. Div. Docket No. A-06-68
- v. -	Decision No. 2068
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

John J. Kane Regional Center – Glen Hazel (Glen Hazel), a Pennsylvania skilled nursing facility (SNF), appealed a January 23, 2006 decision by Administrative Law Judge (ALJ) Anne E. Blair, John J. Kane Regional Center – Glen Hazel, DAB CR1394 (2006) (ALJ Decision). At issue before the ALJ was a $1,500 per day civil money penalty (CMP) imposed by the Centers for Medicare & Medicaid Services (CMS) on Glen Hazel for its alleged noncompliance with Medicare requirements in 42 C.F.R. Part 483.

Based on an assessment of Glen Hazel's response to a resident's cardiopulmonary arrest – a response that included the provision of cardiopulmonary resuscitation (CPR) – the ALJ determined that Glen Hazel was not in substantial compliance with the quality of care requirement in 42 C.F.R. § 483.25 from March 19 through June 2, 2002. The ALJ also determined that Glen Hazel had failed to rebut CMS's evidence that it was not in substantial compliance with 42 C.F.R. § 483.20(k)(3)(ii), which requires a SNF to ensure that its services are performed by qualified persons. Finally, the ALJ determined that the amount of the CMP imposed by CMS for the period of Glen Hazel's noncompliance was unreasonable and therefore reduced the CMP from $1,500 per day to $700 per day.

In this appeal, Glen Hazel challenges the ALJ's determination that it was out of substantial compliance with sections 483.25 and 483.20(k)(3)(ii). We find no merit to Glen Hazel's appeal: the ALJ's findings of fact are supported by substantial evidence, and her conclusions of law are not erroneous. We therefore affirm the ALJ Decision in its entirety.

Legal Background

To participate in the Medicare program, a SNF must comply with the requirements for participation found in 42 C.F.R. Part 483, subpart B. 42 C.F.R. §§ 483.1, 488.3. Compliance with these participation requirements is verified by surveys conducted by state health agencies. 42 C.F.R. Part 488, subpart E.

If a survey finds that a SNF is not in "substantial compliance," CMS may impose one or more enforcement remedies, including a CMP. 42 C.F.R. §§ 488.402(c), 488.406. A SNF is not in "substantial compliance" if it has one or more "deficiencies" (violations of Medicare participation requirements) that create at least the potential for more than "minimal harm" to residents. See 42 C.F.R. § 488.301 (defining "substantial compliance" to mean the level of compliance such that "any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm"); The Windsor House, DAB No. 1942, at 2-3, 61 (2004). CMS's regulations (and we) use the term "noncompliance" to refer to "any deficiency that causes a facility not to be in substantial compliance." 42 C.F.R. § 488.301.

Case Background[1]

During a March 2002 complaint survey, the Pennsylvania Department of Health (state survey agency) found that Glen Hazel had multiple deficiencies, the most serious of which was an alleged violation of 42 C.F.R. § 483.25. CMS Ex. 3. Section 483.25, which sets forth Medicare's general quality of care requirement, provides that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain [his] highest practicable physical, mental, and psychosocial well-being[.]" The state survey agency found that Glen Hazel's

[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.

nursing staff had violated section 483.25 by failing to "follow the facility policy for [CPR], initiate a hospital transfer[,] and obtain emergency medical treatment" for a resident – known here as Resident 1 – who experienced cardiac and respiratory failure on March 13, 2002. Id. at 3-8. The survey also found that Glen Hazel had violated section 483.20(k)(3)(ii) by failing to ensure that certain employees whose CPR certifications had expired were timely re-certified to perform that procedure. Id. at 1-3.

Based on these findings, CMS determined that Glen Hazel was not in substantial compliance during the April 2005 survey and imposed a $1,500 per day CMP that ran from March 19 through June 4, 2002. CMS Ex. 1. (A June 2002 revisit survey found that Glen Hazel was back in substantial compliance as of June 5, 2002. CMS Ex. 2.)

Glen Hazel asked for and received a hearing before the ALJ to contest CMS's enforcement action. Following the hearing and submission of post-hearing briefs, the ALJ issued her decision, which deals mainly with the adequacy of CPR provided to Resident 1 on March 13, 2002. Regarding that issue, the ALJ found the following facts:

When the events in question occurred, Resident 1 was 84 years old and had a number of medical conditions, including dementia. ALJ Decision at 5. "Although at times Resident 1 was alert and oriented to name and was responsive to verbal and tactile stimuli, he was considered to be 'severely impaired' in cognitive skills." Id. Resident 1 did not have a "do not resuscitate" (DNR) order or any other medical order or advance directive stating that CPR was not to be used in the event he experienced cardiac or respiratory arrest. Id.

During the morning of March 13, 2002 –

> R1 was moved to the Facility's nurses' station at around 6:30 a.m. He had a breathing treatment at 8:00 a.m. After another period of time at the nurses' station, R1 went to therapeutic recreation at about 10:00 a.m. Prior to 11:30 a.m. and lunch, R1 was moved back to the nurses' station. A short time later, R1 had noisy breathing, a condition called stridor, indicating a possible obstruction in the windpipe. Nurse Alston took R1's pulse and respirations. Nurse Alston then told R1 that she thought he was having lots of problems and needed to go to the hospital. R1 shook his head no. Another of the Facility's nurses,

> Bernadette Sens, arrived with an antibiotic IV that she intended to administer to R1. A respiratory therapist exited a nearby elevator at this time. He and several other staff members quickly moved R1 to his room. Nurse Alston left to call R1's daughter. Nurse Alston did not call 911. R1's daughter wanted R1 given CPR and/or transferred to a hospital. Nurse Sens did not call 911 either.
>
> In the meantime, the respiratory therapist and two nurse supervisors attempted to assist R1. . . . Someone on the staff retrieved the emergency suction set up and attempted to suction R1's throat. R1 was looking gray and was working harder to breathe. R1 seemed to be awake and held out his finger for a pulse oximeter reading. The staff present on the scene had a difficult time suctioning R1 but finally removed a moderate amount of thick blood-tinged mucus from deep in R1's throat and a granuloma-like piece of tissue from his tongue. Yet, R1's breathing did not improve. Shortly thereafter, R1 stopped breathing and the staff could not find R1's carotid pulse. Therapist Klimek listened by stethoscope to R1's heart and felt no air movement or chest rise and R1's eyes had a vacant look. R1 had been responsive but within five to seven minutes, he had no heartbeat or respiration. The staff then used a bag mask to ventilate R1 and moved him back to his bed, put a bed board underneath him and initiated CPR. Someone on the staff decided to cease CPR after two to three sequences. One of [Glen Hazel]'s nurses, although there is no clear evidence as to which one, pronounced R1 dead at 12:00 pm.

ALJ Decision at 5-6 (citations and footnote omitted).

At the time of Resident 1's death, Glen Hazel had a written policy regarding CPR. ALJ Decision at 6-7. Page 1 of the policy states in relevant part:

> POLICY: It is the policy of the John J. Kane Regional Centers to provide cardiopulmonary resuscitation for residents who experience unexpected cardiac and/or pulmonary arrest unless there is a medical order for withholding of CPR intervention. . . .

> PROCEDURE: As long term care facilities the Kane Regional Centers' mission is not to provide acute resuscitative intervention in the event of cardiopulmonary arrest, as is generally available in an acute general hospital, but rather to have available in unexpected situations the following measures as seen warranted by professional judgment:
>
> 1. Maintenance of airway and artificial respirations.
> 2. Closed chest massage
> 3. Oxygen therapy as indicated
> 4. Transfer to acute care facility via certified ambulance service.

Id. (quoting CMS Ex. 6, at 1). Page 2 of the policy specifies "actions" to be taken when a resident without a "medical order for withholding of CPR" experiences "unexpected cardiac and/or pulmonary arrest." According to this protocol, the first staff member on the scene "[a]ssesses [the] resident and initiates CPR" and also "[c]alls for assistance without leaving [the] resident." CMS Ex. 6, at 2. The second person on the scene notifies the "operator" of the situation, and the operator in turns "[c]alls [the] certified ambulance service for that Regional Center." Id. The policy also calls on the facility to "[t]rain[] all direct care providers in basic life support and the cardiopulmonary resuscitation policy and procedure." Id. at 3.

In its post-hearing brief, CMS argued that Glen Hazel had violated 42 C.F.R. § 483.25 because the nursing staff's response to Resident 1's medical emergency on March 13, 2002 did not follow CPR guidelines published by the American Heart Association (AHA Guidelines). CMS Post-Hearing Br. at 5 (section I.C.), 27-41; see also CMS Ex. 20 ("International Guidelines for 2000 for CPR and ECC"). According to CMS, Glen Hazel failed to follow the AHA Guidelines – as well as its own internal policy – in two key respects: first, the nursing staff did not call 911 upon initiating CPR; and second, the staff stopped CPR after only two cycles of chest compressions, and before paramedics arrived to provide advanced life support. CMS Post-Hearing Br. at 38-41.

In response, Glen Hazel argued that it had no duty to follow the AHA Guidelines because neither CMS's regulations nor its internal CPR policy required the nursing staff to do so. GH Post-Hearing Br. at 13, 19-24. Furthermore, said Glen Hazel, its CPR policy required the nursing staff to provide CPR only in "unexpected

situations" and only when "warranted by professional judgment." Id. at 8, 13-14. Glen Hazel contended that it exercised reasonable professional judgment in stopping CPR after only two compression cycles because nurses in Pennsylvania are permitted to "pronounce death" and because it was apparent to nurses who were attending to Resident 1 that he was "beyond resuscitation" even before CPR was started. Id. at 17. Glen Hazel also contended that the nursing staff's failure to call 911 was reasonable and proper because Resident 1 had a right to make decisions about his own care and had indicated to Nurse Alston that he did not want to go to the hospital. Id. at 9, 16.

The ALJ rejected these and other arguments, concluding that Glen Hazel's response to Resident 1's emergency constituted noncompliance with section 483.25 – that is, a failure to provide the "necessary care and services" to maintain Resident 1's "highest practicable physical, mental or psychosocial well-being[.]" ALJ Decision at 7-14. In support of that conclusion, the ALJ found:

- Resident 1's cardiopulmonary arrest on March 13, 2002 was "unexpected" and "witnessed" by the staff. ALJ Decision at 8. His death "was more expected than others around him because of his age and condition but was not expected to be at any particular time in the near future." ALJ Decision at 8.

- "It is far more likely, both intuitively and according to experts, that a victim can be revived if the arrest is witnessed." Id. at 9.

- "Because [Resident 1] had no DNR order and remained a full code, it was incumbent on [Glen Hazel] to call 911 and initiate CPR at the time of [Resident 1's] witnessed cardiopulmonary arrest. The accepted standard is that when a person does not have a DNR order, CPR is done. Further, if CPR is going to be done, the first step in the process is to call 911 so that additional emergency services can arrive as quickly as possible. No one on [Glen Hazel]'s staff called 911 when R1 arrested." Id. at 9 (citations, emphasis, and footnote omitted).

- The nursing staff should have continued to administer CPR to Resident 1 "for the 10-15 minutes it would have taken for the emergency team to arrive." Id. at 10. The AHA Guidelines "set out a systematic approach to performing CPR that is a nationally recognized

standard." Id. at 11. "The accepted standard for doing CPR requires that CPR continue until one of the following occurs: emergency services arrive; a physician orders CPR to cease; the person being resuscitated begins to have breath and pulse; the CPR provider is too exhausted to continue; or the CPR provider is in immediate harm." Id. "The CPR of only two to three sequences that was afforded [Resident 1] was inadequate." Id.

- "'Professional judgment' is not an appropriate measure of whether CPR should be initiated or continued unless a process is followed. If the phrase 'professional judgment' is contained in a facility's policy, the policy must be fully explained to the residents and their families before admission to the facility." Id. at 10. CMS's expert witness, Dr. Steven A. Levenson, "credibly and persuasively" testified that it "was not appropriate for [Glen Hazel] to fail to call 911 nor to cease CPR once started, based on an amorphous reason such as professional judgment. . . . To the extent that [Glen Hazel]'s [CPR] policy regarding resuscitation allowed the staff to use its 'professional judgment' to make decisions in the moment without following a process in making the decision, the policy does not accord with ethical standards." Id.

- "The 'professional judgment' exception in Petitioner's policy reads like 'fine print.' Those residents and their families who were shown Petitioner's policy should have been able to assume that, as stated in the first paragraph of the policy, if the resident had no DNR order, CPR would be provided and it would be provided as set forth in generally accepted guidelines. Moreover, Petitioner provided no evidence that its CPR policy with the 'professional judgment' exception was explained to prospective residents and their families. Petitioner can argue that it followed the 'fine print' of its CPR policy but Petitioner did not follow the essence of its policy." Id. at 10-11 (citations omitted).

- Resident 1 "did not have signs of irreversible death at the time [Glen Hazel]'s staff ceased CPR." Id. at 11.

- "[Glen Hazel] . . . presented no evidence that [Resident 1] was actually asked if he wanted to go to the hospital, or wanted CPR, or wanted the staff to

> call 911. Rather, [Glen Hazel] presented evidence that, although [Resident 1] was impaired cognitively, and could not engage in a dialogue with his physician about resuscitation and advanced directives, Nurse Alston, having been with [Resident 1] on a more regular basis, could suggest to him in the middle of [his] respiratory distress that he might have to go to the hospital, and could reasonably accept [his] shaking of the head as expressing [his] will about his future care. [Glen Hazel] is unpersuasively stretching an offhand comment and non-specific response into a discussion about R1's medical wishes." Id. at 12 (citations omitted).

- "The potential cruelty or hopelessness of using CPR on a person of R1's age and ill health should have been discussed with R1's family prior to this incident and cannot be used as a rationale for not calling 911 or for not following generally accepted CPR procedures at the time of R1's cardiopulmonary arrest." Id. at 12.

- "Whether a facility has failed to comply with the preliminary language at 42 C.F.R. § 483.25 can depend on whether the facility has followed generally accepted nursing standards." Id. at 14.

- Resident 1 "suffered actual harm as a result of Petitioner's failure to provide R1 with the necessary care and services for R1 to maintain his highest practicable physical, mental or psychosocial well-being in accordance with his comprehensive assessment and plan of care." Id. at 14.

In addition to finding noncompliance with section 483.25, the ALJ determined that Glen Hazel was not in substantial compliance with section 483.20(k)(3)(ii) because it failed to rebut evidence that nursing staff members whose CPR certifications had expired were not timely re-certified to perform that procedure. ALJ Decision at 14-15. Finally, the ALJ found that the amount of the CMP imposed by CMS for Glen Hazel's noncompliance — $1,500 per day — was unreasonable and accordingly reduced the CMP to $700 per day. Id. at 15-17.

Standard of Review

We review a disputed finding of fact to determine whether the finding is supported by substantial evidence, and a disputed conclusion of law to determine whether it is erroneous.

Guidelines for Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs, http://www.hhs.gov/dab /guidelines/ prov.html; Golden Age Nursing & Rehabilitation Center, DAB No. 2026 (2006).

Discussion

The first half of Glen Hazel's appeal brief contains several numbered findings of fact and conclusions of law that it believes are warranted by the record. This presentation suggests a misunderstanding of the Board's role. Our task is not to make de novo findings of fact and conclusions of law but to determine whether the ALJ's factual findings are supported by substantial evidence and her conclusions of law are correct. To that end, the Board's appeal guidelines, a copy of which were mailed to Glen Hazel with the ALJ Decision, instruct an appellant as follows:

> Your request for review must include a written brief specifying findings of fact and conclusions of law with which you disagree, and your basis for contending that each such finding or conclusion is unsupported or incorrect. Do not merely incorporate by reference a brief previously submitted to the ALJ. The basis for challenging each element of the ALJ decision should be set forth in a separate numbered paragraph or section, and the accompanying arguments concisely stated.

Glen Hazel did not adhere to these guidelines. Its appeal brief does not identify the ALJ findings and conclusions with which it disagrees, nor does it present an argument for reversing or modifying those findings and conclusions under the appropriate standards of review. Instead, the brief merely restates or elaborates on arguments earlier presented to the ALJ. Nevertheless, we discuss those arguments to the extent they can be read as a challenge to particular ALJ findings or conclusions. Overall, we find that Glen Hazel's arguments are unsupported by the evidence of record, ignore applicable legal requirements, and amount to post hoc rationalization for plainly deficient conduct by its nursing staff.

A. The ALJ's determination that Glen Hazel was not in substantial compliance with 42 C.F.R. § 483.25 between March 13, 2002 and June 4, 2002 is supported by substantial evidence and is not based on errors of law.

Glen Hazel's overarching contention is that its performance on March 13, 2002 should be judged by determining whether it complied with the facility's internal CPR policy rather than the AHA Guidelines. GH Br. at 17-32. To support that contention, Glen Hazel asserts (accurately) that CMS's regulations do not expressly require a SNF to provide CPR services. Id. at 17. Glen Hazel also asserts that the state survey agency did not charge the facility with failing to perform CPR, only with failing to adhere to its internal policy. Id. at 30. Because that policy does not mention or "purport to follow" the AHA Guidelines, and because federal regulations do not (in Glen Hazel's view) require SNFs to follow external standards for administering CPR, Glen Hazel maintains that failing to follow the AHA Guidelines in this case did not violate Medicare requirements. Id. at 17-18, 22, 27, 30-31. Furthermore, says Glen Hazel, its CPR policy expressly permitted the nursing staff to use "professional judgment" in deciding whether to initiate CPR and implement the other emergency procedures outlined in the policy. Id. at 17. To the extent that it deviated from the AHA Guidelines (or other standard procedures), Glen Hazel insists that it exercised reasonable professional medical judgment in doing so. Id. at 23. Finally, Glen Hazel contends that CMS "clearly misinterpreted" its CPR policy by not construing its professional judgment language as a limitation on its duty to provide CPR and take other emergency measures (such as calling 911). Id. at 28-29.

We find these contentions meritless. First of all, we agree with the ALJ that Glen Hazel's interpretation of the "professional judgment" language in its CPR policy reads like "fine print." The initial paragraph of the policy, which was last updated in 1993, unambiguously committed Glen Hazel to provide CPR to any resident who (1) experienced "unexpected cardiac and or pulmonary arrest," and (2) lacked a "medical order for withholding of CPR intervention." CMS Ex. 6, at 1. The ALJ found, and Glen Hazel does not dispute, that Resident 1 met those two conditions. Professional judgment may apply to selecting the appropriate measures to meet professional standards (e.g., such as determining whether a resident only needs breathing support and/or also needs chest massage); and, indeed, the phrase "as seen warranted by professional judgment" modifies the term "measures" in the policy and precedes the list of possible

measures. In that case, Glen Hazel's staff clearly failed to follow professional standards.

Assuming that the policy allows the nursing staff to use professional judgment in deciding whether to initiate – and when to terminate – CPR for a person in Resident 1's circumstances, the policy fails to specify any criteria for exercising that judgment. In other words, the policy does not specify the medical and other circumstances that the nursing staff ought to consider in deciding whether to deviate from what appear to be the standard procedures for treating a resident who experiences unexpected cardiac or pulmonary arrest and who has no medical order to withhold CPR. By not specifying the factors that properly inform the nursing staff's professional judgment, Glen Hazel's policy does not fulfill its ostensible role to ensure that each resident receives treatment of acceptable quality. See Tr. at 218-220. Glen Hazel's policy is best read to incorporate the AHA Guidelines because the policy's standard procedures largely track the procedures contained in the AHA Guidelines, and because there is evidence that Glen Hazel's nurses receive CPR training modeled on those guidelines. Tr. at 56, 612, 623.

In any event, the nursing staff's actions on March 13, 2002 render Glen Hazel's argument about professional judgment irrelevant. When Resident 1 stopped breathing and lost his pulse on March 13, 2002, Glen Hazel's staff did start CPR. In effect, Glen Hazel's nurses decided, in their professional judgment, that CPR was warranted under the circumstances. Having made that decision, Glen Hazel was required to provide CPR in a manner consistent with accepted professional standards of quality. The Social Security Act provides that a SNF must comply with "accepted professional standards and principles which apply to professionals providing services in such a facility" in order to participate in the Medicare program. Social Security Act § 1819(d)(4), 42 U.S.C. § 1395i-3(d)(4). CMS's regulations reiterate the statutory requirement, stating a "facility must operate and provide services in compliance with . . . accepted professional standards and principles that apply to professionals providing services in such a facility." 42 C.F.R. § 483.75(b). Furthermore, as the ALJ noted (ALJ Decision at 14) and the Board has held, the obligation under section 483.25 to provide "necessary care and services" implicitly requires the SNF to ensure that the services meet professional standards of quality. Spring Meadows Health Care Center, DAB No. 1966 (2005); see also Omni Manor Nursing Home, DAB No. 1920 (2004) (holding that an accepted standard of clinical practice need not be specified in a regulation before it may be considered by an ALJ in assessing whether the SNF was compliant with the quality of care

requirements in section 483.25). According to CMS's interpretive guidelines, services that meet professional standards of quality are services that are provided according to "accepted standards of clinical practice." CMS State Operations Manual (Pub. 7), Appendix P, part II, *Guidelines to Surveyors of Long Term Care Facilities*, at PP-82.4. The possible sources of clinical practice standards include "[s]tandards published by professional organizations," such as the AHA Guidelines. Id.

In light of the foregoing discussion, the outcome of the case depends on the resolution of two key issues: was the provision of CPR "necessary" to enable Resident 1 to attain his "highest practicable physical, mental, and psychosocial well-being" (i.e., was it a nursing service covered by the general quality of care requirement in section 483.25)? If so, did Glen Hazel's attempted CPR of Resident 1 meet accepted standards of quality?

The ALJ's findings on these issues were favorable to CMS, and Glen Hazel has made no attempt to contest them. Glen Hazel does not dispute the ALJ's findings that CPR was a "necessary" service within the meaning of section 483.25. Glen Hazel also does not dispute the ALJ's finding that the AHA Guidelines constitute a nationally accepted standard of medical or clinical practice that applies to nurses in a SNF. Furthermore, Glen Hazel does not dispute the ALJ's finding that, when CPR is started for a resident whose cardiac or respiratory arrest was "witnessed" (as Resident 1's arrest was), the nursing staff is obligated under the AHA Guidelines to (1) call 911 so that emergency services can arrive as quickly as possible, and (2) continue to provide CPR until (a) emergency services arrive, (b) a physician orders CPR to cease, (c) the person being resuscitated begins to have breath and pulse, (d) the CPR provider is too exhausted to continue, or (e) the CPR provider is in immediate harm.[2] Finally, Glen Hazel does not dispute the ALJ's finding that its nursing staff failed

[2] The Board has recognized the applicability of the AHA Guidelines in other decisions. In Royal Manor, the Board noted that "professional nursing standards" require "health care providers dealing with a patient in respiratory distress are to assess need, call 911, and begin the sequence of CPR resuscitation quickly when confronted with a patient with absent or inadequate breathing." DAB No. 1990, at 6 (2005). The Board also noted: "Unrebutted professional nursing standards in evidence establish that a nurse who begins to administer CPR is not permitted to abandon the effort unless physically unable to continue or instructed by a physician to discontinue further efforts." Id. at 7.

to follow the AHA protocol when it delivered CPR to Resident 1 on March 13, 2002, nor does it dispute the ALJ's finding that this failure to adhere to the accepted quality standard for CPR caused "actual harm."

Glen Hazel asserts that medical practice guidelines, like the AHA Guidelines, are not absolute, and that caregivers often exercise their professional judgment to deviate from them because of the unique circumstances of each case. GH Br. at 29-30. Whether or not that statement is true is irrelevant because Glen Hazel failed to produce evidence of any professional standard justifying its deviation from the AHA CPR procedures. Furthermore, there is substantial evidence in the record — most notably, the testimony of Dr. Levenson – to support the ALJ's finding that, *in Resident 1's circumstances* (a "witnessed" cardiopulmonary arrest in a patient with no DNR), it was inappropriate for the nursing staff not to follow AHA procedures. Glen Hazel does not contest the ALJ's reliance on Dr. Levenson's testimony or make an argument that contradictory testimony from its own witnesses deserved more weight.[3] Furthermore, we agree with CMS that Dr. Levenson's testimony deserved more weight than the testimony of Glen Hazel's witnesses based on Dr. Levenson's extensive experience in reviewing cases involving the application of CPR, his superior understanding of and familiarity with the AHA Guidelines, and the consistency of the opinions he expressed in this case with those well-established guidelines.

Glen Hazel also insists that it was under no obligation to call 911 because Resident 1 had essentially refused hospitalization and because calling 911 would certainly have resulted in his transport to the hospital. GH Br. at 18-22, 25, 27-28. Glen Hazel asserts that the following testimony by Nurse Alston supports its position:

> I said, Resident 1, it appears as though you're having a lot of difficulties and you may need to go out to the hospital. And to that he shook his head and said No.

Tr. at 276; see also Tr. at 293.

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[3] Dr. Levenson testified that exercising professional judgment to depart from standard procedures might be appropriate when the nursing staff follows an established decision-making process, one that involves a consideration of facts and evidence at each step of the process. Tr. at 218-220. But none of Resident 1's treatment records indicates that Glen Hazel's nursing staff followed such a process.

For two reasons, this argument is unpersuasive. First, there is no evidence of a connection between Nurse Alston's communication with Resident 1 and the nursing staff's failure to call 911. If Nurse Alston had interpreted Resident 1's negative reaction to her statement that he might have to go to the hospital as a refusal of hospitalization (or other emergency care), she failed to note this in Resident 1's treatment records. See, e.g., GH Ex. 4. There is no evidence that she told other staff members that Resident 1 had refused hospital transport. And none of Glen Hazel's other witnesses admitted to observing, hearing about, or acting upon such information. Furthermore, at the hearing, Nurse Alston made no connection between her communication with Resident 1 and the nursing staff's failure to call 911. When asked why the staff did not call 911, she stated that she did not know the reason. Tr. at 299. Carolyn Pilewski, Glen Hazel's administrator, testified that 911 was not called because Resident 1 died so quickly. Tr. at 600. Finally, surveyors found no documentation of any decision not to call 911. CMS Ex. 3, at 6. There is, in short, no evidence that Glen Hazel decided not call 911 because Resident 1 had expressed a desire not to be hospitalized.

Second, even if there was evidence that Glen Hazel chose not to call 911 based on Resident 1's purported desire not to go to the hospital, it would not excuse the failure to call 911 because Resident 1's wishes regarding hospitalization are not the issue here. The issue is whether Resident 1 wanted CPR and other life-saving measures (such as advanced life support provided by paramedics). It is undisputed that Resident 1 did not have a DNR order or other advance directive stipulating that he was not to be resuscitated. The record also confirms that Resident 1's daughter – who the facility then believed had the power to make healthcare decisions for Resident 1 – told Nurse Alston on March 13, 2002 that she wanted her father to receive CPR.[4] Apart from proffering Nurse Alston's testimony, Glen Hazel does not claim that it ever discussed end-of-life issues with Resident 1, his physician, or his family prior to March 13, 2002. Furthermore, we agree with the ALJ that the brief communication between Resident 1 and Nurse Alston that day, assuming it occurred, was insufficient to ascertain Resident 1's wishes regarding CPR and

[4] See GH Ex. 1 (March 13, 2002 letter from Administrator Pilewski to state survey agency indicating that Resident 1's "POA desired that resuscitation be attempted"); GH Ex. 13, at 4; GH Br. at 19-20.

other emergency life-saving treatment.[5] Nurse Alston's statement to Resident 1 did not mention CPR or attempt to elicit Resident 1's wishes about receiving that service in the event he experienced cardiac or respiratory arrest; the statement simply informed Resident 1 that he might have to go to the hospital to address the breathing problems he was having. Moreover, the meaning of Resident 1's negative reaction to Nurse Alston's statement is unclear because Nurse Alston did not (by her own account) ask a question requiring a yes-or-no answer (do you want to go to the hospital?), and because Resident 1 had significant cognitive limitations that raise doubt about his ability to comprehend the situation. Finally, there is substantial evidence in the record to support the ALJ's finding (ALJ Decision at 12) that it "was simply an inappropriate time to discuss" treatment issues, such as the need or desire for hospitalization, with Resident 1 during his breathing difficulties, and that it was "questionable whether [Resident 1] could have even expressed his desires" about such issues "under non-stressful conditions given his cognitive limitations."[6] See, e.g., Tr. at 263-64; Tr. (Part II) at 31, 40, 52; CMS Ex. 20 (AHA Guidelines), at 25 ("Truly informed decisions [regarding medical care] require that patients receive and understand accurate information about their condition and prognosis, the nature of the proposed intervention, the

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[5] Glen Hazel suggests that Resident 1's reaction to Nurse Alston's statement was a legally valid or effective exercise of his right to refuse hospital transport or CPR under Pennsylvania law. GH Br. at 21. In support of that contention, Glen Hazel cites a Pennsylvania statute which states that a patient with a written advance directive (which the statute describes as a "declaration governing the initiation, continuation, withholding or withdrawal of life-sustaining treatment") may, without regard to physical or mental condition, revoke that directive "at any time and in any manner." 20 Penn. Cons. Stat. §§ 5403, 5404, 5406(a). That statute is clearly inapplicable, however, because Resident 1 did not have a written advance directive regarding end-of-life treatment.

[6] To the extent that Resident 1's response to Nurse Alston's statement could be deemed an advance directive, the facility's policy and CMS regulations required the directive to be documented in the resident's treatment chart. CMS Ex. 7; 42 C.F.R. § 489.102(a)(2); 42 C.F.R. § 483.10(b)(8) (requiring the facility to comply with requirements in 42 C.F.R. Part 489, subpart I regarding advance directives). As indicated, there is no evidence of Nurse Alston's conversation with Resident 1 in his treatment records.

alternatives, and the risks and benefits. The patient must be able to deliberate and choose among alternatives and be able to relate the decision to a stable framework of values. . . . In an emergency, patient preferences may be uncertain, with little time to determine them. In this instance it is prudent to give standard medical care.").

To summarize, the available evidence shows that Resident 1's wishes regarding CPR and related emergency treatment were unknown to the nursing staff on March 13, 2002. Because Resident 1 did not have a DNR and his wishes regarding CPR were unknown, the ALJ properly concluded that Glen Hazel was obligated, by its policy and professional standards of quality, to initiate CPR and call 911 when his breathing and heart stopped.

As for the decision to stop CPR before paramedics arrived, Glen Hazel asserts that CPR may be stopped when death is "evident." GH Br. at 26. It asserts that nurses in Pennsylvania are permitted to "pronounce death under the same medical standards a doctor must use to declare death," and that the nursing staff stopped CPR because it was apparent that Resident 1 was "beyond resuscitation." Id. at 25-26. To support this assertion, Glen Hazel points to testimony by the respiratory therapist and others that Resident 1 appeared to be dead even prior to the initiation of CPR. Id. at 26, 29.

These contentions are wholly unpersuasive. First, in its appeal brief, Glen Hazel does not specify the objective medical signs, observations, and circumstances that, in its view, reasonably led the nursing staff to conclude that Resident 1 was "beyond resuscitation."[7] See GH Br. at 26. Glen Hazel also fails to point to any evidence that its nurses actually applied or followed "medical standards a doctor must use to declare death." In addition, there is no contemporaneous documentation of the nursing staff's reasons for pronouncing death after only two rounds of CPR. Also, none of the witnesses who participated (or may have participated) in the decision to pronounce Resident 1's death provided an account of their decision-making.[8]

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[7] Some of Glen Hazel's witnesses stated that Resident 1 had clinical signs indicating that CPR would be unsuccessful, but the ALJ found that those signs — including dilated pupils and skin mottling – were not signs of "irreversible death." ALJ Decision at 11. Glen Hazel does not contest that finding on appeal.

[8] The ALJ found that it was unclear who pronounced Resident (continued...)

Most significant, Glen Hazel has failed to demonstrate that the pronouncement of Resident 1's death was consistent with the AHA Guidelines or any other accepted medical authority. The fact that a person may exhibit signs of death does not necessarily obviate the caregiver's duty to provide CPR because one of CPR's goals, according to the AHA Guidelines, is the reversal of clinical death, even though that outcome is achieved in only a minority of cases. CMS Ex. 20 (AHA Guidelines), at 24. "Scientific evaluation has shown that there are no clear criteria to predict the futility of CPR accurately." Id. at 29. For that and other reasons, the AHA Guidelines recommend that all patients in cardiac arrest receive CPR unless:

- The patient has a valid DNAR order;
- The patient has signs of irreversible death: rigor mortis, decapitation, or dependent lividity; or
- No physiological benefit can be expected because the vital functions have deteriorated despite maximal therapy for such conditions as progressive septic or cardiogenic shock.

Id. The guidelines further state that, in out-of-hospital situations, healthcare workers should provide basic life support and call for advanced cardiovascular life support as part of their professional duty to respond. The exceptions to this rule are:

- When a person lies dead, with obvious clinical signs of irreversible death (such as rigor mortis, decapitation, or dependent lividity noted above);
- When attempts to perform CPR would place the rescuer at risk of personal injury;
- When the patient or surrogate has indicated that resuscitation is not desired.

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[8](...continued)
1's death. ALJ Decision at 6. Administrator Pilewski testified that Assistant Director of Nursing Mary McNamee was involved in the decision. Tr. at 619. McNamee testified that Nurse Sens pronounced Resident 1's death with her concurrence. Tr. at 821. As indicated, Nurse Sens did not testify in this proceeding, and Nurse McNamee, who did testify, never specified the factors that motivated her concurrence with Nurse Sens.

Id. at 32. Glen Hazel did not allege or show that Resident 1 had "obvious clinical signs of irreversible death" or that it met any of the other exceptions listed above. Dr. Levenson, meanwhile, gave uncontradicted testimony that Glen Hazel had insufficient medical or other reasons to terminate CPR when it did. Tr. at 222-227; Tr. (Part II) at 53.

For the reasons above, we affirm the ALJ's conclusion that Glen Hazel was not in substantial compliance with section 483.25 from March 13, 2002 through June 4, 2002.[9] (Glen Hazel raises no issues here about the duration of this noncompliance.)

B. The ALJ's determination that Glen Hazel was not in substantial compliance with 42 C.F.R. § 483.20(k)(3)(ii) is supported by substantial evidence and is not legally erroneous.

Title 42 C.F.R. § 483.20(k)(3)(ii) requires that a SNF's services "[b]e provided by qualified persons in accordance with each resident's written plan of care" (emphasis added). CMS alleged that Glen Hazel had violated this requirement by failing to ensure that 22 of 174 nursing staff members were timely "re-certified" in CPR and were otherwise qualified to perform that emergency service. See CMS Ex. 3, at 1.

The ALJ found:

> CMS presented evidence that many of [Glen Hazel]'s staff members' CPR certifications had expired and that [Glen Hazel] could not provide copies of all of the nurses' CPR certifications. CMS provided testimony that nursing standards require a facility to have a list of personnel who are certified in CPR. [Glen Hazel]'s policy, however, was to require CPR certification when a nurse was first employed and to provide required annual in-service training on CPR and information on re-certification. Even though CPR certification for facility nurses is not specifically required by the regulations or [Glen Hazel]'s policy, it is hard to imagine how [Glen Hazel] could ensure that CPR services could be performed by qualified persons if re-certification was not required for some staff members and if [Glen Hazel] was unaware of which

[9] Glen Hazel makes a variety of other points and arguments in its appeal brief. We have considered each one but find none of them meritorious or worthy of discussion.

> staff members were so qualified. I find, therefore, that [Glen Hazel] failed to rebut CMS's prima facie case regarding Tag F282.

ALJ Decision at 15 (citations omitted). Glen Hazel's chief response to these findings is that the ALJ misinterpreted its CPR policy as requiring employees to be periodically re-certified in CPR. GH Br. at 33-34. However, the ALJ expressly acknowledged that the policy did not require re-certification. What the ALJ found, in essence, was that Glen Hazel could not have met its obligation *under section 483.20(k)(3)(ii)* to ensure that CPR was performed by "qualified" persons without also ensuring that its staff remained certified to perform that procedure. Glen Hazel has provided no good reason to disturb that finding. Lack of current certification is some – and perhaps strong — evidence that a caregiver is not qualified to perform CPR.[10] Glen Hazel presented no evidence that the nurses whose certifications had expired were — by dint of actual experience or periodic training — qualified to perform CPR despite the lack of current certification. In addition, Glen Hazel does not dispute the ALJ's finding that it was unable produce a list of currently certified staff members. Finally, we note that the Statement of Deficiencies reported that Nurse Sens, who apparently directed the deficient attempt to resuscitate Resident 1, admitted to surveyors that she was unfamiliar with Glen Hazel's CPR policy and was not "currently trained" in CPR. CMS Ex. 3, at 2, 6. In light of these circumstances, the ALJ had ample reasons to conclude that Glen Hazel had failed to prove substantial compliance with section 483.20(k)(3)(ii) by a preponderance of the evidence.[11]

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[10] According to the AHA Guidelines, "[m]ost studies have documented poor [post-training course] performance and poor retention of core BLS skills." CMS Ex. 20, at 12.

[11] Glen Hazel does not dispute that CMS made a prima facie showing of noncompliance. GH Br. at 32-34. Consequently, it was Glen Hazel's affirmative burden (in the proceeding below) to show substantial compliance by a preponderance of the evidence. Batavia Nursing and Convalescent Inn, DAB No. 1911 (2004), aff'd, Batavia Nursing and Convalesent Center v. Thompson, No. 04-3687 (6th Cir. 2005).

C. The reasonableness of the CMP amount is an issue that is not properly before the Board.

As indicated, CMS imposed a $1,500 per day CMP on Glen Hazel for its noncompliance. Finding the amount of the CMP to be unreasonable, the ALJ reduced it from $1,500 per day to $700 per day. CMS now contends, in its response brief, that the record does not support the ALJ's conclusion that $1,500 was an unreasonable CMP amount. Accordingly, CMS asks that we reinstate the $1,500 per day CMP.

We decline to entertain what is, in effect, a request by CMS for Board review of the ALJ's reasonableness findings. In order to obtain Board review of an ALJ's decision, a party must file, within 60 days of receiving notice of that decision, a request for review that specifies the findings of fact and conclusions of law with which it disagrees. 42 C.F.R. § 498.82. CMS did not file a request for review of the ALJ Decision within the allotted 60-day period. Consequently, CMS's objection to the ALJ's reasonableness findings is not properly before us.

Conclusion

We affirm the ALJ's determination that Glen Hazel was not in substantial compliance with 42 C.F.R. §§ 483.25 and 483.20(k)(3)(ii) from March 13, 2002 through June 4, 2002. We also leave undisturbed the ALJ's decision to reduce the CMP imposed by CMS. Accordingly, we sustain the $700 per day CMP imposed on Glen Hazel for the period of noncompliance.

/s/
Judith A. Ballard

/s/
Donald F. Garrett

/s/
Leslie A. Sussan
Presiding Board Member