REGULATORY ANALYSIS OF CPR/DNR ISSUES ACROSS
THE LONG-TERM CARE CONTINUUM

A. Introduction

In light of recent media attention regarding a staff member's refusal to provide cardiopulmonary resuscitation ("CPR") to a resident of a California senior living facility, many long-term care facilities are reevaluating their policies regarding CPR. The following provides an overview of federal and Wisconsin state law and regulations related to the provision of CPR in Residential Care Apartment Complexes ("RCACs"), Community-Based Residential Facilities ("CBRFs"), Licensed Adult Family Homes and Nursing Homes.

B. Federal Law and Guidance

1. Patient Self-Determination Act

Under federal law, the Patient Self-Determination Act ("PSDA") requires facilities to provide written material prior to admission informing each adult of his/her rights under state law to make health care decisions and the facility's written policies respecting the implementation of such rights (e.g., the right to execute an advance directive). While the
PSDA does not explicitly require facilities to provide CPR, it gives facilities the responsibility of ensuring that they not only have written policies related to the implementation of advance directives and other health care decisions, but that they also fully inform the resident of these policies and rights. Additionally, facilities must document in a prominent part of an individual's medical record, whether or not that individual has an advance directive. The PSDA also provides that facilities cannot condition the provision of care or otherwise discriminate against an individual based on whether or not that individual has executed an advance directive.

2. HCFA (n/k/a CMS) Memorandum

Federal law and regulations, including the PSDA, do not provide explicit requirements for the provision of CPR. However, a memorandum issued by the CMS-predecessor, the Health Care Financing Administration ("HCFA"), suggests that the provision of CPR is a requirement for Medicare-certified facilities. This memorandum, which was issued on March 18, 1997 by HCFA (the "Memorandum") to its Associate Regional Administrators, was intended to provide a clarification regarding advance directive requirements. It suggests that a facility with a "do not resuscitate policy" would violate the right of residents to formulate an advance directive, and that providers may only refuse to implement an advance directive on the basis of conscience if permitted under state law. A follow-up memorandum from HCFA dated April 20, 2000 interpreted the Memorandum to mean that Medicare-certified facilities may not refuse to have staff members skilled in resuscitation or refuse to revive a resident who desires to be resuscitated.

3. Discussion of Administrative Law Judge Decisions Related to CPR

In light of the HCFA memoranda and the lack of an explicit CPR requirement in the law and regulations, decisions in administrative proceedings offer a glimpse of federal enforcement related to the provision of CPR and how CPR policies have been interpreted at the federal level. Interestingly, the implementation of certain CPR policies and protocols have led to violations of 42 C.F.R. § 483.25 and citations under F-309.1 As described in more detail below, facilities may find themselves in violation of § 483.25 when staff members do not follow the course of action required by the facility's policy. This enforcement suggests that regardless of the type of CPR policy that a facility has, the most important aspect, other than informing residents, is ensuring that staff members know how to respond in compliance with the policy.

In one instance a facility had a policy for the initiation and continued application of CPR for all "full code" residents in compliance with the American Heart Association CPR Guidelines.2 This policy required CPR to be continued until paramedics arrived or a

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1 Under 42 C.F.R. § 483.25 and F309, residents must receive and “facilities must provide the “necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.” This section has been interpreted broadly to apply to the provision of CPR.

2 It is important to note that CMS has approved of and applied the AHA CPR Guidelines in past ALJ cases.
physician pronounced the resident dead. In this case, the staff member not only failed to initiate CPR and call 911, but a nurse and not a physician pronounced the resident's death.\(^3\) The facility was held to be in violation of § 483.25, in part due to its failure to follow its own policy.

Similarly, facilities have been found to be in violation of federal requirements when staff members are unable to execute a given policy. In Legacy Health and Rehabilitation Center v. CMS, Dec. No. CR2415 (Aug. 17, 2011), CPR was not provided to a resident because staff members believed that individual was classified as Do-Not-Resuscitate ("DNR"), despite the fact that the resident's DNR status was not verified by the facility's staff members.\(^4\) This decision emphasized the importance of being able to execute a policy by having residents' CPR status identified in resident charts or somewhere easy to locate.

Another facility's policy was not clearly written and allowed staff members to use their "professional judgment" to determine whether CPR should be initiated for those residents that did not have advance directives or DNR orders. The Administrative Law Judge ("ALJ") in that case disagreed with the facility's policy for a number of reasons, including the lack of evidence that the policy was explained to residents and their families and the amount of discretion provided to staff members. One of the key factors identified by the ALJ in deciding the case was that the policy did not provide a "process" for determining whether CPR would or would not be appropriate for a given resident.\(^5\) Instead, whether CPR would be provided depended solely on the judgment of the staff member that witnessed the resident in cardiac arrest. This decision is of critical importance because it states that the American Heart Association CPR Guidelines "are accepted as the professional standard of quality." The ALJ tied this standard to the requirement that facilities must follow generally accepted practices and provide a minimum set of services to meet professional standards of quality.

C. Applicable Wisconsin Law and Guidance

1. Early Guidance

Following the effective date of the PSDA, the Wisconsin Bureau of Quality Compliance issued a memorandum entitled "Practice Parameters Regarding the Initiation and Implementation of CPR in Wisconsin Long Term Care Facilities." The memorandum, dated January 9, 1992, offers sample information sheets and policies to address a variety of advance directive implementation options for facilities. While this memorandum is over 20 years old, many of the principles regarding the development and disclosure of written policies to prospective residents are relevant today. This memorandum suggests that one of the options for facilities is to not offer CPR. However, a facility's decision to provide or

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\(^3\) Lakeridge Villa Healthcare Center v. CMS, Dec. No. CR2249 (Sept. 23, 2010).


not to provide CPR must then be supported with written policies and protocols and must be clearly and unambiguously communicated to both potential residents and their families. As described in more detail below, the information provided to the resident, both verbally and in writing, is just as important as the implementation of the underlying policy in the case of an emergency.

It is important to note that more recent guidance in the 1997 and 2000 HCFA memoranda contradicts guidance from the Wisconsin Bureau of Quality Compliance as it relates to the provision of CPR by Medicare-certified facilities, such as nursing homes. As previously described, the HCFA memoranda suggest that Medicare-certified facilities may not have "no-CPR" policies.

a. Application to Assisted Living Facilities and Unlicensed Senior Housing Facilities

The Wisconsin statutes and regulations governing RCACs, CBRFs, and Licensed Adult Family Homes do not contain specific requirements for these facilities to provide CPR or train their staff members to provide CPR. In addition, we are not aware of any such requirements that would apply to unlicensed senior housing facilities. However, the lack of an affirmative requirement does not relieve facilities from having policies to address situations that may necessitate CPR or from fully disclosing this information to residents. If a facility decides it will be a "no-CPR" facility, that fact must be clearly communicated to potential residents and their families. The establishment and disclosure of such "no-CPR" policies will help potential residents make informed decisions and will lay the framework for responding to instances where the provision of CPR is at issue.

b. Application to Nursing Homes

As is the case in the assisted living context, the Wisconsin state statutes and regulations do not contain specific requirements for nursing homes to provide CPR or train their staff members to provide CPR. However, at the federal level, the HCFA memoranda from 1997 and 2000 set forth the CMS position at that time by indicating that Medicare-certified facilities may not establish a policy stating that the facility will not provide CPR.

Notwithstanding the foregoing information, we are not aware of any survey citations that have been issued by the Wisconsin DHS Division of Quality Assurance ("DQA") to Wisconsin nursing homes regarding a facility's decision to be a no-CPR facility. We have recently spoken with high-level DQA administrators who have confirmed that DQA has taken the approach that, so long as a facility (including nursing homes) creates clear written policies and procedures and shares such information with prospective residents and their legal representatives at and prior to admission, that facility may elect to be a no-CPR facility. While this may speak to a relatively low level of exposure from a state survey standpoint, facilities electing not to provide CPR may face risk in federal look-behind surveys. We have been told by CMS administrators that new guidance on CPR policies in nursing homes will be forthcoming in the near future.
Unfortunately, at this point we do not have any information regarding the substantive content of such guidance or the timing of its release.

2. Licensure Requirements and Certification Responsibilities

In addition to looking at the statutes and regulations related to facilities, it is important to understand the scope of the requirements and responsibilities related to nurse licensure and CPR certification. Under state licensure requirements, nurses do not have an affirmative duty or responsibility to provide CPR, regardless of a facility's policy related to CPR. Further, CPR certification does not create a duty or responsibility for the certified person to provide CPR in a given situation. Therefore, while there is the possibility that personnel may have ethical conflicts related to a "no-CPR" policy, the implementation of such policy would not conflict with nurse licensure requirements or any "duty" of CPR-certified personnel.

3. Wisconsin's Good Samaritan Law

Since CPR is considered emergency care, a brief discussion of Wisconsin's "Good Samaritan" law provides context as it relates to the provision of emergency care and potential liability. Wisconsin law outlines three main requirements for a person to be immune from civil liability when acting as a "Good Samaritan": (a) care must be rendered by the "Good Samaritan" at the scene of an emergency; (b) the care rendered must be emergency care; and (c) any emergency care must be rendered by the "Good Samaritan" in good faith. Any person who renders emergency care (e.g., CPR) at the scene of the emergency in good faith will be immune from civil liability related to his/her acts or omissions in providing such care. It is important to note that immunity under the "Good Samaritan" law does not extend to employees trained in health care or health care professionals if/when such individuals render emergency care for compensation or within the scope of their usual and customary employment or practice. This exception likely limits the ability of staff members of many facilities to avail themselves of the protections of the Wisconsin Good Samaritan Law. In other words, it is more likely that protection from liability would extend to a resident's visiting family member or a staff member in an administrative role.

D. Guidance for Assisted Living and Nursing Facilities that Choose to Provide CPR

If a facility holds itself out to residents as being a "full code" facility, it is imperative that facility ensure that staff members are trained to both recognize the need for and to provide CPR. From a staffing perspective, CPR certifications will need to be kept up-to-date as the provision of CPR will be within the scope of employment for certain staff members. Further, adequately trained staff members should be available on a twenty-four hour basis to initiate CPR within the appropriate time period of a witnessed cardiac or respiratory arrest. As previously discussed, the Good Samaritan law does not extend to employees trained in health care or health care professionals that render emergency care within the scope of their employment. This means there would likely be no immunity
from liability for health care staff members of the facility that provide CPR as part of their job requirement. Untrained health care staff members or staff members with a lapsed CPR certification should not be providing CPR on behalf of the facility.

In addition to ensuring that staff members are properly trained, the facility should have a clear written policy detailing the process for calling 911 and initiating CPR for applicable residents. Facilities should also have a process for discussing, identifying and updating the DNR status and other forms of advance health care planning of residents (e.g., Power of Attorney; Declaration to Physicians; Physicians Orders for Life Sustaining Treatment). Potential residents should be made fully aware at, and before, the time of admission that CPR will be provided in the absence of a DNR bracelet or other legal form. Information regarding the facility's CPR policy should be provided both verbally and in writing in admission materials to ensure that potential residents understand the policy of the facility and can make informed decisions about admission and whether or not to execute advance directives.

E. Guidance for Assisted Living and Nursing Facilities That Do Not Provide CPR

If a facility determines that it will not provide CPR, it is critical that program statements, admission agreements and materials, and internal policies clearly reflect the process that will be followed (i.e., the facility will call 911 for cardiac events but will not perform CPR). This information should be provided and clearly and carefully explained to each prospective resident and/or that resident's legal representative and family members prior to admission. Admissions personnel should be trained to answer questions regarding the policy or refer such questions to appropriate staff members. The admission agreement should specifically reference the "no-CPR" policy of the facility as this agreement will be acknowledged and signed by residents or their legal representatives prior to admission.

In addition to informing prospective residents, staff members should also have a full understanding of their responsibilities under the facility's "no-CPR" policy. This means that regardless of whether a staff member is CPR-certified, he/she should not violate the facility's policy. If a staff member were to provide CPR to a resident that does not have a DNR bracelet, the staff member may be liable for any acts or omissions in providing such care. However, this would be a fact-specific analysis that would depend on many factors including whether the staff member could be considered a "Good Samaritan."

F. Recommendations to Providers

Given the recent attention to the provision of CPR in long-term care facilities, it is important to evaluate your facility's position on CPR. If you already have a CPR policy in place, regularly evaluate the implementation of such policy and whether it needs to be updated to ensure that residents are fully informed and staff understand the process. On the other hand, if you do not have a specific policy with regard to CPR, it is important to determine your facility's position, establish it in writing, and communicate it to your residents. Regardless of whether a facility elects to be a CPR or a no-CPR facility, it is imperative that all facilities determine the code status of each of its residents and develop
an easy method of identifying such status that can be quickly recognized by all of its staff members in the event of an arrest.

In light of the HCFA memoranda from 1997 and 2000 and the anticipated guidance from CMS, the parameters for policies related to CPR in nursing homes are not as clear cut. At this point, while we do not believe it is clearly untenable for a nursing home to maintain a no-CPR policy, the most conservative course from a regulatory standpoint is to develop a policy for the provision of CPR. However, if you already have a no-CPR policy in place, you should not currently feel compelled to change your approach or make significant changes if your written materials are consistent with the verbal information provided to prospective residents upon admission. Unless you have another reason to revise your policy, your policy could remain in effect until CMS or the state issues guidance that requires you to make changes.

If you have any questions regarding the contents of this article or would like assistance updating or creating a CPR or no-CPR policy and related admission materials, please contact Rob Heath at 414-298-8205 or rheath@reinhartlaw.com or another member of the Reinhart Boerner Van Deuren s.c. Long-Term Care Facilities, Assisted Living, and Senior Housing practice group.

Attachment