Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Virginia Highlands Health Rehabilitation Center
Docket No. A-10-59
Decision No. 2339
September 30, 2010

REMAND OF ADMINISTRATIVE LAW JUDGE DECISION

Virginia Highlands Health Rehabilitation Center (Virginia Highlands) requests review of the March 4, 2010 decision of Administrative Law Judge (ALJ) Steven T. Kessel. *Virginia Highlands Health Rehab*, DAB No. CR2083 (2010) (ALJ Decision). The ALJ granted summary judgment in favor of the Centers for Medicare & Medicaid Services (CMS), sustaining its determination to impose civil money penalties against Virginia Highlands totaling $247,550. The ALJ found that the undisputed material facts established that Virginia Highlands failed to comply substantially with Medicare participation requirements, CMS's finding of immediate jeopardy was not clearly erroneous, and CMS's determinations as to the penalty amount and duration were reasonable.

As explained below, we conclude that the ALJ erred in granting summary judgment in favor of CMS. The record, when viewed in the light most favorable to Virginia Highlands, raises genuine disputes of fact material to the outcome of this case. Therefore, we remand this case to the ALJ to conduct further proceedings consistent with this decision.

Applicable Law

The Social Security Act (Act) and federal regulations provide for state agencies to conduct surveys of Medicare skilled nursing facilities (SNF) and Medicaid nursing facilities (NF) to evaluate their compliance with the Medicare and Medicaid participation requirements. Sections 1819 and 1919 of the Act; 42 C.F.R. Parts

483, 488, and 498.[1] The participation requirements are set forth at 42 C.F.R. Part 483, subpart B. A facility's failure to meet a participation requirement is called a "deficiency." 42 C.F.R. § 488.301. "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." *Id*. "Noncompliance" is defined as "any deficiency that causes a facility to not be in substantial compliance." *Id*.

Surveyor findings are reported in a statement of deficiencies (SOD), which identifies each deficiency under its regulatory requirement and a corresponding "tag" number used by surveyors for organizational purposes. Each deficiency is assigned a level of severity (whether it has created a "potential for harm," resulted in "actual harm," or placed residents in "immediate jeopardy") and a scope of the problem within the facility (whether it is "isolated," constitutes a "pattern," or is "widespread"). 42 C.F.R. § 488.404; *State Operations Manual* (SOM), CMS Pub. 100- 07, App. P - Survey Protocol for Long Term Care Facilities (available at http://www.cms.hhs.gov/ Manuals/IOM/list.asp), sec. V. A deficiency's scope and severity is designated in the SOD by a letter (A-L). SOM, Ch. 7, at § 7400.5.1.

A long-term care facility determined to be not in substantial compliance is subject to enforcement remedies, which include civil money penalties (CMPs). 42 C.F.R. §§ 488.402(c), 488.406, 488.408. CMS may impose either a per-instance or per-day CMP when a facility is not in substantial compliance. 42 C.F.R. § 488.408(d)(3)(i). A per-day CMP may accrue from the date the facility was first out of compliance until the date it achieved substantial compliance. 42 C.F.R. § 488.440(a)(1), (b). For noncompliance determined to pose less than immediate jeopardy to facility residents, CMS may impose a per-day CMP in an amount ranging from $50-$3,000 per day. 42 C.F.R. § 488.408(d)(1)(iii). For noncompliance determined to pose immediate jeopardy to facility residents, CMS may impose a per-day CMP in an amount ranging from $3,050-$10,000 per day. 42 C.F.R. § 488.408(e)(1)(iii). The regulations set out several factors that CMS considers to determine the CMP amount. 42 C.F.R. §§ 488.438(f), 488.404.

Relevant Background

The Wisconsin Department of Health Services (WDHS) conducted an extended survey at Virginia Highlands from March 2, 2009, to March 24, 2009, resulting in twelve (12) citations, two of which were identified at an immediate jeopardy level. CMS Ex. 1, at 1. The two most serious deficiencies involved violations of 42

[1] The current version of the Social Security Act can be found at http://www.socialsecurity.gov/ OP_Home/ssact/ssact.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross-reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table.

C.F.R. § 483.25(c)(2) (treatment of pressure sores) and 483.25(j) (hydration). CMS Ex. 2, at 1. It was determined that the immediate jeopardy for the pressure sores deficiency began on December 23, 2008 and was removed on March 6, 2009 and that the immediate jeopardy for the hydration deficiency began on February 11, 2009, and was removed on March 24, 2009. *Id*. These two deficiencies were also determined to constitute substandard quality of care as defined by 42 C.F.R. § 488.301. *Id*. at 2.

WDHS revisited Virginia Highlands on May 7, 2009 and May 18, 2009 and verified that the facility had achieved substantial compliance with participation requirements effective April 22, 2009. CMS Ex. 3, at 1. As a result of the deficiencies found during the surveys conducted at Virginia Highlands, CMS imposed a directed plan of correction effective April 27, 2009, and CMPs of $10,000 per day for twenty-two (22) days beginning March 2, 2009 and continuing through March 23, 2009, and $950.00 per day for twenty-nine (29) days beginning March 24, 2009 and continuing through April 21, 2009. *Id*.

Virginia Highlands filed a request for hearing before an ALJ. After the parties had submitted their prehearing briefs, proposed exhibits, and written direct testimony of witnesses, CMS filed a motion for summary judgment. The ALJ granted the motion, basing his decision only on the alleged noncompliance with the hydration requirement. The ALJ found that the undisputed material facts of this case "show that residents of [Virginia Highlands] facility were placed at grave risk for dehydration" and established a likelihood of serious injury, harm, impairment, or death. ALJ Decision at 1, 13. The ALJ also determined that undisputed material facts established the CMP determinations were reasonable in duration and amount. *Id*. at 14.

Standards for Summary Judgment

Summary judgment is appropriate when the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. *See Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986). Although the Federal Rules of Civil Procedure (FRCP) are inapplicable in this administrative proceeding, we are guided by those rules and by judicial decisions on summary judgment in determining whether the ALJ properly granted summary judgment. *See Thelma Walley v. Inspector General*, DAB No. 1367 (1992). The ALJ told the parties that he would decide motions for summary judgment "according to the principles of Rule 56 of the Federal Rules of Civil Procedure and applicable case law." Initial Pre-Hearing Order dated June 15, 2009.

The party moving for summary judgment bears the initial burden of demonstrating that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. *Celotex*, 477 U.S. at 323. If a moving party carries

its initial burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial.'" *Matsushita Elec. Industrial Co. v. Zenith Radio*, 475 U.S. 574, 587 (1986) (quoting FRCP 56(e)). To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact -- a fact that, if proven, would affect the outcome of the case under governing law. *Id*. at 586 n.11; *Celotex*, 477 U.S. at 322. In order to demonstrate a genuine issue, the opposing party must do more than show that there is "some metaphysical doubt as to the material facts . . . .Where the record taken as a whole could not lead a rational trier of fact to find for the nonmoving party, there is no 'genuine issue for trial.'" *Matsushita*, 475 U.S. at 587. In making this determination, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. *See, e.g., U.S. v. Diebold, Inc.*, 369 U.S. 654, 655 (1962).

Under the applicable substantive law, CMS has the initial burden of coming forward with evidence on any disputed facts showing that the provider was not in substantial compliance with Medicare participation requirements. However, the provider bears the ultimate burden of persuasion that it was in substantial compliance with those requirements. *See South Valley Health Care Center*, DAB No. 1691 (1999), *aff'd, South Valley Health Care Center v. HCFA*, 223 F.3d 1221 (10th Cir. 2000); *see also Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 F.App'x. 181 (6th Cir. 2005).

Consequently, if CMS in its summary judgment motion has asserted facts that would establish a prima facie case that the facility was not in substantial compliance, the first question is whether the facility has in effect conceded those facts. If not, the next question is whether CMS has come forward with evidence to support its case on any disputed fact. If so, the facility must aver facts and proffer evidence sufficient to show that there is a genuine dispute of material fact. Ultimately, if the proffered evidence as a whole, viewed in the light most favorable to the facility, might permit a rational trier of fact to reach an outcome in favor of the facility, summary judgment on the issue of substantial compliance is not appropriate. *Madison Health Care, Inc.*, DAB No. 1927 (2004); *Lebanon Nursing and Rehabilitation Center*, DAB No. 1918 (2004).

Whether summary judgment is appropriate is a legal issue that we, like the courts, address de *novo*. *Timothy Wayne Hensley*, DAB No. 2044 (2006), at 2, citing *Crestview Parke Care Center*, DAB No. 1836 (2002), *aff'd in part, Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743 (6th Cir. 2004).

Analysis

1. Virginia Highlands raised a genuine dispute of material fact as to the noncompliance findings arising under 42 C.F.R. § 483.25(j), Hydration.

As previously noted, the ALJ addressed only the noncompliance findings arising under quality of care requirements for hydration. "Quality of care" requirements reflect the overarching objective 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. 42 C.F.R. § 483.25. Each facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. 42 C.F.R. § 483.25(j). The intent of this regulation is to assure that each resident receives a sufficient amount of fluids based on individual needs to prevent dehydration. SOM, App. PP, Interpretive Guidelines, F327, Hydration.

The Board has explained previously that the current regulations governing long-term care facilities are based on an outcome-oriented approach. *Lake Mary Healthcare*, DAB No. 2081, at 17 (2007). The essence of this approach is that the regulations establish the outcomes which facilities must achieve but provide each facility with flexibility to select methods to achieve them that are appropriate to its own circumstances and needs. *See, e.g.*, 54 Fed. Reg. 5316, 5332 (Feb. 2, 1989). A facility's policy generally reflects the methods it has chosen to accomplish the outcomes contemplated under the regulations. As the Board has previously stated, "the outcome being looked at is the quality of care being provided, not just the health outcome for the individual resident." *Spring Meadows Health Care Center*, DAB No. 1966, at 19 (2005).

When considering whether summary judgment is appropriate, the Board has distinguished cases where it is undisputed that a facility failed to provide services according to a resident's plan of care from cases where nursing or medical judgment is involved in determining whether the services in the plan of care and ordered by a resident's physician were adequate to meet a resident's needs. *See e.g.*, *Lebanon Nursing and Rehabilitation Center*, DAB No. 1918, at 9-10 (2004). In this case, CMS did not allege that Virginia Highlands had failed to follow the hydration plans for its residents, but raised other issues regarding the services provided (some of which CMS raised for the first time in its motion for summary judgment). As explained below, in resolving these issues, the ALJ viewed certain "facts" offered by CMS as undisputed by Virginia Highlands or irrelevant without viewing the evidence in the record in the light most favorable to Virginia Highlands.

a. A genuine dispute exists regarding whether a facility is required to track fluid input and output.

The ALJ addressed the noncompliance findings involving hydration for six residents with identified dehydration risk factors. While the ALJ recognized that nothing in the regulation requires tracking of fluid input and output, he concluded that residents at the facility were placed at grave risk for dehydration due to the facility's lack of "objective mechanisms" to assure that a resident's fluid output did not greatly exceed intake. *See, e.g.*, ALJ Decision at 10, 11. According to the ALJ, "a facility cannot possibly assure that an at-risk resident . . . is protected adequately against dehydration unless it has some way of determining that the resident's consumption of fluids equals or exceeds that which he is excreting." *Id.* at 9. The ALJ concluded, in effect, that the only way to assure sufficient fluid intake to prevent dehydration is to track both intake and output.

Virginia Highlands argues on appeal that the ALJ erred in treating monitoring intake and output as a requirement for any resident with risk factors for dehydration. Virginia Highlands further argues monitoring intake and output is but one way to assess a resident's hydration status and is not a requirement of 42 C.F.R. § 483.25(j). P. App. Br. at 13. Virginia Highlands also argues that the ALJ made "credibility determinations throughout his Decision and repeatedly weighed evidence as would be expected after an evidentiary hearing." P. App. Br. at 6.

The Board has previously stated that "a facility's records of fluid intake, or lack thereof, can be relevant in determining whether a resident was provided with sufficient fluid intake to maintain proper hydration and health." *Claiborne-Hughes Health Center*, Dab No. 2223, at 15 (2008). A facility may show it provided sufficient fluid intake to a resident "with evidence other than its records, such as through testimony or laboratory reports. However, the fact that a facility may ultimately rebut reasonable inferences based on the absence of documentation does not make that absence irrelevant." *Id*. at 16. A facility can show compliance with section 483.25(j) if it proves that a resident "became dehydrated despite care that was consistent with professional standards of quality for preventing dehydration in someone of [that resident's] condition." *Community Skilled Nursing Centre*, DAB No. 1987, at 16 (2005)

Here, the ALJ did not cite to anything in the record to support his finding that monitoring of intake and output is the only "objective" means of preventing dehydration. Instead, he seemed to base this finding solely on the statement that dehydration "occurs whenever a resident's fluid output greatly exceeds that resident's intake of fluid." ALJ Decision at 3, citing CMS Ex. 123, at 2, and CMS Ex. 124, at 2. In making this finding, the ALJ failed to view the evidence in the record in the light most favorable to Virginia Highlands.

For example, the Declaration of Surveyor Kathleen Upson, RN, on which the ALJ relies as expert testimony regarding the nature of harm from dehydration, does not state that tracking intake and output is required in order to ensure that a resident receives sufficient fluid intake to maintain proper hydration and health or that tracking is required by professionally recognized standards of care. Instead Nurse Upson states merely that "tracking intake and output (I and O) is an important means of monitoring hydration status." CMS Ex. 124, ¶ 13. For her statement, this surveyor was relying on hydration management guidelines in CMS Exhibit 77. Those guidelines do not state that tracking input and output is the only acceptable means of monitoring hydration status. Instead, they mention various ways of monitoring hydration status. Viewing this evidence in the light most favorable to Virginia Highlands, it can reasonably be read as meaning merely that tracking is one means of monitoring hydration status, but that it is not the only means consistent with professionally recognized standards.

Also, while the Board has held that a facility policy may be evidence of a standard of care, Virginia Highlands' Hydration Management Guidelines state that the interdisciplinary team (IDT) "will determine if Intake & Output (I&O) monitoring is needed as an intervention." CMS Ex. 76, at 4. Read in the light most favorable to Virginia Highlands, this policy indicates that nursing judgment is involved in determining whether such monitoring is needed and that it is not always a necessary intervention.

We also note, in particular, that the plan of care for Resident # 26 (whom we discuss in more detail below) did not require measurement of intake and output each shift, even after diarrhea was added on February 11, 2009 as an additional risk factor. *See* CMS Ex. 35. The ALJ viewed this as a failure by Virginia Highlands to provide for an objective mechanism. For purposes of summary judgment, this evidence, together with the facility policy, could reasonably be viewed as reflecting a judgment by the IDT that monitoring of I&O was not required for Resident # 26.[2]

For five additional residents (Other Residents), the ALJ concluded that undisputed facts established that Virginia Highlands neglected to address the hydration needs of these Other Residents experiencing dehydration risk factors because the facility

[2] We note that the record contains print-outs from the "caretracker" system that Virginia Highlands used to record food and fluid intake and bowel and bladder output. CMS Exs. 118 and 123, ¶ 14. This evidence, when viewed in the light most favorable to Virginia Highlands, shows that the facility was tracking some of the fluid input and output for Resident # 26, but the intake chart refers only to meals. *See also* P. Ex. 22, ¶ 13. The SOD indicated that the facility was aware that the system tracked only fluid provided by the certified nursing assistants (CNAs). *See also* P. Ex. 19, ¶¶ 4-5 (Peterson Affidavit). Under past Board decisions, the facility should have an opportunity to show that Resident # 26 was receiving fluids in addition to those documented. *See, e.g., Claiborne-Hughes Health Center*.

"had nothing in place that would have addressed whether these residents' intake of fluids balanced their output." ALJ Decision at 11. Thus, the ALJ's analysis of these residents is similarly flawed.

b. The evidence in the record regarding Resident # 26 raises genuine disputes of material fact.

The ALJ's analysis centered around Resident # 26. The following facts are undisputed. Resident # 26 was admitted to Virginia Highlands on January 13, 2009. Resident # 26 was taken to a hospital emergency room on February 23, 2009 after falling at the facility. CMS Ex. 43, at 2. He was admitted to an acuity adaptable unit with an impression, in pertinent part, of sepsis with dehydration and fall risk with hematoma on the right forehead. *Id*. at 25. Resident # 26 died on February 24, 2009 with "sepsis secondary to C. difficile with dehydration most likely" noted as the cause of death. CMS Ex. 44. The resident required intravenous fluids at the hospital. *Id*.

The ALJ said it was undisputed that, at about the time of admission, the facility's "dietician determined that the resident needed to consume 2000ccs of fluid daily in order to avoid becoming dehydrated." ALJ Decision at 3. The ALJ also said it was undisputed that on January 24, 2009, Resident # 26's diuretic medication was increased and that the facility did not reassess the resident's fluid intake needs or develop a new care plan that took into account the increased diuretic dosage. *Id*. at 4. Resident # 26 also developed diarrhea after admission to the facility. The ALJ said it was undisputed that the staff at Virginia Highlands did not modify the resident's care plan to account for this additional dehydration risk factor. *Id*.

At the summary judgment stage, Virginia Highlands is not required to convince the decisionmaker that its evidence is more persuasive or credible than CMS's evidence. We agree with Virginia Highlands that, in dismissing the evidence it proffered regarding what it did to assure sufficient fluid intake by Resident # 26 to prevent dehydration, the ALJ failed to view the evidence in the light most favorable to the facility.

For example, the affidavit of Laurel Sormrude, LPN indicates she was personally familiar with Resident # 26 and regularly provided him care and that he was provided with sufficient fluid intake. P. Ex. 22. The ALJ dismissed the Sormrude Affidavit because, in his view, nothing in her affidavit "explains how Petitioner's staff – in light of the increased dehydration risk factors faced by Resident # 26 – addressed how Petitioner would account for these factors." ALJ Decision at 9.

The Sormrude Affidavit, however, did address those factors, attesting, for example, to the following:

- "The protocol at Virginia Highlands is to encourage and ensure the intake of additional fluids for a resident with C. Difficile or diarrhea." P. Ex. 22, ¶ 26; *see also* P. Ex. 20, ¶ 54.

- Resident # 26 would consistently drink three cups of water (1200ccs) and would drink a full cup of water (200ccs) with <u>each</u> medication pass. *Id*., ¶¶ 28, 29.

- "CNAs are instructed to advise nursing staff if a resident has notably dark urine or shows any symptoms of dehydration." *Id*., ¶ 32

The hydration management guidelines at CMS Exhibit 77 refer to noting urine color as a means of monitoring hydration status. The Nursing Daily Skilled Summary sheets in CMS Exhibit 40 indicate that the facility's nurses were checking Resident # 26's urine color and noted it was "yellow."

Also, Resident # 26's care plan itself calls for the following interventions in addition to providing extra fluids at meal time: place fluids at bedside in resident's reach, provide eight ounces of fluids at each medication pass, monitor lab values, and notify physician of change in status. CMS Ex. 35, at 2. The record shows Resident # 26 was receiving medication several times a day. CMS Ex. 38. The care plan also provided that he would be weighed weekly. CMS Ex. 35, at 3. CMS did not allege that Virginia Highlands failed to provide the planned services or that he lost weight after he developed diarrhea. *See* P. Ex. 20, at ¶ 53. Contrary to what the ALJ concluded, this evidence does raise a genuine dispute regarding the facility's response to the resident's risk factors.

Moreover, the ALJ erred in treating the alleged failure of Virginia Highlands to assess and care plan for Resident # 26, when he developed additional risk factors, as facts averred by CMS that were undisputed. The evidence of record shows that Resident # 26's increased diuretic dosage was ordered on January 24, 2009. CMS Ex. 38, at 12, 13; CMS Ex. 42, at 18. CMS's evidence indicates the facility did comprehensive assessments on January 23, January 28 and February 4, 2009 that noted that he was receiving a diuretic. CMS Exs. 31-33. A Resident Assessment Protocol (RAP) summary dated January 26, 2009 indicates that a RAP on Dehydration/Fluid Maintenance was done, resulting in a new care plan. CMS Ex. 33, at 8. Contrary to the ALJ's conclusion, this was <u>after</u> the dosage increase. The RAP report indicates that the assessment was triggered by the diuretic. Viewing this evidence in the light most favorable to Virginia Highlands, a reasonable person could infer that the care plan took into account the increased dosage of the diuretic.

In addition, the ALJ's conclusion that it is undisputed that the facility did not add interventions in response to the Resident # 26 developing diarrhea is not supported by any citations to the record. The SOD states that on the date Resident # 26 developed loose stools, "staff added to the care plan, Resident # 26 is at risk for fluid deficit due to diarrhea, and added the intervention 'check skin turgor each shift and provide 8 ounces of fluid each medication pass.'" CMS Ex. 1, at 101. The SOD did not find this assessment and care planning to be inadequate. In addition, there is evidence in the record indicating that the facility obtained physician orders to address the diarrhea and followed up when the diarrhea continued. CMS Ex. 42.

As noted above, Virginia Highlands proffered nurse testimony that it had a standard protocol to encourage additional fluid intake if a resident had a condition such as diarrhea. P. Ex. 19, ¶ 7; P. Ex. 22, ¶ 26. Virginia Highlands also presented evidence that the IDT discussed Resident # 26's diarrhea and that the dietician was aware of it but was not concerned because he was eating well and taking fluids well, his laboratory values on January 20, January 28 and February 6, 2009 were within normal limits, and he had no weight loss. P. Ex. 22, at 25; P. Ex. 20, ¶¶ 47-49. A reasonable person could infer from this that the dietician thought 2000ccs was adequate, despite the diarrhea.

In short, when the evidence is viewed in the light most favorable to the facility, the record shows that Virginia Highlands raised a genuine dispute about whether the methods chosen by the facility to address Resident # 26's risk factors were adequate to assure sufficient fluid intake to maintain proper hydration and health. This dispute is material to the outcome of this case, and, therefore, the ALJ erred in granting summary judgment

> *c. The evidence proffered by Virginia Highlands regarding Resident # 26's hydration status when he was admitted to the hospital is relevant.*

Virginia Highlands also argues that the ALJ erred in rejecting as irrelevant testimony proffered by Virginia Highlands from Dirk Steinert, M.D., the physician who had been Resident # 26's primary care physician since about 2007 and provided Resident # 26 with care both at the facility and in the hospital. P. App. Br. at 10. Dr. Steinert attested, among other things, to the following:

- He never had any concerns regarding Resident # 26's hydration, and he communicated regularly with the staff at Virginia Highlands. The staff never expressed any concerns regarding Resident # 26's level of hydration or fluid intake. P. Ex. 17, ¶¶ 26, 27.

- "The level of fluid provided to [Resident # 26] at the hospital was not a result of [Resident # 26] receiving insufficient fluid intake while at Virginia Highlands." *Id*., ¶ 31.

- The laboratory reports for Resident # 26 taken at the hospital showed sodium and potassium levels within normal limits, a sign that Resident # 26 did not suffer from volume depletion resulting from any extended period of dehydration. *Id*., ¶¶ 35, 36.

- "Overall, [Resident #26's] labs were not consistent with someone suffering from a severe or extended fluid intake deficit." *Id*. ¶ 38.

- In his professional opinion, sepsis caused Resident # 26's dehydration. *Id*., ¶ 50.

Contrary to what the ALJ concluded, the Steinert Affidavit is clearly relevant to whether, as the ALJ found, Resident # 26 had "advanced dehydration" on his admission to the hospital or not. ALJ Decision at 5. Whether Resident # 26's state of volume depletion and need for fluids had persisted for some time or developed rapidly due to his sepsis is relevant in determining whether Virginia Highlands was, in fact, monitoring him for symptoms of dehydration and whether any noncompliance created the likelihood of serious harm. Also, as discussed below, resolving this issue is, at the very least, relevant in evaluating the facility's degree of culpability for any noncompliance.

While we agree with Virginia Highlands that evidence regarding Resident # 26's hydration status when he was admitted to the hospital is relevant, we do not agree with the facility's assertions that CMS is required to show that Resident # 26 or any of the Other Residents were, in fact, dehydrated. *See* P. App. Br. at 5-6. The absence of actual harm is not a basis for reversing a finding that a facility failed to substantially comply with a participation requirement. *Harmony Court*, DAB No. 1968, at 5 (2005); *see also Claiborne-Hughes* at 17 (CMS is not required to show residents are actually dehydrated or that the facility did not provide them with sufficient fluid intake). As such, on remand, the burden is on Virginia Highlands to establish that it took adequate steps consistent with professional standards of care to ensure that its residents with identified risk factors for dehydration received sufficient fluid intake to maintain proper hydration and health. *See also Community Skilled Nursing Centre* at 16 (SNF had the burden to show that the resident "became dehydrated despite care that was consistent with professional standards of quality for preventing dehydration in someone of [the resident's] condition"); *Sheridan Health Care Center*, DAB No. 2178 (2008) (holding that the lead-in language to the quality of care requirements in section 483.25 obligates a facility to take "reasonable steps" and "practicable measures" to achieve the regulatory end).

Furthermore, in *Woodland Village Nursing Center*, DAB No. 2053 (2007), *aff'd Woodland Village Nursing Ctr. v. U.S. Dep't of Health & Human Svcs.*, 239 F.App'x. 80 (5th Cir. 2007), the Board held that a "hospital diagnosis of dehydration would itself be sufficient to establish CMS's prima facie case." Here, it is undisputed that Resident # 26 was treated with intravenous fluids for dehydration during his admission to the hospital on February 23, 2009. Thus, on remand, the burden is on Virginia Highlands to establish, by a preponderance of evidence, that it took adequate steps, consistent with professional standards of quality, to ensure that Resident # 26 and the Other Residents received sufficient fluid intake to maintain proper hydration and health.

2. The ALJ erred in granting summary judgment on the amounts of the CMPs.

In determining the amount of a CMP, CMS and an ALJ must consider the regulatory factors set out at 42 C.F.R. §§ 488.438(f) and 488.404. 42 C.F.R. § 488.438(e)(3). These factors include the number and seriousness (scope and severity) of the deficiency findings and their relationship to each other, the facility's degree of culpability, and the facility's history of noncompliance in general and specifically with respect to the cited deficiencies.

In this case, the CMP for the immediate jeopardy period is at $10,000 per day, the maximum amount permitted under the regulations, and the CMP for the remaining period is at $950 per day, well above the $50 minimum for non-immediate jeopardy CMPs. 42 C.F.R. § 488.438(a). The total amount is $247,550.

The ALJ determined that the "undisputed material facts establish CMS's civil money penalty determinations to be reasonable in duration and amount." ALJ Decision at 14. The ALJ noted that CMS had based its determinations on Virginia Highlands alleged failure to comply substantially with participation requirements in addition to the alleged noncompliance with the hydration requirements of section 483.25(j). The ALJ also noted that CMS did not move for summary judgment with respect to the alleged noncompliance with the requirements of section 483.25(c)(2) (treatment of pressure sores), which CMS had found was at the immediate jeopardy level, but did base its summary judgment motion on eight other alleged non-immediate jeopardy findings in addition to findings under section 483.25(j).

The ALJ nonetheless concluded that the CMPs were reasonable in amount based the facility's history of noncompliance and on his view of the undisputed, material facts related to the hydration requirement discussed above. This included his view that the facility could not assure proper hydration without measuring output and that the care plans for the residents, including Resident # 26, were not reevaluated or revised even though the residents had developed additional risk factors. Based

on this view, the ALJ determined that "[n]ot only did staff fail to react appropriately to the discovery of hydration risk factors, but they were clueless as to how to react." ALJ Decision at 16. In other words, the ALJ concluded, in effect, that Virginia Highlands had a high degree of culpability. For the reasons explained above, we conclude that Virginia Highlands did establish that there are genuine disputes of fact material to these issues.

We also note that this case is distinguishable from cases in which the Board has determined that an ALJ need not reach every finding of noncompliance cited in a SOD in order to uphold a CMP amount as reasonable. Generally, those cases have involved either imposition of a CMP at the minimum (or close to the minimum) amount of the applicable CMP range, or have involved an ALJ's determination that noncompliance findings at a low level of seriousness were not material to the decision, in light of the more serious findings that were upheld and other factors. *See, e.g., Western Care Management Corp. d/b/a Rehab Specialties*, DAB No. 1921, at 19 (2004); *Magnolia Estates Skilled Care*, DAB No. 2228 (2009); *Alexandria Place*, DAB No. 2245, at 27 n. 9 (2009). In *Magnolia*, the Board noted, as it had before, that there may be instances in which an ALJ's failure to address all of the deficiency findings could affect the remedy imposed by CMS and be prejudicial to the facility, "such as when CMS relies on the additional deficiency findings in setting the amount of a CMP above the minimum amounts specified by regulation. . . ." DAB No. 2228, at 30, citing *Harmony Court* at 3 n.3 (2005).

Here, CMS acknowledges that it set the $10,000 amount "[t]aking into account the number and seriousness of the deficiencies, as well as Virginia Highlands compliance history." CMS App. Br. at 7. When a CMP is imposed at the maximum amount for immediate jeopardy, the fact that there is more than one immediate jeopardy finding is clearly relevant to the issue of whether the amount is reasonable, even if reversing one of those findings might not in all circumstances require reduction of the CMP amount. Similarly, a non-immediate jeopardy CMP amount that is substantially above the minimum may be more supportable if based on numerous noncompliance findings.

CMS relies on the Board's decision in *Jennifer Mathew Nursing and Rehabilitation Center*, DAB No. 2192 (2008) to support its argument that the ALJ properly concluded that the amount of the CMP was reasonable, based on the facts he viewed as undisputed. That reliance is misplaced. In that case, a $10,000 per day CMP (for a total of $70,000) was upheld based on the following factors:

- *the nature and scope of the deficiencies:* there were two factual situations leading to the noncompliance findings at the immediate jeopardy level, one of which was widespread, and seven other undisputed findings of noncompliance, including at the E level (pattern with potential for more than minimal harm),

the F level (widespread with potential for more than minimal harm), and the G level (actual harm);

- *history of noncompliance:* Jennifer Matthew had been designated as a special focus facility, there were previous findings of immediate jeopardy and substandard quality of care, and approximately eight facility employees were criminally convicted of falsifying medical records and patient neglect because they claimed to have provided care that they had not provided;

- *degree of culpability:* facility staff were guilty of widespread neglect, disregarding resident care, comfort and safety; staff's conduct and arguments demonstrated disregard for resident comfort; Jennifer Matthew continued to trivialize the residents' real suffering as ordinary discomforts of life; and the facility was also culpable for failing to investigate the circumstances of a resident's death.

DAB No. 2192, at 40; *see also Life Care Center of Tullahoma*, DAB No. 2304, at 62 (2010) (holding a $6,550 per day CMP not warranted where CMS did not pursue a number of widespread, immediate jeopardy findings).

We do not intend to establish a general rule that one finding of noncompliance at the immediate jeopardy level with a pattern of noncompliance could never support a CMP of $10,000 per day. There may be circumstances where the relevant factors to be considered in determining the amount weigh very heavily in favor of imposing the maximum amount. Here, however, we are in a summary judgment posture. The ALJ viewed as immaterial certain facts alleged by Virginia Highlands that, at the very least, if proven, would show its culpability was not as high as the ALJ judged it to be based on his view of the undisputed facts. Also, as CMS concedes, Virginia Highlands raised genuine disputes of material fact regarding the finding of noncompliance cited at the immediate jeopardy level that the ALJ did not reach.

As noted, CMS relied on eight other findings of alleged noncompliance for its motion for summary judgment. As Virginia Highlands points out, with respect to the noncompliance findings regarding clinical records, CMS's motion relied on factual assertions different from those cited in the SOD as the basis for the noncompliance finding. That Virginia Highlands had not disputed those factual assertions does not mean that Virginia Highlands had conceded that those facts established noncompliance with the clinical records requirement – an issue that had not previously been raised by CMS. Indeed, while Virginia Highlands did not come forward in response to the summary judgment motion with affirmative evidence to dispute this or the other seven additional noncompliance findings on which CMS relied, Virginia Highlands did raise the issue of whether the evidence proffered by CMS, viewed in the light most favorable to Virginia Highlands, was

sufficient to support the findings of noncompliance. P. Response to Motion for Summary Judgment at 2-6. Since the ALJ did not rely on these other findings, he did not address this issue, nor do we.

Finally, as Virginia Highlands points out, it is undisputed that the immediate jeopardy related to the alleged noncompliance with section 483.25(c)(2) (treatment of pressure sores) was abated as of March 6, 2009. To the extent that noncompliance with this section is used to justify imposition of the $10,000 per-day CMP, some reduction in the amount may be warranted as of that date, once the record has been further developed as to the relevant factors.

Conclusion

For the reasons explained above, we remand this case to the ALJ for further proceedings consistent with this decision. On remand, the ALJ may address any of the noncompliance findings and is not limited to those raised at the summary judgment stage or discussed here.

_____/s/_____
Leslie A. Sussan

_____/s/_____
Stephen M. Godek

_____/s/_____
Judith A. Ballard
Presiding Board Member