Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	)	DATE: November 1, 2006
Woodland Village Nursing Center,	)	
Petitioner,	)	Civil Remedies CR1367 App. Div. Docket No. A-06-38
- v. -	)	Decision No. 2053
Centers for Medicare & Medicaid Services.	)	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Woodland Village Nursing Center (Woodland, Petitioner), a Mississippi skilled nursing facility (SNF), appeals a November 16, 2005 decision by Administrative Law Judge (ALJ) Keith W. Sickendick. Woodland Village Nursing Center, DAB CR1367 (2005) (ALJ Decision). In that decision, the ALJ upheld the determination of the Centers for Medicare & Medicaid Services (CMS) that Woodland was not in substantial compliance with a regulation requiring it to provide residents with sufficient fluids to maintain proper hydration and health. The ALJ also determined that $100 per day was a reasonable amount for the civil money penalty (CMP) imposed by CMS for the period July 16 through September 19, 2002.

In addition to the record from the ALJ proceeding, the record for our decision consists of the parties' briefs and the transcript of an oral argument conducted by telephone on June 21, 2006. As we discuss below, Woodland made no persuasive arguments, and we affirm the ALJ Decision, which is supported by substantial evidence on the record as a whole and free from legal error.

Applicable legal provisions

SNFs participating in the Medicare program are subject to survey and enforcement procedures set out in 42 C.F.R. Part 488, subpart E, to determine if they are in substantial compliance with applicable program requirements which appear at 42 C.F.R. Part 483, subpart B. "Substantial compliance" means a level of compliance 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. "Noncompliance," in turn, is defined as "any deficiency that causes a facility to not be in substantial compliance." 42 C.F.R. § 488.301.

A SNF found not to be in substantial compliance is subject to various enforcement remedies. 42 C.F.R. §§ 488.402(c), 488.408. CMS may impose CMPs ranging from $50-$3,000 per day for one or more deficiencies that do not constitute "immediate jeopardy" but that either cause actual harm or create the potential for more than minimal harm, and from $3,050-$10,000 per day for deficiencies constituting immediate jeopardy. 42 C.F.R. § 488.438(a). Within the applicable range, the regulations provide a number of factors that CMS considers in determining an appropriate CMP amount. These factors are the facility's history of noncompliance, its financial condition, its degree of culpability for the cited deficiencies, the scope and severity of those deficiencies, and the relationship between or among the deficiencies resulting in noncompliance. 42 C.F.R. § 488.438(f). A CMP may start to accrue as of the date that the facility was first out of compliance, as determined by CMS or the state, and continues until the date the facility achieves substantial compliance. 42 C.F.R. § 488.440(a),(b).

Background

The Mississippi Department of Health (State agency) identified the deficiency that is the subject of Woodland's appeal in a complaint investigation of Woodland's facility that ended July 16, 2002. Based on the State agency's recommendations, CMS determined that Woodland was not in substantial compliance with the Medicare and Medicaid participation requirement at 42 C.F.R. § 483.25(j) addressing hydration with respect to four residents, and the requirement at 42 C.F.R. § 483.25(d)(2) addressing the treatment of urinary incontinence with respect to one of those residents. CMS imposed a CMP of $600 per day that began on July 16 and ended September 19, 2002, based on a revisit survey by the State agency that determined that Woodland had attained substantial compliance effective September 20, 2002.

Woodland appealed CMS's enforcement action, and the ALJ scheduled a hearing. By motion dated January 20, 2004, the parties jointly moved that the case be decided on the written record, and Woodland waived the right to have an oral hearing.

In his decision, the ALJ determined that CMS had a basis for imposing a CMP because Woodland was not in substantial compliance with section 483.25(j) with respect to one resident, Resident 4. However, the ALJ concluded that CMS failed to make a prima facie showing of violations of either regulation with respect to the other three residents and reduced the CMP from the $600 per day imposed by CMS to $100 per day. CMS did not appeal the ALJ Decision. Woodland appeals CMS's basis for imposing a CMP and the reasonableness of the $100 per day amount of the CMP. Accordingly, the issues before us are whether the ALJ's determinations that Woodland was not in substantial compliance with respect to Resident 4 and that a CMP of $100 per day is reasonable are supported by substantial evidence and free from legal error.

The regulation on which the deficiency finding is based provides as follows:

> 42 C.F.R. § 483.25 Quality of care.
>
> 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.
>
> * * *
>
> (j) Hydration. The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.

Regarding Resident 4, the ALJ made the following findings of fact and conclusions of law, which are numbered as in the ALJ Decision:

> Findings of fact
>
> 4. During the period May 24, 2002 through June 9, 2002, Resident 4 consumed less liquid than recommended by Petitioner's registered dietician.
>
> 5. On June 9, 2002, Resident 4 was admitted to the hospital from Petitioner's facility and she was

suffering from a urinary tract infection (UTI) and dehydration.

6. Petitioner knew that Resident 4 was at risk for dehydration, Petitioner had care planned for the risk, and Petitioner's records reflect decreased consumption of liquids by Resident 4 prior to her hospitalization on June 9, 2002.

7. Resident 4 suffered actual harm by becoming dehydrated.

Conclusions of law

4. Section 483.25(j) of Title 42 C.F.R. requires that a facility provide residents with sufficient fluid intake to maintain proper hydration and health.

5. To make a *prima facie* showing of a violation of 42 C.F.R. § 483.25(j), CMS must show that a facility did not provide a resident proper hydration and such showing may be by evidence of signs and symptoms of insufficient fluid intake, abnormal laboratory values, or a diagnosis of dehydration.

7. Petitioner violated 42 C.F.R. § 483.25(j) (Tag F 327) with respect to Resident 4 but not with respect to Residents 5, 6, and 7.

8. The proposed CMP of $600 per day for the period July 16, 2002 through September 19, 2002 is not reasonable, but a CMP of $100 per day for that period is reasonable.

Woodland appeals finding of fact 7 and conclusion of law 7 as it pertains to Resident 4. Woodland also appeals the portion of conclusion of law 8 holding that a CMP of $100 per day is reasonable. In its arguments, however, Woodland actually disputes only the basis for imposing any CMP, not whether the $100 per day amount of the CMP is reasonable assuming such a basis exists.

In his discussion, the ALJ held that the resident's hospitalization with dehydration was prima facie evidence that Woodland failed to ensure that the resident was properly hydrated as required by the regulation. Woodland failed to rebut CMS's prima facie case, the ALJ wrote, because Woodland presented no competent medical evidence in support of its position that the resident was not dehydrated, a position that was contrary to the

diagnoses of treating physicians and observations contained in Woodland's records and those from the hospital. ALJ Decision at 11-13.

The ALJ noted that Woodland did not dispute that the resident consumed less liquid than Woodland's registered dietician had recommended.[1] Id. He also noted that Woodland did not dispute that a Resident Assessment Protocol (RAP) for dehydration/fluid maintenance was triggered for the resident on June 6, 2002, three days before the resident's admission to the hospital.[2] Id.

The ALJ concluded that the $600 per day CMP that CMS had imposed was not reasonable because CMS had failed to prove violations of 483.25(d)(2) and (j) with respect to the three other residents but that a CMP of $100 per day was reasonable given his findings with regard to Resident 4. As noted above, CMS did not appeal that determination.

Standard of Review

We review an ALJ's decision to determine if it is supported by substantial evidence on the record as a whole and free of legal error. Guidelines for Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs, www.hhs.gov/dab/guidelines/prov.html (DAB Appellate Review Guidelines); Golden Age Nursing & Rehabilitation Center, DAB No. 2026 (2006).

Before the ALJ, a facility must prove substantial compliance by the preponderance of the evidence once CMS has established a prima facie case that the facility was not in substantial compliance with one or more of the participation requirements.

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[1] The registered dietician recommended a fluid intake of 1325 ccs per day in a nutritional assessment completed on May 30, 2002. Petitioner Ex. 9, at 101.

[2] Resident Assessment Protocols address a minimum of 18 "domains," each covering a broad subject related to patient health, well-being, or treatment; one of these domains is "dehydration/fluid maintenance." Park Manor Nursing Home, DAB No. 2005, at 36 (2005), citing 42 C.F.R. § 483.315(f). A facility uses RAP guidelines to identify and assess problems that might require care planning. Id. Thus, the RAP here identified Resident 4 as having a risk for dehydration that might require care planning. It also cited the dietician's recommendations.

Batavia Nursing and Convalescent Center, DAB No. 1904 (2004), aff'd, 129 Fed.Appx. 181 (6th Cir. 2005); Cross Creek Health Care Center, DAB No. 1655 (1998).

Discussion

1. The only ALJ finding appealed by Woodland is not necessary to his conclusion that Woodland violated 42 C.F.R. § 483.25(j), and Woodland's arguments about the legal requirements of 42 C.F.R. § 483.25(j) do not accurately reflect or undercut the ALJ's bases for that conclusion.

Woodland appeals only one of the ALJ's findings of fact, the finding that Resident 4 suffered actual harm by becoming dehydrated. The ALJ's finding of actual harm is not necessary to his conclusion that Woodland was not in substantial compliance with 42 C.F.R. § 483.25(j); all that is required is a finding that the deficiency had the potential for more than minimal harm. 42 C.F.R. §§ 488.301, 488.402(c), 488.430(a). In that respect, the ALJ's findings of fact 4-6 support his legal conclusion that Woodland violated 42 C.F.R. § 483.25(j), i.e., that the deficiencies under that regulation posed at least a risk for more than minimal harm to Resident 4. Although Woodland disputes the ALJ's reliance on certain evidence underlying findings of fact 4-6 (such as the hospital diagnosis of dehydration), Woodland does not dispute the findings themselves or specifically deny that it had a deficiency posing the risk of more than minimal harm.[3] Instead, Woodland argues that CMS and the ALJ applied an erroneous legal interpretation of what 42 C.F.R. § 483.25(j) requires for substantial compliance.

Woodland argues that the ALJ erroneously based his Decision upholding a deficiency under 42 C.F.R. § 483.25(j) on a survey finding that Woodland failed to comply with its own policy requiring that a resident's physician be notified when, for a period of three consecutive days, the resident's fluid intake is

[3] Based on these characteristics of Woodland's appeal, the Board arguably would not need to address the evidentiary record. However, Woodland does dispute the ALJ's reliance on certain evidence underlying his findings and also questions "whether CMS presented . . . prima facie evidence to support the findings and deficiencies as cited on the Form 2567, and if so, whether Petitioner rebutted CMS's prima facie case." Petitioner Br. at 2. Accordingly, in the next section of this decision, we do discuss the evidentiary disputes and conclude that substantial evidence in the record as a whole supports the ALJ's findings.

less than the facility's registered dietician's recommendation.[4] Woodland argues that this finding does not allege any violation of the regulation requiring that a facility "must provide each resident with sufficient fluid intake to maintain proper hydration and health." Woodland further argues that a registered dietician's recommendation for fluid intake is not the same as the "sufficient fluid intake" to maintain proper hydration or health that the regulation requires, and that Woodland's failure to notify the resident's physician after three days of fluid intake below the dietician's recommendation does not constitute a failure to provide sufficient fluid intake within the meaning of the regulation. Woodland also notes the State agency findings that Woodland failed to complete a Dehydration Risk Assessment upon admission and failed to care plan for problems facing residents at risk for dehydration but argues that none of these findings evidences failure to comply with the regulation.

We find no merit in these arguments. First, they do not accurately reflect the bases for the ALJ Decision. The ALJ did not base his decision on Woodland's failure to comply with its policy of physician notification or any assessment or care planning failures. Instead, the ALJ based his determination on the hospital's diagnosis of dehydration, which he concluded demonstrated that Woodland had failed to provide sufficient fluid intake to maintain proper hydration and health. The ALJ also concluded that the dehydration was consistent with other findings noted in the SOD, such as Woodland's failure to provide the amount of hydration recommended by the dietician, a finding that Woodland does not dispute. ALJ Decision at 11-13. The ALJ explicitly stated that he did not base his decision on Woodland's failure to follow its policy: "CMS's allegations that Petitioner failed to follow its policy add nothing to the *prima facie* showing, except to bolster it by highlighting that Petitioner had recognized and care planned for a risk of dehydration for Resident 4 and then failed to follow through with its own protocol to prevent it." ALJ Decision at 12. We agree with the ALJ that the hospital diagnosis of dehydration would itself be sufficient to establish CMS's prima facie case. We also agree that the diagnosis is consistent with the other findings on the SOD which Woodland does not dispute, including the undisputed fact that the resident's recorded fluid intake at Woodland's facility was less than recommended for at least seven out of 11 days. Petitioner Ex. 2, at 8-9.

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[4] Woodland cites a finding to that effect in the Statement of Deficiencies (SOD) that the State agency issued following its investigation of Woodland's facility that ended on July 16, 2002.

Furthermore, since the ALJ Decision, and our decision upholding it, does not turn on Woodland's failure to follow its dehydration policy, the cases Woodland cites for the proposition that a facility's failure to follow its own policies can never be the basis for a deficiency absent a specific regulatory requirement to that effect are irrelevant. However, we note that Carehouse Convalescent Hospital, DAB No. 1799 (2001), the only Board decision cited by Woodland for that principle, does not support Woodland's position. In Carehouse, the Board rejected CMS's argument that the facility had violated the requirement for maintaining acceptable parameters of nutritional status by failing to monitor the resident's weight loss and refer the resident to its weight variance committee as facility policy required. In doing so, the Board stated that "monitoring and the maintenance of records and assessments is not a specific component of the regulation under which this deficiency finding was leveled." Carehouse at 25. However, that statement is far from a holding that a facility's failure to follow its own policies can never be a basis for a deficiency citation under any regulation unless expressly required by that regulation. Moreover, the Board's statement in Carehouse must be viewed in the context of the Board's conclusion that the ALJ had correctly found the petitioner in compliance with the nutrition regulation because the regulation did not require maintenance of weight per se but, rather, maintenance of acceptable nutritional status which, according to expert testimony, would not necessarily be reflected by weight. Thus, the Board viewed the facility's weight loss policy, or at least the specific aspects of that policy relied on by CMS, as immaterial. In the case of the dehydration regulation, the sufficiency of fluid intake is specifically addressed by the regulation; thus, whether the facility followed its policies with respect to monitoring and reporting on fluid intake would be relevant, at least for persons regarded as at risk for dehydration. The dietician regarded Resident 4 as at risk for dehydration due to her being on Lasix. Petitioner Ex. 9, at 101.

Additionally, Woodland's argument that section 483.25(j) does not require that the facility follow its policy to notify a resident's physician of decreased fluid intake, or adhere to the registered dietician's recommendation for fluid intake, ignores the general lead-in language in 42 C.F.R. § 483.25, that "[e]ach 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." The lead-in language is based on the statutory description of the services required of SNFs in section 1819(b) of the Social Security Act,

and the statute and the regulations as a whole are based on the premise that the facility has (or can contract for) the expertise to plan for and provide care and services to maintain the resident's highest practicable functional level. Spring Meadows Health Care Center, DAB No. 1966, at 17-18 (2005). Thus, "[w]hen a facility adopts a policy that calls on the nursing staff to take affirmative actions to safeguard resident health and safety, it is reasonable to infer (in the absence of evidence to the contrary) that the facility did so because such actions are necessary to attain or maintain resident well-being." Id. at 20.

Based on this language, the Board has held that a facility's failure to comply with physician's orders or to follow its own policy, as well as the failure to provide services in accordance with a plan of care based on a resident's comprehensive assessment, can constitute a deficiency under section 483.25. Lakeridge Villa Health Care Center, DAB No. 1988, at 22 (2005), citing The Windsor House, DAB No. 1942, at 55-56 (2004), Batavia Nursing and Convalescent Center at 35-36 and Spring Meadows at 16-17. In Spring Meadows, the Board observed that CMS may reasonably rely on a facility policy as evidencing the facility's evaluation of what must be done to attain or maintain a resident's highest practicable physical, mental, and psychosocial well-being, as required by section 483.25.

Thus, Woodland's failure to follow its policy and the recommendations of its dietician could support a prima facie showing of a violation of the regulation since one could reasonably infer that the policy and recommendations reflect Woodland's determinations of what care and services were necessary to permit the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being as required by the regulation.

2. Woodland has not shown that the resident received adequate hydration or was not dehydrated, and substantial evidence supports findings of fact 4-6.

As indicated above, Woodland does not appeal findings of fact 4-6 but does question the hospital diagnosis of dehydration. Woodland also asserts that it provided the resident with adequate hydration as required by the regulation and that Resident 4 displayed no signs of dehydration until her last day at the facility after which Woodland responded appropriately by admitting her to the hospital. We first note that clinical signs of dehydration or a diagnosis of dehydration are not necessarily required before CMS can find a violation of section 483.25(j). The regulation focuses on whether the facility is providing

services to maintain sufficient hydration and whether any failure to do so has the potential for more than minimal harm. Where a resident has been found to be at risk for dehydration, as Resident 4 was here, the compliance analysis must begin with what the facility did to mitigate that risk. To that end, its policies and whether it provided the amount of fluids recommended by the resident's dietician can be critical.[5]

Furthermore, Woodland has not presented any evidence that undercuts the hospital diagnosis of dehydration. Woodland disputes the hospital diagnosis of dehydration on the ground that the resident's urine specific gravity, which Woodland asserts is the prime laboratory indication of dehydration, was 1.015 upon admission to the hospital. Woodland argues that this reading is within the normal range of 1.003 to 1.029, and, thus, not consistent with a diagnosis of dehydration. Petitioner Br. at 9, citing CMS Ex. 14, at 88. Woodland presented no medical evidence showing that the specific gravity of Resident 4's urine ruled out a diagnosis of dehydration or that the diagnosis was incorrect. In addition, although Woodland asserts that the blood-urea nitrogen (BUN) and creatinine readings the resident displayed at the hospital were caused by acute renal failure (one of the

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[5] To this extent we conclude that the ALJ's analysis focused too restrictively on whether CMS has shown actual dehydration or clinical signs that CMS's State Operations Manual (SOM) directs surveyors to look for to determine that a resident is not properly hydrated, such as dry skin and mucous membranes, cracked lips, poor skin turgor, thirst, fever, or abnormal laboratory values. SOM, Guidance to Surveyors, at App. PP. As the ALJ himself noted, the SOM contains two probes – stated in the alternative – for surveyors to use, not just the clinical signs probe on which he relied. ALJ Decision at 10-11. The second probe asks whether the facility has provided residents with adequate fluid intake to maintain proper hydration and health. The SOM also states that the intent of the hydration regulation is to assure that the resident receives a "sufficient amount of fluids based on individual needs to prevent dehydration." The SOM further states that the "amount needed" is specific for each resident and fluctuates with the resident's condition. Thus, it is appropriate for CMS and state survey agencies to consider whether a resident is receiving the amount of fluids that a facility's dietician has determined meets the resident's specific needs. The ALJ's reading of the SOM could prevent CMS from acting preemptively to protect a resident who is not receiving needed fluid intake but is not yet exhibiting the signs and symptoms of dehydration.

resident's admitting diagnoses), Woodland acknowledges that those readings could support a diagnosis of dehydration. Transcript of oral argument (Tr.) at 7.

The ALJ relied on the hospital's diagnosis of dehydration, as shown in hospital records stating that the resident had been found to be dehydrated upon admission to the emergency room. CMS Ex. 14, at 13. The ALJ found the diagnosis of dehydration by treating physicians in a hospital setting to be highly credible and probative, because the hospital physicians and staff actually observed and treated Resident 4 and were in the best position at the time to opine as to her status and the nature of her condition. ALJ Decision at 12. The physicians based their treatment of the resident on their diagnoses and so had a reason to diagnose her carefully. Woodland did not dispute that dehydration was diagnosed at the hospital or present any persuasive reason to question that diagnosis.[6]

Regarding the resident's hydration at the facility, Woodland asserts that fluid intake totals for the seven days for which complete records were kept (out of 11 days) indicate that the resident received more than 83% of the registered dietician's recommended intake, and that "[a]ny reasonable person would certainly recognize" that the resident "was provided at least a *sufficient* amount of fluid intake to maintain proper health and hydration as required." Petitioner Br. at 8 (Woodland's italics); Petitioner Ex. 2, at 8-9. As the ALJ observed, however, Woodland's assertion that 83% of the recommended fluid intake was sufficient to maintain the resident's heath and hydration is not a matter of common knowledge and Woodland offered no evidence to support it. ALJ Decision at 13. Woodland produced no statements of physicians or other medical authorities verifying its assertion. Woodland also cites nurses notes from two days showing that the resident was spoon-fed "2CAL" and offered "Ensure" at meals and between, but did not demonstrate that this constituted sufficient hydration. Petitioner Br. at 11, citing Petitioner Ex. 9, at 62, 71. Moreover, Woodland has not established how much fluid the resident received, as it concedes that its fluid intake records for the resident were not complete, and that its 83% figure was only for days for which complete records were available. Tr. at 7, 12.

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[6] Woodland also implies that the hospital's emergency room physician had a financial motive to diagnose dehydration as the hospital was a "DRG hospital" that is paid "per diagnosis." Tr. at 7. As discussed above, however, Woodland provided no evidence showing that the diagnosis of dehydration was incorrect.

The nutritional assessment completed by Woodland's registered dietician on May 30, 2002 states that Resident 4 was at risk for dehydration secondary to Lasix and recommends a daily level of fluid intake needed to address that risk. Petitioner Ex. 9, at 101. Woodland denies that it completed any other assessment of Resident 4's risk for dehydration.[7] Tr. at 12-13. Woodland does not explain how it could determine that the resident's fluid needs were anything other than what its registered dietician stated on the nutritional assessment, in the absence of any other hydration risk assessment. Furthermore, as the ALJ noted, a RAP for dehydration was, in fact, completed on June 6, 2002, three days before Resident 4's admission to the hospital. Petitioner Ex. 9, at 28, 39-40. That RAP cited "dietary notes" as the location of the documentation for this assessment. Id. at 28.

Woodland argues that, while at its facility, Resident 4 displayed none of the clinical signs that the SOM directs surveyors to look for to determine that a resident is not properly hydrated, such as dry skin and mucous membranes, cracked lips, poor skin turgor, thirst, fever, or abnormal laboratory values. Woodland notes that the ALJ rejected CMS's deficiency finding relating to the other residents based on the lack of evidence of such clinical signs. Woodland argues that nurses notes during the resident's stay show that none of those signs were present and that on some occasions the opposite signs were. Petitioner Br. at 11, citing Petitioner Ex. 9, at 44-77. Woodland argues that the resident did not show signs of dehydration until her last day at the facility when she became unresponsive, that the facility took appropriate action by taking her to the hospital, and that the resident's failure to consume fluid or food in the 24 hours prior to becoming unresponsive should not be construed as harm occurring at the facility, in light of the "diligent treatment and monitoring" detailed in the nurses notes. Petitioner Br. at 13-14; Tr. at 17. We have already concluded that the absence of clinical signs of dehydration is not dispositive. Furthermore,

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[7] Woodland asserts that its initial assessment showed the resident's dehydration risk as 4, with over 10 considered high risk, citing its Exhibit 9, beginning at page 45. Tr. at 13. However, the Admission Nursing Assessment at pages 45-46 of that exhibit contains no reference to or evaluation of the risk of dehydration. An undated hydration risk assessment is incomplete. Petitioner Ex. 9, at 79. The Minimum Data Set to be completed within 14 days of admission does not show dehydration risk, and does not report the level of fluid intake in the space provided, although it indicates that the resident needed the assistance of one person to eat and drink. Id. at 117-28.

none of the other residents cited by the ALJ was diagnosed with dehydration.

Moreover, Woodland does not dispute that the resident ate and drank very little in the 24 to 48 hours leading to her hospital admission and that her condition improved significantly upon being properly re-hydrated, facts that the ALJ found consistent with the resident having been dehydrated upon admission. ALJ Decision at 12, citing CMS Ex. 14, at 13, 51-52. Woodland also does not dispute that a RAP for dehydration/fluid maintenance was triggered for the resident on June 6, 2002, three days before admission to the hospital. ALJ Decision at 12, citing CMS Ex. 14, at 14, 25-26; Petitioner. Ex. 9, at 28, 39-40. Thus, Woodland's assertions that it had no reason to suspect that the resident was not receiving sufficient fluids are not consistent with record evidence that the ALJ cited in his decision.

Thus, substantial evidence in the record supports the ALJ's findings regarding CMS's basis for imposing a CMP, and Woodland has not shown any error in the ALJ's legal conclusions.

3. Imposition of a CMP of $100 per day for the period July 16, 2002 through September 19, 2002 is reasonable.

The ALJ considered whether the CMP imposed by CMS was reasonable, applying the factors at 42 C.F.R. § 488.438(f) as he was required to do. The ALJ determined that the $600 per day CMP imposed by CMS was not reasonable since CMS proved noncompliance only with respect to one of the residents identified on the SOD, and CMS does not appeal the reduction. However, the ALJ concluded that a $100 per day CMP is reasonable under the relevant factors, including the factor addressing the seriousness of a deficiency, given the ALJ's finding that Resident 4 suffered actual harm as a result of the deficiency. ALJ Decision at 14-15.

Woodland appeals the ALJ's determination regarding the reasonableness of the CMP but its brief actually challenges only CMS's basis for imposing any CMP. We have upheld the ALJ's determination that CMS had a basis for imposing a CMP. Having found a basis for imposing a CMP in some amount, the ALJ was not authorized to review CMS's decision to impose a CMP; neither could he reduce the CMP to zero. 42 C.F.R. §§ 488.408(g)(2), 488.438(e)(1),(2). Thus, the ALJ correctly limited his inquiry to whether the amount of the CMP was reasonable. Woodland does not cite any error in the ALJ's analysis on that issue or argue that the record does not support the ALJ's conclusion, taking into consideration the factors at 42 C.F.R. § 488.438(f), that $100 per day for the period of noncompliance was a reasonable

amount. We find no error in his analysis, and substantial evidence supports the $100 per day amount. We note that while the ALJ based his conclusion, in part, on his finding that Resident 4 suffered actual harm, that finding is not essential to finding $100 per day a reasonable amount. That amount is only $50 more than the minimum amount CMS can impose, and Woodland has not argued that the difference is unreasonable. Furthermore, while Woodland has disputed the diagnosis of dehydration, it has not disputed that if the diagnosis is accepted, as it has been by the ALJ and the Board, dehydration on its face can constitute actual harm. In addition, where, as here, the dehydration is so severe that it requires hospitalization, the conclusion that harm has occurred appears unassailable. Accordingly, we summarily affirm the ALJ's determination that a $100 per day CMP for the period July 16 through September 19, 2002 is reasonable.

Conclusion

For the reasons discussed above, we affirm and adopt the ALJ Decision in its entirety, including the findings of fact and conclusions of law that Woodland disputed on appeal.

/s/
Judith A. Ballard

/s/
Leslie A. Sussan

/s/
Sheila Ann Hegy
Presiding Board Member