

## Legal Issues



By Janet K. Feldkamp, JD, RN, LNHA

# Facilities at Risk When CPR Isn't Implemented

Post-acute care facilities, including some skilled nursing facilities, continue to struggle with consistent initiation of cardiopulmonary resuscitation for residents who have chosen to elect CPR in the event of cardiac arrest. The failure of SNFs to appropriately implement CPR continues to result in an immediate jeopardy citation by state survey agencies and in civil money penalties and other sanctions for facilities receiving citations. Facility management, including the physicians and medical directors, should review the policies and procedures related to CPR to ensure that their facility is well-prepared to implement a CPR intervention determined by the physician orders and the applicable legal requirements.

**Nursing facilities have a responsibility to have and implement policies that provide for immediate CPR intervention for residents who do not have a current DNR order in place.**

Despite the fact that the effectiveness of CPR is reduced for individuals outside of the acute care setting, and also reduced as individuals age, the decision regarding a resident's code status is a legally binding determination that must be documented by a physician. Each resident or his/her legal decision maker has the right to make medical choices, including the determination of code status, in consultation with the attending physician. A study from the Archives of Internal Medicine published in 2000 found that despite previous contradictory study results, individuals older than 80 years survive to hospital discharge at a lesser rate than do younger individuals. In the SNF setting, even with diminished survival rates, the legal decision for the implementation of CPR or that of a no code or limited code status still must be issued as a physician order.

To highlight some of the confusion in the area, the Centers for Medicare & Medicaid Services issued guidance to the state survey agencies in October 2013 regarding CPR services in nursing facilities. "Survey & Certification: 14-01-NH" requires SNFs to implement policies to provide for at least basic CPR, in accordance with or in the absence of advance directives, before the arrival of

emergency medical services (EMS), in the event a resident experiences cardiac arrest. CMS cited past policies and practices of some SNFs that did not provide all residents experiencing cardiac arrest with CPR prior to the arrival of EMS. The issuance of the guidance followed news reports about concerns over CPR implementation in a California continuing care community. The policy at the California community was not to perform CPR on residents, but to simply contact local EMS for resuscitation at the time of the community's response to the cardiac arrest. Now, CMS has clarified that all Medicare and Medicaid certified nursing facilities must have a policy for at least basic CPR, yet facilities across the country continue to receive regulatory citations due to failure to initiate CPR or failure of adequate performance of CPR.

### Penalties Add Up

A CMS regional manager recently told me at least eight facilities in the country were cited for immediate jeopardy for improper implementation of CPR in the second quarter of 2014. Historically, citation penalties often have been the retrospective imposition of civil money penalties back dated to the date of the failure to implement CPR, even when the identification of lack of action was not determined until a later date through a complaint or standard survey.

A December 2010 departmental appeals board (DAB) appellate division case upheld a citation at F309 (quality of care) cited at Woodland Oaks, KY, for inappropriately withholding CPR from a resident with end-stage renal disease who did not show signs of irreversible death and did not have a do-not-resuscitate (DNR) order in the medical record. The facility was cited for immediate jeopardy and received a civil money penalty (\$4,550 per day for 23 days) for placing this resident and other residents at risk of death or serious harm for failing to implement timely resuscitative measures.

The facility argued that its policy was supported by the Kentucky Board of Nursing advisory opinion statement. This advisory opinion statement indicates that CPR is inappropriate, even when the resident had no DNR order, when a person exhibits obvious signs of irreversible death. However, the DAB found that the resident did not show signs of irreversible death when the resident was found cool to the touch and without vital signs. The DAB case discussion indicated that the signs of irreversible death listed by the Kentucky Board of Nursing include lividity, rigor mortis,

and algor mortis, and that the resident, according to the facility's own nursing notes, did not display these signs prior to the pronouncement of death. After-the-fact handwritten statements by several nurses were determined by the court to be self-serving and unreliable evidence.

A Michigan facility was cited in May 2012 with multiple immediate jeopardy and actual harm citations by failing to resuscitate a full code resident. The resident had a recent change of condition related to pneumonia and was having increasing respiratory distress. When a licensed practical nurse found the resident without a pulse or respiration, she tried to arouse the resident and performed "sternal percussions." The facility did not undertake appropriate resuscitation efforts or summon EMS personnel, and the resident died at the facility without receiving CPR. The citations included failure to appropriately notify the physician with all the pertinent information; failure to follow appropriate standards of nursing care by failing to implement CPR and summon EMS, per policy; and failure to provide necessary care and services by not assessing, monitoring, and providing prompt intervention for an acute condition change. The citations resulted in a fine of \$101,000 and the imposition of other sanctions.

These cases illustrate that following the facility's policies and understanding the state laws related to resuscitation are vital to the management of the facility. Failing to implement the level of resuscitation ordered for residents, despite the resident's current clinical condition and multiple complicating disease states, can create significant risk for facilities.

### Document, Educate, Review

Good practices for CPR policies and actions at a nursing home include:

- ▶ Periodic review by the management and the medical director of all policies related to emergency response requiring staff to initiate CPR.
- ▶ Distribution of information on advance directives as required by the Patient Self-Determination Act of 1990, as well as education of residents, families, and staff regarding advance directives.
- ▶ Education of staff, including periodic drills, to ensure that the staff can competently perform the needed resuscitation processes.
- ▶ Documentation in resident records of timely CPR initiation and documentation confirming that CPR was efficiently and timely performed until the resident was transferred into the care of EMS providers or otherwise handed off to other appropriate health care professionals.

▶ Clear documentation in the resident's medical record of the advance directive related to resuscitation that complies with state law and federal certification requirements. Clear identification of the resident's code status per the facility's policy.

▶ Periodic review of the resident's advance directive with the resident or the resident's legal decision-maker, as resident choices may change over time.

▶ Periodic quality assurance audits of the accuracy of documentation related to identification of facility residents' code status.

Nursing facilities have a responsibility to have and implement policies that provide for immediate CPR intervention for residents who do not have a current DNR order in place (i.e., indicating no CPR). Staff education and training are key components of a successful CPR policy. Facilities must ensure that all residents have accurate, up-to-date code status documented according to policy. Staff must know how to determine resident code status, and when and how CPR is indicated for residents who are full code status. A clear and well-communicated CPR policy can prevent serious state survey citations and, most importantly, ensures that resident preferences at the end of life are appropriately addressed and honored. 

*This column is not to be substituted for legal advice. The writer, JANET K. FELDKAMP, practices in various aspects of health care, including long-term care survey and certification, certificate of need, health care acquisitions, physician and nurse practice, managed care and nursing related issues, and fraud and abuse. She is affiliated with Benesch Friedlander Coplan & Aronoff, LLP of Columbus, OH. You can comment on this and other columns at [www.caringfortheages.com](http://www.caringfortheages.com), under "Views."*

## C.A.S.T. Program

AMDA's Companion and Spouse Travelers Program allows AMDA – The Society for Post-Acute and Long-Term Care Medicine meeting attendee spouses and guests to explore the Louisville area. Visit the Wild Turkey Distillery, the Louisville Slugger Museum, and the Muhammad Ali Center just to start. Pre-registration for C.A.S.T. members ends Feb. 25, so don't delay. Visit [www.paltmedicine.org/c-a-s-t-registration/](http://www.paltmedicine.org/c-a-s-t-registration/).