Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
City of Oaks Health & Rehab Center, (CCN: 34-5513)	)	Date: April 21, 2008
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-06-527
	)	Decision No. CR1772
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

I sustain the determination of the Centers for Medicare and Medicaid Services (CMS) to impose a civil money penalty (CMP) against Petitioner, City of Oaks Health & Rehab Center (Petitioner or facility), for failure to comply substantially with federal requirements governing participation of long-term care facilities in Medicare and State Medicaid programs. For the reasons that follow, I uphold the CMP of $4000 per day from February 5, 2006 through March 31, 2006, based on a finding of immediate jeopardy, and the CMP of $500 per day for the period from April 1, 2006 through May 1, 2006. Additionally, I uphold the prohibition on Petitioner conducting a nurse aide training or competency evaluation program (NATCEP) for a two-year period.

I. Background

This case is before me pursuant to a request for hearing filed by Petitioner dated June 19, 2006. Petitioner is a long-term care provider located in Raleigh, North Carolina.

By letter dated March 29, 2006, CMS informed Petitioner that based on a complaint investigation completed on March 12, 2006, by the North Carolina State Survey Agency (State Agency), it was imposing selected remedies due to Petitioner's failure to be in substantial compliance with the applicable federal requirements for long-term care facilities. The remedies were based on immediate jeopardy deficiencies under Tags F157, F327, and F490. The letter informed Petitioner that CMS was imposing the following remedies:

- CMP of $3050 per day effective February 16, 2006, and continuing through March 11, 2006.

- CMP of $100 per day effective March 12, 2006, and continuing until the facility achieved substantial compliance.

- Denial of Payment for New Admissions (DPNA), effective June 12, 2006.[1]

- Termination of the provider agreement, effective September 12, 2006.[2]

By letter dated April 19, 2006, CMS informed Petitioner that based on a complaint investigation completed on April 1, 2006, by the State Survey Agency, more conditions in Petitioner's facility were found to be out of substantial compliance. CMS informed Petitioner that as a result of the April 1, 2006 survey, it was imposing additional remedies due to Petitioner's failure to be in substantial compliance with the applicable federal requirements for long-term care facilities. The remedies were based on immediate jeopardy deficiencies under Tags F157, F309, and F490. The letter informed Petitioner that CMS was imposing the following remedies:

- CMP of $4000 per day effective February 5, 2006, and continuing through March 31, 2006.

- CMP of $500 per day effective April 1, 2006, and continuing until the facility achieved substantial compliance.

- DPNA, effective June 12, 2006.

- Termination of the provider agreement, effective September 12, 2006.

On June 19, 2007, Petitioner submitted its "Waiver of Oral Hearing." By Order dated June 20, 2007, I vacated the July 10, 2007 hearing date scheduled for this case and instructed the parties to submit witness declarations and proposed exhibits by July 20, 2007. CMS offered 31 exhibits (Exs.), identified as CMS Exs. 1-31. I receive CMS Exs. 1-31 into evidence without objection. Petitioner offered 23 exhibits, identified as P. Exs. 1-23. I receive P. Exs. 1-23 into evidence without objection. In my June 20, 2007 Order,

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[1] The DPNA was no longer in effect as of May 2, 2006.

[2] Petitioner came into substantial compliance prior to the effective date of the termination of the provider agreement, and therefore, the termination was not effectuated.

I also instructed the parties to submit opening briefs (CMS Br. and P. Br.) and response briefs (CMS Response and P. Response). The parties subsequently, submitted their respective briefs, as directed.

Based on the documentary evidence, the arguments of the parties, and the applicable law and regulations, I find that Petitioner was not in substantial compliance, at the immediate jeopardy level, on the dates determined by the State Agency and CMS. I further find that CMS was authorized to impose a CMP of $4000 per day for noncompliance from February 5, 2006 through March 31, 2006, a $500 per day CMP for non compliance from April 1, 2006 through May 1, 2006, and a prohibition on Petitioner conducting a NATCEP for a two-year period.

II. Applicable Law and Regulations

Petitioner is considered a long-term care facility under the Social Security Act (Act) and regulations promulgated by the Secretary of Health and Human Services (Secretary). The statutory requirements for participation by a long-term care facility are found at sections 1819 and 1919 of the Act, and at 42 C.F.R. Parts 483 and 488.

Sections 1819 and 1919 of the Act invest in the Secretary authority to impose CMPs and DPNAs against a long-term care facility for failure to comply substantially with participation requirements.

Facilities that participate in Medicare may be surveyed on behalf of CMS by state survey agencies in order to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-488.28; 42 C.F.R. §§ 488.300 - 488.335. Pursuant to 42 C.F.R. Part 488, CMS may impose either a per day CMP or a per instance CMP against a long-term care facility when a state survey agency concludes that the facility is not complying substantially with federal participation requirements. 42 C.F.R. §§ 488.406, 488.408, and 488.430. The penalty may start accruing as early as the date that the facility was first out of compliance until the date substantial compliance is achieved or the provider agreement is terminated. 42 C.F.R. § 488.440.

The regulations specify that a per day CMP that is imposed against a facility will fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMPs, of from $3050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents, and in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1), (d)(2). The lower range of CMPs, of from $50 per day to $3000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii).

The regulations define the term "substantial compliance" to mean:

> [A] level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

42 C.F.R. § 488.301.

"Immediate jeopardy" is defined to mean:

> [A] situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

42 C.F.R. § 488.301.

In determining the amount of the CMP, the following factors, specified at 42 C.F.R. § 488.438(f), must be considered:

1. the facility's history of noncompliance, including repeated deficiencies;
2. the facility's financial condition;
3. the seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404; and
4. the facility's degree of culpability.

The Act and regulations make a hearing before an administrative law judge (ALJ) available to a long-term care facility against whom CMS has determined to impose a CMP. But the scope of such hearings is limited to whether an *initial determination* made by CMS is correct. Act, section 1128A(c)(2); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). A facility may challenge the scope and severity level of noncompliance found by CMS only if a successful challenge would affect the range of CMP amounts that could be collected by CMS or impact upon the facility's nurse aide training program. 42 C.F.R. §§ 498.3(b)(14) and (d)(10)(I). Pursuant to 42 C.F.R. §§ 483.151(b)(2) and (e)(1), a state may not approve and must withdraw any prior approval of a NATCEP offered by a long-term care facility that: (1) has been subject to an extended or partial extended survey under sections 1819(g)(2)(B)(I) or 1919(g)(2)(B)(I) of the Act; (2) has been assessed a CMP of not less than $5000; or (3) has been subject to termination of its participation agreement, denial of payment, or the appointment of temporary management. CMS's determination as to the level of noncompliance "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). This includes CMS's finding of immediate jeopardy. *Woodstock Care Center*, DAB No. 1726, at 9 (2000), *aff'd, Woodstock Care Center v. U.S. Dept. of Health and Human Services*, 363 F.3d 583 (6th Cir. 2003). In a CMP case, CMS must make a *prima facie* case that the facility has failed to comply

substantially with participation requirements. To prevail, a long-term care facility must overcome CMS's showing by a preponderance of the evidence. *Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd, Hillman Rehabilitation Center v. U.S. Dept. of Health and Human Services*, No. 98-3789 (GEB), slip op. at 25 (D.N.J. May 13, 1999).

III. Issues

A. Whether the facility was complying substantially with federal participation requirements on the dates CMS determined to impose a CMP.

B. Whether CMS's determination of immediate jeopardy was clearly erroneous.

C. Whether the amount of the penalty imposed by CMS is reasonable, if noncompliance is established.

IV. Findings and Discussion

The findings of fact and conclusions of law noted below, in italics, are followed by a discussion of each finding.

A. Petitioner was not in substantial compliance with federal participation requirements from February 5, 2006 through May 1, 2006.

1. The facility failed to consult with Resident No. 4's (R4) physician and legal representative and Resident No. 3's (R3) physician when there was a significant change in the residents' physical status. 42 C.F.R. § 483.10(b)(11) (Tag F157).

Resident No. 4

The regulation at 42 C.F.R. § 483.10(b)(11)(B) requires that a facility immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is–

> a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) . . . .

CMS alleges that, based on interviews and medical record review, Petitioner failed to notify R4's physician and Petitioner failed to notify R4's legal representative or an interested family member when there was a significant change in her physical condition. R4 was admitted to the facility on February 25, 2005, with diagnoses of hyperglycemia,

hypertension, renal insufficiency, dehydration, obesity, hyperlipidemia, coronary artery disease, cerebral vascular accident, diabetic neuropathy, and peripheral venous disease. P. Ex. 7, at 1. She had both long and short term memory problems and impaired decision making skills. P Ex. 7, at 35, 63. The care plan dated May 3, 2005, noted that R4 was at risk for dehydration. P. Ex. 7, at 78, 82. The Resident Assessment Protocol Summary dated May 10, 2005, also indicated that R4 was at risk for dehydration. CMS Ex. 6, at 8-14. The care plan that Petitioner's staff developed for the resident included several interventions designed to assure that R4 received adequate fluids, including:

1. Provide routine fluids with meals, medications, [and] snacks;

2. Record fluid intake;

3. Monitor weights;

4. Assess labs;

5. Offer additional fluids between meals;

6. Monitor for signs and symptoms of dehydration.

P. Ex. 7, at 82. The Supplemental Assessment Information Dietary form indicated that R4's daily fluid needs were 2943 cubic centimeters (cc). CMS Ex. 6, at 28. This form was signed by the dietary manager and it did not indicate that R4 was receiving insufficient fluids or that she was dehydrated.

I find that R4 experienced a significant change which required notification of R4's physician and R4's legal representative. The Departmental Appeals Board (Board) has determined that a significant change occurs when a resident is experiencing symptoms that are a significant departure from those previously experienced, regardless of whether the symptoms arise from a new condition or a previously existing one. *Batavia Nursing and Convalescent Inn v. CMS*, DAB No. 1027 (2003). R4 was totally dependent on Petitioner's staff for eating and drinking, and it was Petitioner's responsibility to make sure that she was sufficiently nourished. It is clear that Petitioner did not properly monitor R4's changes in her eating and drinking habits, and Petitioner did not address R4's diminishing appetite or her declining fluid intake with appropriate action.

Petitioner's staff was required to maintain daily records documenting R4's consumption of food and fluids, according to the facility's dietary manager. The dietary manager indicated that staff relies on these daily records to determine a resident's daily fluid intake. CMS Ex. 2, at 8-9. R4's January 2006 and February 2006 Individual Meal/Fluid Intake forms (IM/FI form) indicate that she was not consistently consuming fluids even

relatively close to her daily fluid needs of 2943 cc. R4's daily total fluid intake ranged from approximately 600-1440 cc, according to her January 2006 IM/FI form. CMS Ex. 6, at 6. R4's February 2006 IM/FI form indicated that her daily total fluid intake ranged from approximately 530-960 cc, which was a sharp drop when compared to the previous month. CMS Ex. 6, at 7.

Petitioner's contention is that there is not a specific point in time when R4's hydration status reached a point of significant decline. P. Br. at 5. I disagree. On February 16, 2006, R4 left the facility for the hospital. Two days prior to R4 being transferred to the hospital, her total fluid intake was 540 cc and 530 cc, respectively. In fact, on February 11, 2006, R4's meal and fluid intake were not recorded for breakfast or lunch. On February 12, R4 did not have any meal or fluid intake for lunch. On February 14, 2006, R4 refused the dinner meal and had 60 cc of fluid intake for dinner. The following day, on February 15, 2006, R4 only ate 25 percent of her meal, according to the IM/FI form, and had a fluid intake of 50 cc. CMS Ex. 6, at 7.

CNA Marissa McCoy was responsible for determining R4's intake on the IM/FI sheet on February 14 and 15, 2006. CNA McCoy stated that she had made a nurse aware of R4's decreased appetite and fluid intake on the 14th and 15th of February. CMS Ex. 2, at 10; Ex. 6, at 36. Another CNA, Tonya Cruder, noticed R4's decreased appetite also. Celeste Cooper, RN, reported to Dr. Terence Fleming that a CNA had noticed that R4 had a "markedly decreased appetite and was eating very little over the past week." CMS Ex. 6, at 36-37.

The evidence offered by CMS supports a finding that the resident's fluid intake during January and February 2006, especially during February 11-15, 2006, constituted a significant change in R4's condition. Petitioner argues that because Petitioner's documentation does not capture all of a resident's intake, CMS's calculations of oral intake, based on the documents, are incorrect. P. Br. at 6. However, the significant change is not based solely on the calculations of oral intake that are documented in Petitioner's forms. CNA Cruder noticed that there was a marked change in R4's appetite and intake, she notified a nurse, but the facility did not view this as a significant change in R4's condition. Whether harm results from the significant change is irrelevant as long as a resident is put at risk for serious harm by the failure to notify. *See Woodbine Healthcare*, DAB CR1200 (2004). There were no Nurses Notes concerning R4's decreased fluid intake from a period of late January to the time that R4 went to the hospital in mid-February. According to an interview of Nurse Cooper, a CNA did inform her, at an undetermined date and time, that R4 usually would eat more. According to the February 16, 2006 Emergency Physician's Report, R4 was described as being critically ill and as suffering from acute renal failure as a result of dehydration. CMS Ex. 6, at 41.

The significant change in R4's condition placed R4 at risk for serious injury, harm, impairment, or death. A severe lack of fluids, especially in an elderly individual, is likely to cause serious injury, harm, impairment, or death. Dr. Christopher Nelson of the emergency department was one of the physicians who treated R4 when she was transferred to the hospital. It was Dr. Nelson's observation that R4 was dehydrated when she arrived at the emergency room. Dr. Nelson also indicated that R4 was six or eight liters down on free water. Dr. Nelson's opined that R4 could have had a cumulative water deficit over the last ten days to two weeks. CMS Ex. 12, at 31. Petitioner argues that the emergency department physician, Dr. Nelson, guessed that R4 was suffering from dehydration upon admission to the emergency department. P. Br. at 8. Petitioner relies on the declaration of Dr. James S. Parsons, who concluded that R4's medical decline was not the result of insufficient fluid intake in Petitioner's facility. P. Br. at 18; P. Ex. 20. It was Dr. Parson's medical opinion that the main cause for R4's decline was her underlying diabetic nephropathy, which is a disease of the kidneys that impairs excretion of waste. P. Ex. 20. It was also Dr. Parson's opinion that R4's worsening condition due to diabetic nephropathy developed over a few hours, instead of days or weeks. *Id.* While Dr. Parson's medical opinion must be considered, I find that the observations of the emergency department's physician, Dr. Nelson, are more persuasive. Dr. Nelson actually examined R4 and gave convincing reasons for his observations. Also, Dr. Nelson's observations are more credible, not only because he actually observed R4, but also because he has no reason to give anything other than his experienced medical opinion. Finally, what is at issue isn't R4's medical decline, but rather that the facility did not do what should have been done to properly hydrate R4. Thus, her inadequate fluid intake constituted a significant change in her condition. Dr. Parson never addressed Dr. Nelson's observation that R4 was down six to eight liters on free water. This type of water deficit would seem to point towards dehydration.

The facility did not notify R4's physician of her decreased fluid intake during January through to February 16, 2006. According to CMS, during a March 10, 2006 interview, Dr. Rekha Jain indicated that no changes regarding R4's condition had been reported to her prior to February 16, 2006. She also indicated that it would be her expectation that Petitioner's nursing staff alert her to changes in a resident's condition. CMS Ex. 2, at 8. Nurse Cooper indicated that she did not make a notation in the Nurse's Notes, nor did she notify the physician or a family member regarding R4's decreased appetite. CMS Ex. 2, at 9.

Petitioner also failed to notify R4's legal representative or an interested family member within a reasonable amount of time after R4 underwent a significant change in her condition. There is no record of the facility contacting R4's legal representative or any family member regarding R4's decreased intake, her fluid deficit, or her generally declining condition. According to a facility form, R4's legal representative notified facility staff in-person of her concern of the lack of action and the lack of notification by

Petitioner. CMS Ex. 6, at 30. R4's legal representative informed Petitioner that she never received a phone call from Petitioner prior to the resident being sent to the hospital. *Id.* R4's legal representative also voiced her concerns over R4's condition and she explained that "The M.D. from the emergency room just called and [R4] is severely dehydrated. [R4's] sodium and potassium levels are critical and your facility should be very aware of this." *Id.* Petitioner contends that there was not any type of significant change prior to or immediately before R4 was sent to the emergency department. For the reasons stated above I find Petitioner's contentions relating to whether R4 experienced a significant change as baseless.

Resident No. 3

R3 was admitted to the facility on February 3, 2006, with diagnosis of: thrombotic cerebrovascular accident, hypertension, hypothyroidism, gastroesophageal reflux disease, coronary artery disease, chronic renal insufficiency, urinary tract infection, mild anemia, and moderate bilateral carotid stenosis. P. Ex. 10, at 1. R3 also had a diagnosis of diabetes mellitus with history of hypoglycemia. *Id.* R3 was treated at WakeMed Rehabilitation Hospital from January 19 - February 3, 2006. *See* CMS Ex. 18. The hospital's History and Physical report for R3, dated January 19, 2006, indicated that her blood sugar levels would continue to be monitored by hospital staff and adjustments in medications would be made as needed. CMS Ex. 18, at 6.

On February 28, 2002, Petitioner implemented a series of routine standing orders. CMS asserts that one of these standing orders, Standing Order No. 11, entitled "Blood Sugar Protocol" stated that:

> IF BLOOD SUGAR IS <60 MG/DL AND PATIENT IS RESPONSIVE GIVE 4 OZ OF ORANGE JUICE WITH 2 PACKETS OF SUGAR PO [by mouth] OR PER G-TUBE, MONITOR RESIDENT AND RECHECK BLOOD SUGAR, HOLD ROUTINE INSULIN AND NOTIFY MD IF BLOOD SUGAR REMAINS < 60.
>
> IF BLOOD SUGAR IS > 400 MG/DL CALL MD OR ON-CALL PHYSICIAN AND TREAT AS ORDERED.

CMS Ex. 18, at 28.

R3's physician ordered that R3 undergo finger stick glucose testing twice a day, she prescribed Glipizide[3] for R3 to take once a day, and she approved the use of the facility's standing orders. CMS Ex. 18, at 26. CMS asserts that R3's finger stick values were lower than the 60 mg/dl limit from February 5-8, 2006, and facility staff continued to administer the glucose lowering drug Glipizide to R3 without consulting R3's physician. CMS Br. at 37. Also, R3's fluid/meal intake ranged from 25 percent to 50 percent during the time period of February 5-8, 2006, which should have added an additional level of concern. CMS contends that R3's physician should have been notified because R3's physical status had changed to the level that qualifies as a significant change. CMS Br. at 37.

On February 12, 2006, at 8:45 a.m., R3 was non-responsive and her blood glucose level was 21 mg/dl. The Nurse's Notes state that pudding and orange juice were given to R3. Glucagon[4] was given to R3 and she was still non-responsive. Facility staff called 911 and R3 was transferred to the hospital. In the emergency room, R3 was treated with intravenous Dextrose 50 and her blood sugar increased to 63 mg/dl. R3 was admitted to the hospital from February 12-20, 2006, for treatment of hypoglycemia and monitoring. CMS Exs. 18, at 10; 14, at 15, 16.

R3's blood glucose levels from February 5-8, 2006, coupled with the glucose lowering medication that the facility was administering and R3's decreased fluid/meal intake presented a situation that was inherently dangerous and should have prompted Petitioner to notify R3's physician. Petitioner argues that R3 did not exhibit a significant change in condition until she had a hypoglycemic event on February 12, 2006, which required hospitalization. P. Br. at 25. Petitioner contends that a significant change in condition requires the identification of "a discrete 'tipping point' at which the resident's condition deviated so significantly from the baseline that immediate notification of the physician was required." *Id.* I am not required to identify an exact tipping point; however, it is sufficiently evident that the significant change occurred sometime during February 5-8. R3's Medication Administration Record for February 2006 indicated the following finger stick glucose test values:

February 5, 2006 (6:30 a.m.)	37 mg/dl
February 6, 2006 (6:30 a.m.)	32 mg/dl

[3] Glipizide is a drug that lowers blood glucose levels.

[4] Glucagon is a medication that increases glucose levels.

February 7, 2006 (6:30 a.m.)	49 mg/dl
February 8, 2006 (6:30 a.m.)	54 mg/dl

P. Ex. 4, at 3-4

Considering that for four consecutive days R3's glucose level was assessed to be less than the 60 mg/dl level, Petitioner should have determined that this alone signified that R3's physician should be notified. Additionally, the medication that was being administered to R3 and R3's fluid/meal intake should have also been taken into consideration as to whether facility staff should notify R3's physician of her low glucose levels. A resident need not suffer adverse affects as a result of her significant change; a facility has a duty to notify a physician if a resident's change in condition creates an increased risk for serious harm. *See Woodbine Healthcare*, DAB CR1200.

Petitioner also contends that Standing Order No. 11 for R3[5] indicates by its very language that when there is a blood glucose reading of less than 60, the nursing staff should initiate the procedure listed in the standing order without first notifying a physician. P. Br. at 26. I do not find Petitioner's argument persuasive. The standing order for R3 was ineffective and did not instruct the facility staff of precisely when to notify R3's physician. There was a pattern of low blood glucose levels that should have alerted Petitioner that the standing order was ineffective and that physician intervention was necessary. Petitioner also alludes to the fact that R3's physician examined R3 on February 9, 2006. *See* P. Br. 25-29. However, R3's physician was contacted on February 9, 2006, concerning a possible urinary tract infection and facility staff did not notify R3's physician of R3's low blood glucose levels nor did they notify R3's physician of her level of fluid/meal intake. R3's physician informed the State Agency surveyors that the facility did not notify her of R3's insufficient meal intake and low blood glucose levels and that she "would have remembered if the nursing staff called [her] about a pattern of sugars that were that low." CMS Exs. 14, at 4, 6; 22, at 45.

I am not persuaded by Petitioner's contention that the fact that R3 was only eating 25%-50% of the meals provided by the facility should not be a factor in whether R3 experienced a significant change because it was not uncommon for R3 to consume such a minimal portion of her meals. P. Br. at 27-28. All factors that led to CMS determining that a significant change had occurred with R3 sometime between February 5-8, 2006

[5] "Blood Sugar Protocol" standing order documented at CMS Ex. 18, at 28, and quoted on page 10 of this decision.

must be viewed in their entirety. The low fluid/meal intake in addition to the blood glucose reducing medication in addition to R3's blood glucose levels during those four days in early February are primary indicators that R3 experienced a significant change in her condition.

I find that Petitioner failed to immediately consult with R4's physician and notify R4's legal representative or family when there was a significant change in R4's physical status. I also find that Petitioner failed to immediately consult R3's physician when there was a significant change in R3's physical status. Petitioner did not consult with R4's physician, in a timely manner, regarding R4's decreased fluid intake. Petitioner did not notify the legal representative or responsible family member of R4's drastically decreased appetite, or that R4 had been transferred to the hospital. Petitioner did not consult with R3's physician, in a timely manner, as to R3's low blood glucose levels. Therefore, I find that CMS established a *prima facie* case under Tag F157. Petitioner has not overcome that showing by a preponderance of the evidence. For reasons given below, I find CMS's finding of immediate jeopardy for R4 and R3 was not clearly erroneous.

2. The facility failed to provide R4 and Resident No. 7 (R7) with sufficient fluid intake to maintain proper hydration and health. 42 C.F.R. § 483.25(j) (Tag F327).

Resident No. 4

The regulation at 42 C.F.R. § 483.25(j) requires that a facility provide each resident with sufficient fluid intake to maintain proper hydration and health. CMS alleges that Petitioner failed to provide adequate hydration for R4 and R7. CMS also alleges that this failure to properly hydrate R4 and R7 constitute immediate jeopardy. CMS Br. at 24.

The diagnosis and medical history of R4, including R4's dehydration problems upon admittance to the facility, were discussed previously under Finding No. 1. CMS contends that because R4 had long and short-term memory problems, she was unable to reliably express her need to drink fluids and she had to rely on facility staff to make sure she was properly hydrated. CMS Br. at 24. According to CMS, R4 received only 20%-40% of her daily fluid need in January and 18%-32% of her daily fluid need in February. CMS Ex. 6, at 7. CMS contends that in February there were several indicators that R4 was not being properly hydrated. Once R4 was sent to the hospital, according to CMS, the physician that treated R4 in the emergency room opined that R4 was dehydrated. CMS contends that several factors can lead to dehydration, including poor food intake and chronic diseases, and to counter the causes of dehydration a facility must provide early lab evaluations and use preventative dehydration programs. CMS Br. at 26.

Petitioner asserts that R4 consumed meals and fluids at or near her normal baseline status during the months of January and February of 2006 and that R4's daily total intake was not completely documented because only fluids offered at meals are documented. P. Br. at 12. Also, according to Petitioner, R4 was on a planned weight change program and part of that program included R4 consuming 76%-100% of her meals. *Id.* Petitioner contends that the daily fluid requirement of 2943 cc should not apply to R4 because of her renal insufficiency condition. *Id.* According to Petitioner, R4's daily fluid requirement should have been 2100 cc. *Id.* at 13, 14. Petitioner asserts that R4 received fluids during snacks, during medications given orally, and while eating foods with sufficient water content. *Id.* According to Petitioner, R4 did not exhibit any of the signs or symptoms of someone who was dehydrated.

The evidence offered by CMS supports a finding that Petitioner failed to provide R4 with sufficient fluid intake to maintain proper hydration and health. R4's daily fluid intake for February 1-15, 2006, was the following:

February 1, 2006	840 cc
February 2, 2006	840 cc
February 3, 2006	960 cc
February 4, 2006	960 cc
February 5, 2006	840 cc
February 6, 2006	840 cc
February 7, 2006	960 cc
February 8, 2006	840 cc
February 9, 2006	720 cc
February 10, 2006	900 cc
February 11, 2006	360 cc[6]
February 12, 2006	960 cc

[6] R4's breakfast and lunch fluid intake was not recorded on February 11, 2007.

February 13, 2006	960 cc
February 14, 2006	540 cc
February 15, 2006	530 cc

CMS Ex. 6, at 7. The daily values from R4's fluid intake form are substantially less than the fluid amounts that were recommended for R4 by the facility's dietician. Petitioner's argument that R4 could consume as little as 76% of her meals because she was on a planned weight change program is not relevant as to whether she received adequate hydration. Petitioner's contention relating to meal intake was considered in my analysis of whether R4 experienced a significant change; but as for Petitioner's deficiency relating to whether R4 received adequate hydration, the effect of her meal intake was minimal at best whether she received enough fluids.

I am also not persuaded by Petitioner's contentions that R4's daily fluid requirement was actually 2100 cc instead of 2943 cc and that R4's daily total intake was not completely documented. Neither of Petitioner's contentions is supported by the record. I was unable to find anything in the record where the facility's dietician documented R4's daily fluid intake as 2100 cc. Since the dietician developed a dietary assessment expressly for R4, it would seem to follow that the dietician's assessment is the most credible resource when determining what R4's fluid intake should have been. The declaration by Bronda Burton Walker, R.N. is not as credible as it relates to R4's fluid intake. Ms. Walker is the Director of Regulatory Affairs and Policy Implementation for Petitioner and she had no direct contact with R4 and did not participate in the formulation of R4's dietary assessment in any way. In Ms. Walker's declaration, she asserts that R4's daily fluid intake should actually have been 2100 cc because of renal insufficiency. P. Ex. 23, at 4. Petitioner's assertions that R4 was given sufficient fluids is undercut by Petitioner's dietitian, who placed R4's minimum daily fluids at 2943 cc. If R4's daily fluids should have been less than 2943 cc, Petitioner's dietitian should have accounted for the factors that would decrease R4's minimum daily fluids and an adjustment should have been made accordingly to R4's care plan. However, R4's dietary assessment, completed by the dietary manager, indicates that R4's fluid needs were indeed 2943 cc. P. Ex. 7, at 85.

A second argument by Petitioner, as it relates to whether R4 was properly hydrated, is that the surveyors failed to account for hundreds of cc fluids because certain fluids passed out daily are not recorded. Petitioner indicated that fluids are given between meals at every medication pass, during a bedtime snack, and that there is even fluid content in meals that surveyors failed to consider. P. Br. at 13, 14. Petitioner's contentions are unconvincing. It is highly unlikely that the facility could make up the difference of documented fluids with unrecorded fluids between meals. Furthermore, I am confounded as to why a facility that knows that a resident is at risk for dehydration would not take

every opportunity to record all of that resident's fluid intake. If Petitioner considered that fluids given at medication passes and during bedtime snacks should have been counted toward the resident's fluid intake requirements, it should have done a better job of closely monitoring and documenting her record appropriately. It is disingenuous of Petitioner to contend that the records do not reveal that R4 was adequately hydrated because of its failure to document all of her fluid intake. It is also irrelevant to consider what is given without knowing what is consumed. In the case of Petitioner, neither is documented. Also, Petitioner once again uses the declaration of Ms. Walker to support its contention that more fluids were distributed than documented. However, once again, Ms. Walker was not R4's caregiver, and therefore she has no direct personal knowledge regarding R4's fluid intake. P. Ex. 23. The simple fact is that Petitioner's contentions must be supported by the record, and in the case of additional fluid intake by R4 other than at breakfast, lunch and dinner, the record is void. As for fluid content in meals, it seems reasonable to me that this was taken into consideration and accounted for when the facility's dietician determined R4's fluid intake. Clearly, it should be assumed that fluid content in the resident's meals are not part of the calculation of fluid intake that a resident must consume. I infer that R4's recommendation of 2943 cc is the measurable intake of cc and the measurable intake of cc is what is documented by Petitioner.

It is also clear that this failure to keep R4 properly hydrated was likely to cause serious injury, harm, impairment or death. On February 16, 2006, when R4 was transferred to the hospital, the emergency room physician, Dr. Nelson, diagnosed R4 with dehydration. CMS Ex. 6, at 39; CMS Ex. 12, at 31. As mentioned previously, Dr. Nelson also indicated that R4 was six or eight liters down on free water. It was Dr. Nelson's opinion that R4 could have had a cumulative water deficit over the last ten days to two weeks. CMS Ex. 12, at 31. The Board's finding in *Woodland Village*, DAB No. 2053 (2006) is instructive in this case. In *Woodland Village*, the ALJ found that Petitioner was out of compliance with 42 C.F.R. § 483.25(j) because Petitioner did not provide a resident with proper hydration. The Board upheld the ALJ's decision in Woodland and found that an emergency room physician's diagnosis of dehydration could support the ALJ's finding that Petitioner did not comply with 42 C.F.R. § 483.25(j). The Board went on to explain that "Where a resident has been found to be at risk for dehydration . . . the compliance analysis must begin with what the facility did to mitigate that risk." *Id.* at 7. R4 was admitted to the facility as being at risk for dehydration. Petitioner did not do all it could to mitigate the risk of dehydration. I am not persuaded by Petitioner's expert testimony, as an emergency room physician's diagnosis and the statement from the emergency room physician is more credible. In addition to the evidence given by the emergency room physician, lab tests support CMS's argument that R4 was dehydrated. A severe lack of water, especially in an elderly individual, is likely to cause serious injury, harm, impairment, or death.

Resident No. 7

According to the Statement of Deficiency (SOD), R7 was admitted to the facility with diagnoses that included: End Stage Renal Disease, Hemodialysis, Chronic Obstructive Pulmonary Disease, Alzheimer's Dementia, and Hyperlipidemia. CMS Ex. 2, at 45; P. Ex. 2, at 45. R7's Care Plan dated November 2, 2005, indicated she was at risk for dehydration. CMS Ex. 9, at 6. The SOD indicates that R7's Medication Administration Record for March 2006 stated that R7 received dialysis three times each week. CMS Ex. 2, at 45; P. Ex. 2, at 45. The SOD also indicated that the Dietary Assessment dated June 1, 2005, recommended 1489 cc for R7.

R7's daily fluid intake for March 1-10, 2006, was the following:

March 1, 2006	720 cc
March 2, 2006	740 cc
March 3, 2006	480 cc
March 4, 2006	840 cc
March 5, 2006	600 cc
March 6, 2006	920 cc
March 7, 2006	1080 cc
March 8, 2006	600 cc
March 9, 2006	360 cc
March 10, 2006	340 cc

CMS Ex. 9, at 1.

CMS contends that R7 was not receiving the proper amount of fluids. The daily values from R7's fluid intake form are substantially less than the fluid amounts that were recommended for R7 by the facility's dietitian. Petitioner argues that in the case of R7, as it was for R4, residents are given sufficient amounts of fluids when the fluids given during medications and snacks are factored in. However, I am again not persuaded by Petitioner's explanation for a resident's insufficient documented fluid intake. According to the SOD, when asked by the surveyors about R7's fluid intake, a facility nurse

explained that the CNAs report to her about any residents who have insufficient fluid intake and that the CNAs give residents fluids between meals. However, the surveyors observed instances where fluids were never fully passed out to the residents by CNAs when a shift change occurred during the fluid passes. CMS Ex. 2, at 7. Fluid intake is documented in the resident's daily intake form and it is evident from this form that even factoring in the occasional fluids during snacks or during medications that R7, who was at risk for dehydration, was not receiving sufficient fluid intake. It is also apparent that insufficient hydration for a resident in R7's condition is likely to cause serious harm or death. Therefore, I agree with CMS that Petitioner's noncompliance with 42 C.F.R. § 483.25(j) in this particular case does constitute immediate jeopardy.

I find that Petitioner failed to provide proper hydration to R4 and R7. R4 and R7 had serious medical conditions and were at risk for dehydration. R4 and R7's documented daily fluid intake was substantially lower than the daily fluid intake recommended by the facility's dietitian. When R4 was unresponsive and transferred to the hospital, she was diagnosed as dehydrated by the Emergency Department's physician. The analysis of a ten-day sampling of R7's IM/FI form shows that R7 was in danger of dehydration as well. Therefore, I find that CMS established a *prima facie* case under Tag F327. Petitioner has not overcome that showing by a preponderance of the evidence.

3. The facility failed to provide R3 with 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. 42 C.F.R. § 483.25 (Tag F309).

The regulation at 42 C.F.R. § 483.25 (*Quality of Care*) requires a facility to provide each resident with 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.

CMS alleges that Petitioner failed to provide adequate quality of care to R3. R3's diagnosis and condition were previously explained under Finding 1. R3 was a diabetic and her blood sugar levels had to be monitored daily. R3 was also subject to Standing Order No. 11[7], and was administered Glipizide according to orders from her physician. CMS Ex. 18. Petitioner briefly argues that the facility appropriately monitored R3 for hypoglycemia and meal intake and that facility staff appropriately intervened and notified the physician of R3's change in status on February 12, 2006, when R3 did not respond appropriately to nursing interventions. P. Br. at 29.

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[7] "Blood Sugar Protocol" standing order documented at CMS Ex. 18, at 28, and cited on page 10 of this decision.

Petitioner's contentions are not convincing. Charge Nurse Jennifer Reinhold, LPN, obtained the Finger Stick test results from February 6-8, 2006. According to CMS, Ms. Reinhold had been unaware of R3's poor meal intakes, she was unfamiliar with the standing orders for low blood sugar levels, and she was unaware that she had to "document" for R3. Charge Nurse Penny Ruil, LPN, documented the Finger Stick test results for February 5, 2006 at 6:30 a.m. According to CMS, Ms. Ruil was unsure of what she did when R3's blood sugar registered low. She could not recall whether a doctor was called, and she conceded that she failed to document whatever measures she took. The facility's Director of Nursing and Quality Improvement Coordinator were interviewed on or about March 29, 2006 (R3 had been hospitalized February 12, 2006) and, CMS asserts, they were both unaware of the events that led to R3's hospitalization. CMS Br. at 39. According to CMS, the facility's administrator indicated on March 30, 2006 that he was unaware of R3's condition. *Id.* CMS contends that Petitioner did not properly address the resident's diabetic management until March 29, 2006. *Id.* Also, CMS contends that according to R3's records, Petitioner failed to follow the facility's Standing Order No. 11, Blood Sugar Protocol, that was to be implemented if R3's blood glucose level fell below 60 mg/dl. I agree with CMS that facility staff was largely unaware of the events leading up to R3's hospitalization. I also agree with CMS that Petitioner failed to follow Standing Order No. 11, specifically by failing to call R3's physician if the procedures given in that standing order were not effective. I find that Petitioner failed to provide R3 with the necessary quality of care that is required pursuant to 42 C.F.R. § 483.25. For reasons given below, I find CMS's finding of immediate jeopardy for R3 was not clearly erroneous.

4. The facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical well-being of R3, R4 and R7. 42 C.F.R. § 483.75 (Tag F490).

The regulation at 42 C.F.R. § 483.75 requires a facility to 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.

Section 483.75 of 42 C.F.R. requires the administration of a facility be licensed under applicable state and local licensure law as well as in compliance with federal, state, and local laws and professional standards. A facility's policies and procedures must comply with this and other applicable regulations and the administration must ensure that its staff follow and implement the facility's policies and procedures. Whether a facility is in compliance with 42 C.F.R. § 483.75 is dependent on whether the facility is in substantial compliance with other regulations which govern the participation requirements of long-term care facilities. *See Asbury Center at Johnson City*, DAB No. 1839 (2002); *see also*, *Odd Fellow and Rebekah Health Care Facility*, DAB No. 1839 (2002). In *Asbury*, the

facility contended that CMS had failed to prove the existence of a separate deficiency relating to administration because the administrative deficiency was based exclusively on other immediate jeopardy deficiencies. *Id.* The Board, in *Asbury*, agreed with the ALJ that the "administrative deficiency is a derivative deficiency based on findings of other deficiencies." *Id.* at 11. Also, in *Odd Fellow* the Board explained that "the existence of independent deficiencies may constitute a *prima facie* case that a facility has not been administered efficiently or effectively as required by section 483.75." *Odd Fellow* at 11.

Petitioner failed to consult with R4's physician and notify R4's family of a significant change in her physical status. Petitioner failed to consult R3's physician that there was a significant change in her physical status. Petitioner failed to provide R4 and R7 with sufficient fluid intake to maintain proper hydration and health. Petitioner failed to provide R3 with adequate quality care. Petitioner's administration failed to carry out fully the supervisory aspects relating to the deficiencies concerning R4, R3, and R7. These deficiencies were found by CMS to be at the immediate jeopardy level of noncompliance. As discussed below, I have found that CMS's findings of immediate jeopardy for these deficiencies were not clearly erroneous**.** Petitioner acknowledges that the administrative deficiency is derivative of the deficiencies cited under Tags F157, F327, and F309. P. Br. at 24, 29-30. Because the administrative deficiency is a derivative deficiency based on the findings of other deficiencies, Petitioner is out of compliance with 42 C.F.R. § 483.75. I find that CMS established a *prima facie* case under Tag F490.

> ***5. The facility failed to allow Resident No. 2 (R2), Resident No. 6 (R6), and Resident 8 (R8) to: choose activities, schedules, and health care consistent with their interests, assessments, and plans of care and make choices about aspects of their life in the facility that were significant to them. 42 C.F.R. § 483.15(b) (Tag F242).***

The regulation at 42 C.F.R. § 483.15(b) requires the facility to allow the resident to:

> (1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;
>
> (2) Interact with members of the community both inside and outside the facility; and

> (3) Make choices about aspects of his or her life in the facility that are significant to the resident.

CMS alleges that Petitioner failed to allow R2 and R6 to take showers when they desired. CMS also alleges that Petitioner failed to allow R6 and R8 to get out of bed when they wanted to. CMS Br. at 30-32. CMS contends that only allowing the residents to take a limited number of showers a week, when they desired more days to take showers, and the facility's failure to assist the residents with getting out of bed before lunch "deprived the residents of having an input concerning their schedules and daily lives in matters that were significant to the residents' existence and daily living." *Id.* at 30. According to CMS, R6 and R8, who were a married couple and shared a room together, often missed their shower time and frequently were not allowed to get out of bed until after lunch. CMS asserts that R6 required extensive assistance with bathing and dressing and that even though he usually was awake and alert as early as 5 a.m., he had to wait an inordinate amount of time because facility staff would not assist him until after lunch. Furthermore, according to CMS, since R8 roomed with R6, many times she did not receive the level of assistance that she needed to get out of bed or take a shower. CMS asserts that on March 9, 2006, at 2:30 p.m., State Agency surveyors observed R6 being told by an CNA that it was not his shower day when he requested a shower and that he would have to wait until the night shift to be assisted to take a shower. *Id.* at 31.

According to CMS, R2, who was non-ambulatory and needed assistance with transfers, dressing and bathing, informed the State Agency surveyors that her "shower days" were two days a week and on occasion facility staff failed to give her a shower on her scheduled shower day. CMS Br. at 31. CMS argues that the residents desired to be permitted to take more weekly showers, and that the facility's restriction placed on the number of days a resident was assisted in taking a shower, in effect, did not allow a resident to make choices pursuant to 42 C.F.R. § 483.15(b).

Petitioner asserts in its hearing request that a shower schedule was prepared due to the number of residents who needed assistance in the facility. According to Petitioner, residents were accommodated by giving residents their preferred shower times when the facility became aware that some residents were not satisfied with their shower schedule. Hearing Request at 3.

I find that R6, R8, and R2 were unable to make choices about aspects of their lives in the facility that were significant to them. CMS Ex. 2, at 19-20; 23-24. R6, R8, and R2 were made to wait an unreasonable amount of time to receive assistance in taking showers and getting out of bed. Also, Petitioner's restrictive policy of two showers a week for some of

the residents was excessively limited. Petitioner did not provide enhancement of these three residents' quality of life in accordance with 42 C.F.R. § 483.15(b). Therefore, I find that CMS established a *prima facie* case under Tag F242. Petitioner has not overcome that showing by a preponderance of the evidence.

> ***6. The facility failed to ensure that Resident No. 5 (R5) and Resident No. 10 (R10) received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 42 C.F.R. § 483.25(a)(3) (Tag F312).***

The regulation at 42 C.F.R. § 483.25(a)(3) requires a facility to ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

CMS alleges that Petitioner failed to provide timely and routine incontinence checks for R5 and R10. CMS Br. at 32. According to CMS, R5 was to receive total assistance with all activities of daily living including toileting. CMS asserts that R5 was coded as incontinent of bowel and bladder at all times and that according to R5's care plan she should frequently be checked for incontinence. *Id.* According to CMS, a family member informed a surveyor that R5 had been sitting with a family member from 10:30 a.m. until 1:05 p.m. without being checked for wetness. At 1:35 p.m., R5 was returned to her bed, and according to CMS, the CNA who cared for R5 did not thoroughly check R5 for wetness and the CNA only checked the top of the brief. CNA asserts that it was discovered, upon examination, that R5's brief was wet in places other than where the CNA had checked. *Id.* at 32, 33.

According to CMS, urinary incontinence was added to R10's care plan on March 8, 2006. On March 10, 2006, the State Agency surveyors initiated an incontinence watch from 11:55 a.m. until 3 p.m. CMS asserts that during their incontinence watch, R10 was not moved or checked for wetness. CMS Br. at 33.

Petitioner asserts in its hearing request that the CNA who checked R5's brief for wetness believed R5's brief was dry because a wetness indicator in the diaper did not change to the appropriate color. Petitioner does concede that the bottom of R5's brief was wet, but contends that the wetness indicator is to blame for the CNA not changing the brief. Hearing Request at 4.

I find that R5 and R10 were unable to carry out activities of daily living and required necessary services by the facility to maintain personal hygiene. CMS Ex. 7; CMS Ex. 2, at 20, 23-24. R5 and R10 were allowed to wear wet briefs for an unacceptable amount of time on the dates of March 9, 2006 and March 10, 2006 respectively. Petitioner did not provide the necessary services for R5 and R10 to maintain good personal hygiene.

Therefore, I find that CMS established a *prima facie* case under Tag F312. Petitioner has not overcome that showing by a preponderance of the evidence.

7. The facility failed to ensure that it is free of medication error rates of five percent or greater. 42 C.F.R. § 483.25(m)(1) (Tag F332).

The regulation at 42 C.F.R. § 483.25(m)(1) requires that a facility be free of medication error rates of five percent or greater.

CMS alleges that Petitioner exceeded the allowance for medication errors on or about March 29, 2006. CMS Br. at 44. According to CMS, there were medication errors made on or about March 29, 2006, in the facility's administration of medication to R3 and R6. CMS asserts that a facility staff member administered five ml more of Alamacone (Mylanta) than what R3's physician had prescribed. CMS also asserts that the facility administered six dosages of medication to R6 orally despite R6's physician's orders that the dosages be administered through the gastrostomy tube (g-tube). *Id.*

On or about March 29, 2006 at 8:10 a.m., R3 was administered 20 ml of Mylanta even though R3 was to be administered 15 ml of Mylanta per physician's orders dated February 20, 2006. CMS Ex. 14, at 32; CMS Ex. 23 at 3. On or about March 29, 2006 at 8:45 a.m., R6 was orally administered Certagen, Bumex, Lexapro, potassium chloride, Vitamin E, and Vitamin C despite doctor's orders, dated March 22, 2006, that these dosages be administered through the g-tube. CMS Ex. 23, at 1. A review of the State Survey agency's Medication Pass Worksheet shows that among 50 medication observations by the state surveyor, there were seven errors. *See* CMS Ex. 23. That is an error rate of 14 percent. Petitioner has exceeded the five percent medication error rate by making errors in medications administered to R3 and R6.

Petitioner indicated in its hearing request that it disagreed with State Survey agency's finding that it was not in substantial compliance with 42 C.F.R. § 483.25(m)(1) with respect to R3 and R6. However, in its written submissions Petitioner does not address CMS's allegation that it must be free of medication error rates of five percent or greater. Therefore, I find that CMS established a *prima facie* case under Tag F332. Petitioner has not overcome that showing by a preponderance of the evidence.

8. The facility failed to ensure that its menus met the nutritional needs of R3 and were followed. 42 C.F.R. § 483.35(c) (Tag F363).

The regulation at 42 C.F.R. § 483.35(c) requires that the facility's menus meet the nutritional needs of residents, be prepared in advance, and be followed.

CMS alleges that Petitioner failed to prepare a menu for R3 in advance and follow the prepared menu. CMS Br. at 45. According to CMS, when R3 was admitted to the facility, R3's doctor's orders required R3 to be on a pureed vegetarian diet. *Id.* CMS asserts that the food service manager did not have a planned vegetarian menu and instead the facility served R3 only the vegetables that were listed on the regular diet menu. Also, CMS asserts, R3 was not provided an evening snack. *Id.* According to CMS, the State Survey team was unable to find a planned vegetarian diet. *Id.* CMS contends that the facility is not in compliance with section 42 C.F.R. § 483.35(c) because a vegetarian menu was not prepared in advance and followed by the facility for R3. CMS argues that merely serving R3 the vegetables that are listed on the facility's regular menu did not meet the nutritional needs of R3.

In the State Surveyor's interview on March 29, 2006, with the facility's dietary manager, Deborah Brooks, CDM, Ms. Brooks indicated that the facility does not have a dietary menu. CMS Ex. 22, at 10. Ms. Brooks also indicated that R3 is served whatever vegetables are on the regular menu and beans if on the menu. Additionally, R3 is not served snacks. *Id.*

The nutritional needs of vegetarian residents includes: breads, cereals, rice, and pastas; vegetables; fruits; dairy products; and legumes and meat substitutes. A facility must ensure that a resident is provided with all the nutrients that an individual needs. For a resident who follows a vegetarian diet, alternate sources of nutrients must be provided to replace the nutrients provided in meats, milk, cheese, and eggs. CMS Ex. 18, at 40. Petitioner has not met the nutritional needs of R3 by serving her the vegetables and beans on the regular menu. Additionally, Petitioner did not prepare a vegetarian menu in advance for R3.

Petitioner indicated in its hearing request that it disagreed with state agency's finding that it was not in substantial compliance with 42 C.F.R. § 483.35(c) with respect to R3. However, in its written submissions Petitioner does not address CMS's allegation that it failed to ensure that its menus met the nutritional needs or R3. Therefore, I find that CMS established a *prima facie* case under Tag F363. Petitioner has not overcome that showing by a preponderance of the evidence.

B. CMS's Finding of immediate jeopardy was not clearly erroneous.

Immediate jeopardy exists where a "provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. For a finding of immediate

jeopardy, it is not necessary to show that the noncompliance caused serious injury, harm, impairment, or death. It is sufficient to show that the noncompliance was likely to cause serious injury, harm, impairment, or death. *Fairfax Nursing Home, Inc.*, DAB No. 1794, at 14 (2001).

It is Petitioner's burden to prove clearly erroneous a finding by CMS that a deficiency puts residents at immediate jeopardy. 42 C.F.R. § 498.60(c)(2). Here, CMS established strong *prima facie* evidence of immediate jeopardy level deficiencies under Tags F157, F327, F309, and F490. Petitioner contends in its brief that there were no immediate jeopardy level deficiencies with respect to R3, R4, and R7. Petitioner argues that for R3 and R4, there was no "tipping point" where a significant change occurred. Also, Petitioner argues that CMS has failed to prove that there was a likelihood of serious injury or harm to these residents. P. Br. at 30. As for R4 and R7, Petitioner argues that these residents received sufficient hydration through undocumented means.

Again, I am not persuaded by Petitioner's arguments. R3's low blood glucose readings along with her diminished appetite and the fact that she was on a medication that lowered her blood glucose levels should have prompted Petitioner to call R3's physician. R4 and R7 were admitted by Petitioner as at risk for dehydration. With both these residents, there was a pattern where their daily fluid intake baselines were not being met. With both these residents, Petitioner failed to take appropriate action. Furthermore, Petitioner failed to contact R4's physician and legal representative immediately when a significant change occurred in this resident's condition. The overwhelming evidence is that Petitioner's staff was inattentive to the needs of R3, R4, and R7. Petitioner failed in providing these residents with a level of care that is mandated by the regulations. Petitioner knew or should have known that its inattentiveness was likely to cause serious injury, harm, impairment, or death to these residents. Moreover, Petitioner's systemic flaw equally exposed other residents similarly situated to the likelihood of suffering serious injury, harm, impairment, or death. Petitioner has not proved that CMS's determination of immediate jeopardy was clearly erroneous.

C. The amount of the CMPs is reasonable.

CMS imposed a $4000 CMP for each day of noncompliance at the immediate jeopardy level from February 5 through March 31, 2006. CMS also imposed a $500 per day CMP for deficiencies at the less than immediate jeopardy level from April 1 through May 1, 2006. Originally, CMS imposed a $3050 per day CMP from February 16 through March 11, 2006, and a $100 per day CMP from March 12, 2006, until the facility achieved substantial compliance. However, after a second survey was completed (April survey), the time period that Petitioner was found to be out of compliance at the immediate jeopardy level was extended to February 5 through March 31, 2006, and the per day CMP for each day of noncompliance at the immediate jeopardy level was increased to $4000.

Also, during the April survey, additional noncompliance was found at the less than immediate jeopardy level and CMS increased the CMP from $100 to $500. Petitioner achieved substantial compliance on May 2, 2006.

When an ALJ finds that the basis for imposing a CMP exists, the ALJ may not: (1) set a penalty of zero or reduce the penalty to zero; (2) review the exercise of discretion by CMS to impose a CMP; and (3) consider any factors in reviewing the amount of the penalty other than those specified by regulation. 42 C.F.R. § 488.438(e). I have found that a basis exists for CMS to impose a CMP because I have found that Petitioner was not in compliance with 42 C.F.R. § 483.10(b)(11), 42 C.F.R. § 483.25(j), 42 C.F.R. § 483.25, 42 C.F.R. § 483.75, 42 C.F.R. § 483.15(b), 42 C.F.R. § 483.25(a)(3), 42 C.F.R. § 483.25(m)(1), and 42 C.F.R. § 483.35(c). I must, therefore, review *de novo* whether the amount of the CMP is reasonable by considering four factors specified in 42 C.F.R. § 488.438(f). These four factors are: (1) the facility's history of noncompliance, including repeated deficiencies; (2) the facility's financial condition; (3) the scope and severity of the deficiencies, the relationship of one deficiency to other deficiencies, a facility's prior history of noncompliance with reference to the deficiency at issue (factors specified in 42 C.F.R. § 488.404); and (4) the facility's degree of culpability.

Petitioner has not questioned the duration of the deficiencies, but has argued that the deficiencies cited as immediate jeopardy do not rise to a level of immediate jeopardy. Petitioner contends that the immediate jeopardy citation in this case is inappropriate because CMS has failed to prove that there was a likelihood of serious injury or harm as a result of the cited deficiencies. P. Br. at 30. I have already amply discussed the basis for a finding of noncompliance at the immediate jeopardy level.

There is no evidence in the record regarding the facility's history of noncompliance or the facility's financial condition. Therefore, I will focus on the scope and severity of the deficiencies and the facility's degree of culpability. The regulations define culpability as neglect, indifference, or disregard for resident care, comfort or safety. 42 C.F.R. § 488.438(f)(4). In this case, Petitioner failed to consult with R3 and R4's physicians when there was a significant change in their status. Such a failure placed R3 and R4 at risk of serious injury, harm, impairment, or death. Both R3 and R4 had to be rushed to the hospital and in both cases, if Petitioner had recognized or been more cognizant that these residents experienced a significant change, the risk of serious injury, harm, or death could have been prevented or minimized. CMS has shown that Petitioner failed to take appropriate action in the cases of R3, R4, and R7, and that as a result, these residents were placed at risk of serious harm or death. Pursuant to *Asbury*, the administration

deficiency is a derivative deficiency based on the findings of other deficiencies and since Petitioner has not overcome CMS's *prima facie* case by a preponderance of the evidence that it was in compliance with 42 C.F.R. § 483.10(b)(11) and 42 C.F.R. § 483.25(j), Petitioner is also out of compliance with 42 C.F.R. § 483.75 at the immediate jeopardy level.

Also, the facility was cited for several non immediate jeopardy deficiencies. These deficiencies ranged from medication errors to not preparing and following a menu for a vegetarian resident. The non-immediate jeopardy deficiencies either caused actual harm to the residents or had the potential for causing actual harm to the residents. CMS has imposed CMPs closer to the minimum level for both immediate jeopardy and non-immediate jeopardy level deficiencies. In view of the foregoing, I find that the amount of the CMP is reasonable.

D. Petitioner is properly subject to a two-year prohibition on conducting a NATCEP.

As I have found Petitioner to be noncompliant at the immediate jeopardy level with a participation requirement under 42 C.F.R. § 483.25 (Quality of Care), a two-year prohibition of Petitioner's conducting a NATCEP is required by law.

V. Conclusion

Based on the documentary evidence, the arguments of the parties, and the applicable law and regulations, I find that Petitioner was not in substantial compliance at the immediate jeopardy level from February 5, 2006 through March 31, 2006, and that the imposition of a CMP of $4,000 per day during that period is reasonable. Additionally, a CMP of $500 per day from April 1, 2006 through May 1, 2006 is also reasonable. The two-year prohibition on conducting a NATCEP is consistent with the law and regulations.

/s/
José A. Anglada
Administrative Law Judge