Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Delmar Nursing & Rehabilitation Center,
(CCN: 085041),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-12-1212

Decision No. CR3156

Date: March 14, 2014

DECISION

Petitioner, Delmar Nursing & Rehabilitation Center (Petitioner or facility), is a long-term care facility located in Delmar, Delaware, that participates in the Medicare program. Based on a complaint survey completed on May 15, 2012, the Centers for Medicare & Medicaid Services (CMS) determined that Petitioner was not in substantial compliance with Medicare participation requirements. CMS imposed against Petitioner a per instance civil money penalty (PICMP) of $6,000 for noncompliance with 42 C.F.R. § 483.25.

Petitioner appealed, and CMS moved for summary judgment. I grant summary judgment in favor of CMS because the undisputed evidence establishes that the facility was not in substantial compliance with Medicare requirements. Specifically, Petitioner did not provide the necessary care and services to a resident in accordance with a physician's order, the resident's plan of care, and the facility's policy. I also find that the PICMP that CMS imposed is reasonable.

I. Background

The Social Security Act (Act) sets forth requirements for nursing facilities' participation in the Medicare program and authorizes the Secretary of the U.S. Department of Health and Human Services (Secretary) to promulgate regulations implementing those statutory provisions. Act § 1819 (42 U.S.C. § 1395i-3). The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may "pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a) (42 U.S.C. § 1395aa(a)); 42 C.F.R. § 488.10. Each facility must be surveyed once every 12 months, and more often if necessary, to ensure it corrects identified deficiencies. Act § 1819(g)(2)(A) (42 U.S.C. § 1395i-3(g)(2)(A)); 42 C.F.R. §§ 488.20(a), 488.308.

Here, surveyors from the Delaware Health and Social Services Division of Long Term Care Residents Protection (state survey agency) conducted a complaint survey of Petitioner that ended on April 9, 2012 and another complaint survey that ended on May 15, 2012. The state survey agency also completed a standard recertification survey of Petitioner on May 17, 2012. Based on their findings, CMS determined that the facility was not in substantial compliance with participation requirements.

By letter dated June 21, 2012, CMS referenced the April 9, May 15, and May 17, 2012 surveys and explained it would be imposing a mandatory denial of payment for new admissions (DPNA), effective July 9, 2012. By letter dated July 10, 2012, CMS notified Petitioner that it was imposing a PICMP of $6,000 based on the alleged deficiency under 42 C.F.R. § 483.25 (Tag F309) cited in the May 15, 2012 survey. CMS Ex. 5. The state survey agency conducted a revisit on July 16, 2012, finding that Petitioner's facility remained out of substantial compliance.

On August 20, 2012, Petitioner timely requested a hearing to contest CMS's findings of noncompliance, specifically Tag F309 cited in the May 15, 2012 survey, and Tags F249 and F469 cited in the May 17, 2012 survey. Petitioner also requested review of the DPNA and PICMP remedies set forth in the CMS notices issued on June 21, 2012 and July 10, 2012. The case was assigned to me for hearing and decision. On September 7, 2012, I issued an Acknowledgment and Initial Prehearing Order establishing a briefing schedule. In accordance with that schedule, CMS submitted its prehearing exchange, consisting of its prehearing brief, exhibit and witness lists, and 31 exhibits (CMS Exs. 1-31). Petitioner responded with its prehearing exchange, consisting of its prehearing brief (P. Prehearing Br.), exhibit and witness lists, and 18 exhibits (P. Exs. 1-18). CMS then

filed a motion for summary judgment (CMS Br.), and Petitioner filed a response in opposition to CMS's motion for summary judgment (P. Response).

On October 19, 2012, CMS filed a Motion for Partial Dismissal for Cause and Supporting Brief and Exhibits. By letter dated November 7, 2012, Petitioner voluntarily withdrew its challenges to the DPNA remedy and two tags, Tag F249 and Tag F469, which were cited in the May 17, 2012 survey. Petitioner stated that its appeal would focus only on the Tag F309 "G" level deficiency cited at the May 15, 2012 survey and the PICMP that was imposed specifically for that deficiency. Based on Petitioner's actions, CMS's motion for partial dismissal became moot.

II. Issues

Whether the undisputed evidence establishes that:

A. Petitioner was not in substantial compliance with 42 C.F.R. § 483.25; and

B. the PICMP that CMS imposed is reasonable.

III. Findings of Fact and Conclusions of Law

A. Summary judgment is appropriate.

CMS moves for summary judgment relying on the following facts, which are undisputed unless otherwise noted. Resident 1 (R1) was a 30-year old male who was admitted to Petitioner's facility on March 6, 2012. His diagnoses included insulin-dependent diabetes mellitus since childhood, hypertension, history of cerebrovascular accident, transient ischemic attack, and peripheral neuropathy. P. Ex. 3, at 1; CMS Exs. 11; 14, at 1, 8; 15; 16; 21, at 1. R1 had been hospitalized several times for diabetic ketoacidosis, acute renal insufficiency, and uncontrolled hypertension. *See* CMS Ex. 21, at 66. Prior to his admission, R1 had been hospitalized in January 2012, and his diagnoses included diabetic ketoacidosis, acute renal insufficiency, and hypothermia. CMS Ex. 21, at 1-5, 45, 70-74, 76.

R1's care plan incorporated his physician's order for three daily AccuCheck (finger stick) tests to test his blood glucose levels. P. Ex. 2, at 3 (Physician's Written Statement In Lieu of Direct Testimony, ¶ 7); *see* CMS Ex. 14, at 1-2. On March 10 and March 14, 2012, R1's medical records show Petitioner's staff only checked R1's blood glucose twice per day. Further, on March 16, 2012, at around 9:00 p.m., R1 was sweating and took a shower. P. Ex. 11, at 2 (CNA's Written Statement in Lieu of Direct Testimony, ¶ 5). According to the CNA, R1's sweating was due to the fact that he had physically exerted himself from propelling in his wheelchair between floors. P. Ex. 11, at 2 (CNA's Written Statement in Lieu of Direct Testimony, ¶ 5). An AccuCheck performed on R1 at

5:07 p.m. was documented as within normal limits. Although it is not documented in R1's medical records, a LPN claims to have checked R1's blood glucose level again at around 9:00 p.m., with another finger stick test, which she claims was also within normal limits. P. Ex. 10, at 2-3 (LPN's Written Statement in Lieu of Direct Testimony, ¶¶ 5, 7, 10).

Around 6:00 - 6:30 a.m. the next morning on March 17, a nurse found R1 unresponsive. An AccuCheck test performed on R1 at 6:50 a.m. showed a blood glucose level of 53. CMS Ex. 11; *see* CMS Ex. 9, at 20; CMS Ex. 30, at 9 (State nurse surveyor's Written Statement in Lieu of Direct Testimony, ¶ 28). The nurse administered Glucagon to R1 to raise his blood glucose levels. R1 remained unresponsive, staff called 911, and R1 was transported to the hospital where he subsequently died a few days later on March 22, 2012. CMS Ex. 11; *see* CMS Ex. 9, at 21; CMS Ex. 30, at 9-10 (State nurse surveyor's Written Statement in Lieu of Direct Testimony ¶¶ 29-31); CMS Ex. 22, at 1-5, 17-21.

In moving for summary judgment, CMS alleges that it is undisputed that Petitioner's staff did not conduct blood glucose checks on two days for R1 as required by his physician's order and plan of care, in violation of 42 C.F.R. § 483.25. CMS alleges further that the undisputed evidence shows that Petitioner failed to follow its hypoglycemia management policy when staff witnessed R1 sweating on March 16, 2012, also in violation of 42 C.F.R. § 483.25.

Summary judgment is appropriate when a case presents no issue of material fact, and its resolution turns on questions of law. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48 (1986); *Livingston Care Ctr. v. United States Dep't of Health and Human Servs.*, 388 F.3d 168, 173 (6th Cir. 2004). *See also Illinois Knights Templar Home*, DAB No. 2274, at 3-4 (2009) (*citing Kingsville Nursing Ctr.*, DAB No. 2234, at 3-4 (2009)). The moving party may show the absence of a genuine factual dispute by presenting evidence so one-sided that it must prevail as a matter of law, or by showing that the non-moving party has presented no evidence "sufficient to establish the existence of an element essential to [that party's] case, and on which [that party] will bear the burden of proof at trial." *Livingston Care Ctr.,* 388 F.3d 168, 173 (*quoting Celotex Corp. v. Catrett*, 477 U.S. 317, 323-24 (1986)). To avoid summary judgment, the non-moving party must then act affirmatively by tendering evidence of specific facts showing that a dispute exists. *See Matsushita Elec. Indus. Co. v. Zenith Radio Corp.,* 475 U.S. 574, 586 n.11 (1986); *see also Vandalia Park,* DAB No. 1939 (2004); *Lebanon Nursing and Rehab. Ctr.,* DAB No. 1918 (2004). To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but it must furnish evidence of a dispute concerning a material fact. *Illinois Knights Templar Home*, DAB No. 2274, at 4; *Livingston Care Ctr.*, DAB No. 1871, at 5 (2003).

In examining the evidence for purposes of determining the appropriateness of summary judgment, I must draw all reasonable inferences in the light most favorable to the non-

moving party. *Brightview Care Ctr.*, DAB No. 2132, at 2, 9, 10 (2007); *Livingston Care Ctr.*, 388 F.3d at 168, 172; *Guardian Health Care Ctr.,* DAB No. 1943, at 8 (2004). However, drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions. *Cedar Lake,* DAB No. 2344, at 7 (2010); *Guardian Health Care Ctr.,* DAB No. 1943, at 11 ("A dispute over the conclusion to be drawn from applying relevant legal criteria to undisputed facts does not preclude summary judgment if the record is sufficiently developed and there is only one reasonable conclusion that can be drawn from those facts.").

My specific findings of undisputed facts and conclusions of law are set forth in the bold italicized headings and supported by the discussions continued in the sections below.

B. The undisputed evidence establishes that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25 because Petitioner did not provide necessary care and services to R1 when it did not follow R1's physician's orders, R1's plan of care, or the facility's hypoglycemia management policy.

The opening provision of 42 C.F.R. § 483.25 (quality of care), which implements section 1819(b)(2) (Medicare) of the Act, states:

> Each resident must receive and the facility 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.

42 C.F.R. § 483.25.

The quality of care legislation and regulatory requirements are "based on the premise that the facility has (or can contract for) the expertise to first assess what each resident's needs are (in order to attain or maintain the resident's highest practicable functional level) and then to plan for and provide care and services to meet the goal." *Spring Meadows Health Care Ctr.*, DAB No. 1966, at 16 (2005). The regulation thus "imposes on facilities an affirmative duty designed to achieve favorable outcomes to the highest practicable degree." *Windsor Health Care Ctr.*, DAB No. 1902, at 16-17 (2003), *aff'd, Windsor Health Care Ctr. v. Thompson*, No. 04-3018 (6th Cir. 2005). The facility must take "reasonable steps" and "'practicable' measures to achieve that regulatory end." *Clermont Nursing & Convalescent Ctr.*, DAB No. 1923, at 21 (2004), *aff'd*, *Clermont Nursing & Convalescent Ctr. v. Leavitt*, 142 F. App'x 900 (6th Cir. 2005).

Accordingly, the Departmental Appeals Board (Board) has held that the language of 42 C.F.R. § 483.25 requires skilled nursing facilities to furnish the care and services set forth

in a resident's care plan, to implement doctors' orders, to monitor and document the resident's condition, and to follow its own policies. *See, e.g., Alexandria Place*, DAB No. 2245 (2009) (upholding this deficiency where a petitioner failed to provide care in accordance with a doctor's order); *Kenton Healthcare, LLC*, DAB No. 2186 (2008) (upholding this deficiency where a petitioner did not follow standards in a care plan for supervision); *Spring Meadows,* DAB No. 1966, at 17 ("the clearest case of failure to meet [section 483.25] is failure to provide one of the specific services outlined in the subsections or failure otherwise to follow the plan of care based on the comprehensive resident assessment"); and *St. Catherine's of Findley*, DAB No. 1964, at 13 n.9 (2005) (determining that a facility's admission that it failed to follow its own supervision care plan may make summary judgment appropriate). The quality of care provision also implicitly imposes on facilities a duty to provide care and services that, at a minimum, meet accepted professional standards of quality "since the regulations elsewhere require that the services provided or arranged by the facility must meet such standards." *Spring Meadows* DAB No. 1966, at 17, *citing* 42 C.F.R. § 483.75.

1. The undisputed evidence establishes that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25 because Petitioner did not provide necessary care and services to R1 in accordance with his physician's order regarding glucose blood checks.

R1's physician, who was also Petitioner's Medical Director, ordered the facility test R1's blood glucose three times a day. CMS Ex. 14, at 1-2. The physician's order required glucose testing at 6:00 a.m., 11:00 a.m., and 4:00 p.m. CMS Ex. 14, at 1-2. R1's care plan incorporated the physician's order. P. Ex. 2, at 3 (Physician's Written Statement In Lieu of Direct Testimony, ¶ 7); *see* CMS Ex. 14, at 1-2.

In alleging that Petitioner failed to provide the necessary care and services to R1 under 42 C.F.R. § 483.25, CMS relies on the undisputed fact that Petitioner's staff did not check R1's blood glucose levels in accordance with the physician's order on two days. The AccuCheck results form shows that on March 10 and 14, Petitioner's staff performed glucose checks on R1 only twice, rather than three times as ordered. On March 10, Petitioner's staff only checked R1's blood glucose at 7:01 a.m. and 2:41 p.m. On March 14, Petitioner's staff only checked R1's glucose at 5:27 a.m. and 1:22 p.m. CMS Ex. 12.

Petitioner concedes that on March 10 and March 14, its staff failed to check R1's blood glucose three times each day. However, Petitioner argues that these were "two random instances" which had no impact on R1's well-being and that CMS is attempting to hold Petitioner to a standard of perfection under 42 C.F.R. § 483.25. P. Response at 6-7. Moreover, Petitioner argues that R1 was a "competent, mobile, self-determining young man" who had a history of being noncompliant in his own care. P. Response at 6-8. Petitioner contends that the record contains indications of R1's noncompliance and that it is likely that the missed blood glucose checks on March 10 and March 14 were due to the

fact that R1 refused to have his glucose tested. P. Response at 8. Petitioner argues that given these circumstances, it is not reasonable to conclude that it failed to provide necessary care and services to R1.

In support of its position that R1 was a non-compliant resident, Petitioner relies upon, among other things, the written direct testimony of R1's physician. According to R1's physician, R1 was reluctant to have his blood glucose checked more than twice a day. P. Ex. 2, at 3 (R1's Physician's Written Statement in Lieu of Direct Testimony, ¶ 7). Petitioner also notes that its expert stated in his declaration of direct testimony that patients with a long history of Type 1 diabetes "frequently will not submit to [testing] 3 times a day." P. Ex. 16, at 4 (Petitioner's Expert's Declaration, ¶ 16). Petitioner asserts that R1 refused to have his blood sugar checked on at least four occasions: March 8 at 6:00 a.m, March 13 at 11:00 a.m., March 13 at 4:00 p.m., and March 16 at 4:30 p.m. P. Ex. 2, at 3 (R1's Physician's Written Statement in Lieu of Direct Testimony, ¶ 7); P. Ex. 8, at 1; CMS Ex. 10, at 1; *see* P. Prehearing Br. at 5. For purposes of summary judgment, I will accept that Petitioner may have been reluctant to have his blood glucose checked more than twice a day on March 10 and 14.

However, Petitioner does not dispute that, if Petitioner was in fact reluctant to have staff check him, its staff did not document the reluctance. I find that Petitioner has not come forward with any documentation showing that R1 was noncompliant with his blood glucose testing on March 10 and March 14. Whenever R1 refused to have his blood glucose tested, Petitioner's staff was able to specifically document the refusals in his medication record as a code "1", which corresponded to "Drug Refused." *See* P. Ex. 8, at 1; CMS Ex. 10, at 1. R1's physician relies on this documentation for his assertion that at times R1 refused testing ("*according to his medical records* while at the Facility, [R1 refused] on at least four occasions."). P. Ex. 2, at 3 (R1's Physician's Written Statement in Lieu of Direct Testimony, ¶ 7) (emphasis added).

R1's medication administration record shows that Petitioner's staff did, in fact, document times when R1 refused blood glucose testing. According to these records, Petitioner's staff documented that R1 refused a total of four AccuCheck tests on March 8, March 13, and March 16. P. Ex. 8, at 1; CMS Ex. 10, at 1. However, under the dates of March 10 and March 14, there are no notations indicating that R1 refused any AccuChecks. P. Ex. 8, at 1; CMS Ex. 10, at 1.

To defeat CMS's motion for summary judgment, Petitioner must do more than make a bald assertion that the likely explanation for any missed blood glucose tests on March 10 and 14 was due to the fact that R1 refused to have the tests performed. *Matsushita,* 475 U.S. 574, at 586 (finding the opposing party must do more than show that there is "some metaphysical doubt as to the material facts.") Here, Petitioner has not come forward with any specific evidence to support the claim that R1 refused efforts to test his glucose on the relevant dates. The uncontroverted evidence, therefore, leads to only one reasonable

conclusion – Petitioner's staff failed to perform the three glucose checks on R1 on March 10 and 14, as ordered by his physician.

2. The undisputed evidence establishes that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25 because Petitioner did not provide necessary care and services to R1 in accordance with his plan of care regarding glucose checks and related medication dosage.

On R1's care plan, dated March 6, 2012, Petitioner's staff listed diabetes mellitus as a problem to address. P. Ex. 3, at 4; CMS Ex. 17, at 1. The care plan listed the following approach for controlling R1's diabetes: "[a]dminister medications and obtain lab values per order." P. Ex. 3, at 4; CMS Ex. 17, at 1. The care plan directed staff to administer 15 units of Lantus at bedtime and Humalog at breakfast, lunch, and dinner according to a sliding scale depending on R1's blood glucose readings.[1] P. Ex. 3, at 4; CMS Ex. 17, at 1. As explained above, R1's care plan also incorporated his physician's order for three daily AccuChecks. P. Ex. 2, at 3 (Physician's Written Statement In Lieu of Direct Testimony, ¶ 7); *see* CMS Ex. 14, at 1-2.

CMS argues that the missed blood glucose tests on March 10 and March 14 show that Petitioner not only violated R1's physician's order but also violated R1's care plan. CMS Br. at 3, 5, 6. Petitioner, in its response brief, has not presented any additional arguments establishing a factual dispute on this issue other than to contend that they were "isolated incidents of deviation from a care plan." P. Response at 12.

3. The undisputed evidence establishes that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25 because Petitioner did not provide necessary care and services to R1 in accordance with its hypoglycemia management policy despite staff observations of R1's diaphoresis.

The Board has held that CMS may reasonably rely on a facility's policy relating to the care and treatment of its residents as evidencing the facility's understanding of what must be done to attain or maintain residents' highest practicable physical, mental, and psychosocial well-being, as required by 42 C.F.R. § 483.25. *The Laurels at Forest Glenn*, DAB No. 2182, at 18 (2008) (citing *Spring Meadows*, DAB No. 1966, at 16-20. Such a policy "is also evidence of the standard of care the facility expect[s] its staff to provide" and of professional standards of care. *The Laurels at Forest Glenn*, DAB No. 2182, at 18 (citing *Oxford Manor*, DAB No. 2167, at 5-6 (2008)). Consequently, the

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[1] Lantus and Humalog are medications used to help control glucose levels. *See* CMS Ex. 28, at 5; P. Ex. 16, at 3. On March 11, 2012, R1's physician discontinued the sliding scale and issued a new sliding scale to be followed for the administration of Humalog, which was still dependent on R1's glucose readings. CMS Ex. 14, at 4.

Board has decided, a facility's failure to follow or implement its own resident care policy may constitute a deficiency under 42 C.F.R. § 483.25. *The Laurels at Forest Glenn*, DAB No. 2182, at 18.

It is undisputed that Petitioner had a hypoglycemia management policy in effect for residents with diabetes during the relevant time period. Petitioner's policy, titled "Diabetes: Hypoglycemia Management," instructs its nurses how to monitor residents for signs of hypoglycemia. CMS Ex. 23. The policy listed the following signs and symptoms: diaphoresis, tremors, pallor, tachycardia, and cold, clammy skin. CMS Ex. 23, at 1. If a resident exhibited any of the aforementioned signs or symptoms, the policy instructed the nurses to perform a finger stick for a baseline blood glucose reading. CMS Ex. 23, at 1. The policy required recordation of *all* finger stick results. CMS Ex. 23, at 2. The policy also stated, "[t]he following protocol will be carried out for abnormal fingerstick blood sugars unless specific physician's orders specify otherwise." The policy then explicitly described a protocol when a "fingerstick blood sugar [is] less than 65 and/or exhibits any signs or symptoms of hypoglycemia." CMS Ex. 23, at 2. Under this scenario, the policy required staff to: administer glucose in the form of either food (milk with graham crackers or orange juice with sugar) or glucose gel; immediately notify the nursing supervisor; record vital signs in the nursing notes; notify the physician of the resident's vital signs within 15 minutes; and repeat the finger stick blood sugar test within 30 minutes. CMS Ex. 23.

Petitioner's policy also sets out a protocol when a "fingerstick blood sugar [is] less than 50 OR there is acute confusion, delirium, or unresponsiveness." CMS Ex. 23, at 2. Under this scenario, the policy required staff to: administer Glucagon; record the resident's vital signs in the nursing notes; notify the physician of the vital signs and action taken within 15 minutes; and repeat the finger stick blood sugar test within 30 minutes.

There is no dispute that R1 had a sweating episode on the night of March 16, 2012. CMS has come forward with evidence alleging that Petitioner's nursing staff did not follow its hypoglycemia management policy, which CMS claims was triggered by observation of R1's sweating episode. Contrary to Petitioner's hypoglycemia policy, the nursing staff did not record R1's baseline blood glucose reading, vital signs, and did not immediately notify the nursing supervisor that he was sweaty around 9:00 p.m. on March 16, 2012, nor did they notify his physician of R1's condition within 15 minutes (or at all) that evening. Further, R1's medical records contain no documentation that staff did notice R1 to be sweating or that nursing staff closely monitored R1 and observed him frequently for the next 24 hours. *See* CMS Ex. 23, at 2; CMS Ex. 30, at 7 (nurse surveyor's Written Statement in Lieu of Direct Testimony, ¶ 23).

The next morning, around 6:00 a.m. or 6:30 a.m., a nurse found R1 unresponsive, and, at 6:50 a.m., his blood glucose reading was 53. The staff administered Glucagon to R1 to

raise his blood glucose levels and notified his physician. R1 continued to remain unresponsive, staff called 911, and R1 was transported to the hospital where he subsequently died on March 22, 2012. CMS Ex. 9, at 20, 21; CMS Ex. 11; *see* CMS Ex. 22, at 20-21; CMS Ex 28, at 5 (CMS's Expert Witness's Written Statement in Lieu of Direct Testimony, ¶ 22); CMS Ex. 30, at 9-10 (State nurse surveyor's Written Statement in Lieu of Direct Testimony, ¶¶ 28-31).

Petitioner does not dispute that there is no documentation related to R1's sweating episode contemporaneously recorded on the night of March 16, 2012. Petitioner argues, however, that R1's sweating episode did not trigger its hypoglycemia management policy. Petitioner contends that R1 did not have "profuse" or "excessive" sweating, and thus, did not satisfy the definition of diaphoresis under its policy such that monitoring was necessitated. P. Response at 9-10. Petitioner claims further that CMS's only evidence concerning R1's sweating comes from the surveyor's notes of interviews with its staff. P. Response at 9 n.7. According to Petitioner, R1 was not in any distress and his sweating episode "was attributable to physical exertion and <u>not</u> a hypoglycemic episode." P. Response at 9-10 (emphasis in original). Petitioner also points out that R1 never had a glucose reading below the threshold minimum of 65 prior to 6:50 a.m. on March 17. Petitioner notes that its staff had in fact performed an AccuCheck test on R1 around 5:07 pm, and the recorded blood glucose reading was 129, which is "clearly not in the range of hypoglycemia." P. Prehearing Br. at 19; *see* CMS Ex. 12.

Petitioner relies on the definition of "diaphoresis" found in Webster's New World College Dictionary (4th ed. 2004), which defines "diaphoresis" as "perspiration, esp[ecially] when profuse." P. Prehearing Br. at 20. Petitioner also relies on the Board's decision in *Life Care Ctr. of Tullahoma*, in which the Board noted that the facility's Medical Director had testified that "[c]ommon symptoms of low blood sugar (hypoglycemia) include excessive perspiration, weakness, faintness or dizziness, blurred vision, tremors, tachycardia (racing heartbeat), headache, or even sudden unconsciousness." P. Prehearing Br. at 20, citing *Life Care Ctr. of Tullahoma*, DAB No. 2304, at 12 n.2.

As further support that its hypoglycemia policy was not implicated by R1's sweating episode, Petitioner cites the testimony of both R1's physician and its medical expert witness. P. Prehearing Br. at 18-19; P. Exs. 2, 16. R1's physician states:

> [Petitioner's hypoglycemia] Policy is not implicated unless a resident is exhibiting any of the enumerated symptoms <u>and</u> a blood glucose reading registers below 65 or above 350. Even if Resident 1's reported sweating were consistent with diaphoresis, and I understand that it was not, Resident 1's blood glucose readings around the time the sweating was observed were within normal limits. Second, it would be

> irrational to implement the procedures contained in the Policy if a patient was exhibiting only one of the symptoms contained therein and did not have a blood glucose reading indicating hypoglycemia . . . . [I]t is my understanding that the sweating was attributable to a known and obvious cause – Resident 1's physical exertion – and has not been described anywhere in the record as the type of profuse or excessive sweating that would raise a concern that Resident 1 was diaphoretic.

P. Ex. 2 (R1's Physician's Written Statement in Lieu of Direct Testimony, ¶ 6).

In Petitioner's medical expert's declaration, the expert echoes the physician's statement in stating that "[t]here is no evidence" to support that R1's sweating episode represented a "pathological event requiring further evaluation and/or treatment." The expert claims that R1 was "hot from exercise" and there was no basis to conclude that he was diaphoretic and Petitioner's hypoglycemia policy should have been evoked. The expert also notes that a nurse observed R1 around 3:00 a.m. on the morning of March 17, 2012, and "he was his usual normal self and was talking with no problems." According to the expert, someone who has had a hypoglycemic event would not reasonably be expected to improve without any interventions. P. Ex. 16 (Petitioner's Medical Expert's Declaration, ¶¶ 21-23, 27).

Neither R1's physician nor Petitioner's expert witness had any first hand observation of R1's sweating episode on the night of March 16, 2012. Their knowledge of R1's sweating is derived after the fact, from their review of R1's records and statements of Petitioner's staff.[2] I note further that the record they reviewed lacked any contemporaneous documentation related to R1's sweating episode. Nevertheless, I accept, for purposes of summary judgment, that R1 was not profusely or excessively sweating. I also accept that during that time R1 did not have a glucose reading below the threshold minimum of 65 prior to 6:50 a.m. on March 17, 2012. Further, I also accept that R1's sweating was due to his physical exertion as a result of propelling himself in his wheelchair. However, Petitioner's assertions do not create any disputes of material fact. Moreover, the claims by R1's physician and Petitioner's expert witness that only profuse or excessive, non-exercise-related, sweating would be considered a hypoglycemic symptom sufficient to trigger the facility's hypoglycemia policy has no support in the plain language of Petitioner's policy.

It is unreasonable for me to make an inference for summary judgment purposes that Petitioner's policy actually required an observation of *profuse* sweating or that Petitioner

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[2] Petitioner's expert also indicated that he had reviewed CMS's prehearing brief and related exhibits.

excepted sweating due to physical exertion from its policy. I do not have to accept as true inferences that are unreasonable for the purposes of summary judgment. *See Brightview Care Ctr.*, DAB No. 2132, at 10. Petitioner's hypoglycemia policy does not make exceptions for different types or causes of diaphoresis or sweating. CMS Ex. 23. Nowhere is there any language that further defines diaphoresis or states that a resident's sweating must be profuse or excessive to trigger the policy. Based on the plain language of the policy, any diaphoresis, regardless of the degree of sweating, would be sufficient to trigger the protocols. Moreover, even if R1's sweating may have been caused by his physical exertion rather than a change in his blood glucose level, this is irrelevant inasmuch as Petitioner's policy does not instruct its nurses to ascertain the cause of a resident's sweating. The fact that R1 was having a sweating episode was sufficient, in and of itself, to trigger Petitioner's hypoglycemia policy.

Further, the Webster's Dictionary definition of "diaphoresis" on which Petitioner relies would not preclude R1's sweating episode from triggering Petitioner's policy. The relied-upon dictionary definition does not state that diaphoresis refers only to "profuse sweating." The definition is worded to state that diaphoresis is perspiration, and notes that it "especially" includes "profuse" perspiration.

Despite arguing that the facility's hypoglycemia policy did not apply to R1's sweating episode, Petitioner does purport, however, that a LPN performed an additional AccuCheck test on R1 around 9:00 p.m. on March 16, and that the blood glucose reading was 135, which is normal. P. Ex. 10, at 2 (LPN's Written Statement in Lieu of Direct Testimony, ¶ 7). The LPN admits that she did not record this blood glucose result anywhere in R1's medical records. P. Ex. 10, at 2 (LPN's Written Statement in Lieu of Direct Testimony, ¶ 7). According to Petitioner, because the finger stick test returned a normal reading, R1 was "not in distress" and its staff was not required to take any further actions under its hypoglycemia policy. P. Response at 10-11.

For purposes of summary judgment, I will accept that Petitioner's LPN took an unrecorded finger stick test of R1 around 9:00 p.m., which would be around the time of R1's sweating episode. I also accept that this test satisfied, in part, Petitioner's hypoglycemia policy's requirement as it regarded a baseline finger stick. Moreover, I accept that the LPN obtained a normal blood glucose reading for R1, which she did not document in R1's medical records.

Although the LPN may have administered the finger stick test as required under Petitioner's policy, it is undisputed that Petitioner's nurses failed to record it as required or take any further actions after staff observed R1 sweating. Petitioner disputes whether further action was necessary by relying on R1's physician's statement. P. Prehearing Br. at 19. In his written statement quoted above, R1's physician stated that Petitioner's "Policy is not implicated unless a resident is exhibiting any of the enumerated symptoms <u>and</u> a blood glucose reading registers below 65 or above 350." P. Ex. 2 (R1's Physician's

Written Statement in Lieu of Direct Testimony, ¶ 16) (emphasis in original). According to R1's physician, it was "irrational to implement the procedures contained in the Policy if a patient was exhibiting only one of the symptoms contained therein and did not have a blood glucose reading indicating hypoglycemia." P. Ex. 2 (R1's Physician's Written Statement in Lieu of Direct Testimony, ¶ 16).

I need not accept R1's physician' assertions because they are inconsistent with and unsupported by the plain language of Petitioner's hypoglycemia policy. As stated above, Petitioner's policy explicitly sets out a protocol that its nurses are to follow in a situation where a resident's blood sugar reading is "less than 65 and/or exhibits any signs or symptoms of hypoglycemia." CMS Ex. 23, at 2 (emphasis added). The "and/or" phrasing contained in the policy contradicts R1's physician's claim that a resident has to exhibit both a hypoglycemic symptom and an abnormal blood glucose reading to trigger the policy.

Although R1 apparently had a normal blood glucose reading when the LPN checked him around 9:00 p.m., there can be no dispute that the "and/or" phrasing (versus an inclusion of simply the word "and") in Petitioner's protocol meant that the presence of R1's sweating, *even in the absence of an abnormal blood sugar reading*, triggered Petitioner's policy. Because R1 had a sweating episode, Petitioner's nurses should then have implemented all of the following steps of the protocol, especially including: notifying the nursing supervisor immediately, recording his vital signs in the nursing notes, notifying his physician within 15 minutes, monitoring R1 closely until his blood sugar was in the normal range "and/or" he was asymptomatic, then observing him frequently for 24 hours with documentation in the nursing notes and the 24-hour report, and transferring him to the hospital if he failed to respond to the foregoing interventions. CMS Ex. 23, at 2.

In her written statement, the state agency nurse surveyor confirmed that she found no documentation in Petitioner's records that its nurses had notified the nursing supervisor or R1's physician that R1 had a sweating episode and found no documentation that Petitioner's nurses observed him frequently for 24 hours, as required by Petitioner's policy. CMS Ex. 30, at 7 (State nurse surveyor's Written Statement in Lieu of Direct Testimony, ¶ 23). Petitioner has not challenged these statements of the nurse surveyor.

The uncontroverted evidence establishes that Petitioner's staff did not follow the plain language of its hypoglycemia management policy when facility staff observed R1 having a sweating episode on March 16, 2012. Because its staff did not follow the policy, Petitioner thus failed to provide the necessary care and services to R1 under 42 C.F.R. § 483.25.

C. The PICMP that CMS imposed is reasonable.

In determining whether the $6,000 PICMP amount imposed against Petitioner is reasonable, I consider the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of noncompliance, including repeated deficiencies; 2) the facility's financial condition; 3) factors specified in 42 C.F.R. § 488.404; and 4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort, or safety. The absence of culpability is not a mitigating factor. The factors in 42 C.F.R. § 488.404 include: 1) the scope and severity of the deficiency; 2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and 3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

I also consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found. *CarePlex of Silver Spring*, DAB No. 1683, at 8 (1999). I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Ctr.*, DAB No. 1848, at 21 (2002); *Cmty. Nursing Home*, DAB No. 1807, at 22-26 (2002); *Emerald Oaks*, DAB No. 1800, at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1683, at 8.

Other than claiming in its prehearing brief that the $6,000 PICMP is "unreasonable," Petitioner has not otherwise come forward with any evidence with respect to any of the regulatory factors that would affect my consideration of the amount of the penalty. P. Prehearing Br. at 25; *see* 42 C.F.R. § 488.438(f). In discussing the burden of proof regarding the regulatory factors, the Board has held that "an ALJ or the Board properly <u>presumes</u> that CMS considered the regulatory factors and that those factors support the amount imposed." *Pinecrest Nursing & Rehab. Ctr.,* DAB No. 2446, at 23 (2012) (emphasis in original; citations omitted). Thus, CMS is not required to present evidence regarding each regulatory factor. Instead, the burden is on Petitioner "to demonstrate, through argument and the submission of evidence addressing the regulatory factors, that a reduction is necessary to make the CMP amount reasonable." *Pinecrest Nursing & Rehab. Ctr.,* DAB No. 2446, at 23, quoting *Oaks of Mid City Nursing & Rehab. Ctr.,* DAB No. 2375, at 26-27 (2011).

Nonetheless, I am compelled to comment on the seriousness of Petitioner's noncompliance. Vigilant monitoring of blood sugar levels in a diabetic resident is critically important. Here, Petitioner's nursing staff did not perform the required number of blood glucose checks on R1 on March 10 and March 14, 2012, in contravention of R1's physician's order. Because of this noncompliance, on those two dates staff would not have obtained required blood glucose readings necessary to monitor R1's condition and would not have been able to administer the proper dosage of R1's sliding scale diabetes medication under his care plan, which was dependent on his blood glucose

levels. Further, on March 10, 2012, Petitioner's staff failed to follow R1's care plan because they did not administer sliding scale Humalog at all to R1 on that date. These deficiencies alone substantiate the amount of the penalty.

In addition, Petitioner's staff did not implement its hypoglycemia management policy when R1 had a sweating episode. By not executing the steps outlined in the facility's policy, which included heightened monitoring, notification of the nursing supervisor and the physician, and documentation in R1's medical records, staff clearly put R1 at risk for serious harm. I thus find that Petitioner is also culpable for that noncompliance.

Given the seriousness of Petitioner's noncompliance and its culpability, I find that a PICMP of $6,000, which is in the middle of the allowable PICMP range ($1,000 to $10,000), is a reasonable remedy for Petitioner's failure to comply substantially with Medicare requirements. 42 C.F.R. §§ 488.408(d)(iv), 488.438(a)(2).

As set forth above, I grant summary judgment in favor of CMS finding that the undisputed material facts establish that Petitioner was not in substantial compliance with quality of care Medicare requirements and that the PICMP CMS imposed is reasonable.

/s/
Joseph Grow
Administrative Law Judge