Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: December 31, 2008
Claiborne-Hughes Health Center,	
Petitioner,	Civil Remedies CR1815 App. Div. Docket No. A-08-130
	Decision No. 2223
- v. -	
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF
ADMINISTRATIVE LAW JUDGE DECISION ON REMAND

Claiborne-Hughes Health Center (Claiborne) appealed the July 10, 2008 decision on remand of Administrative Law Judge (ALJ) Steven T. Kessel upholding the imposition of a civil money penalty (CMP) and a denial of payment for new admissions (DPNA) by the Centers for Medicare & Medicaid Services (CMS). Claiborne-Hughes Health Center, DAB CR1815 (2008) (ALJ Decision). CMS imposed these remedies based on a survey completed September 6, 2006.

For the reasons explained below, we reverse the ALJ's conclusion that Claiborne was not in substantial compliance with 42 C.F.R. § 483.15(g)(1); we conclude that Claiborne was not in substantial compliance with 42 C.F.R. § 483.25(j); and we reduce the amount of the CMP but uphold the imposition of a DPNA.

Relevant background

Claiborne is a skilled nursing facility that participates in the Medicare program and is located in Franklin, Tennessee. In an August 2006 survey, the state survey agency found that Claiborne

was not in substantial compliance with multiple program requirements at an immediate jeopardy level. The state survey agency conducted a revisit and complaint survey in September and found continuing noncompliance that no longer posed immediate jeopardy.

Based on these surveys, CMS imposed a CMP of $3,050 per day from July 18, 2006 through September 4, 2006, a CMP of $100 per day from September 5, 2006 through September 17, 2006, a denial of payment for new admissions from August 20, 2006 through September 17, 2006, and other remedies that are not at issue here.

Claiborne appealed CMS's determinations. The appeal of the August survey was docketed before the ALJ as C-07-31; the appeal of the September revisit was docketed as C-07-111. The August survey set forth noncompliance findings under seven specific regulatory requirements. 07-31 CMS Ex. 1.[1] The September revisit set forth noncompliance findings under three requirements. 07-111 CMS Ex. 1. The ALJ consolidated the two cases. Order Consolidating Cases dated June 7, 2007.

Pursuant to the parties' agreement, the ALJ issued a decision based on their written submissions, which included briefs, written direct testimony, and exhibits. Claiborne-Hughes Health Center, DAB CR1687, at 2. In that decision, the ALJ sustained one noncompliance finding from the August survey and the remedies imposed by CMS for July 18, 2006 through September 4, 2006, and one noncompliance finding from the September revisit and the remedies for that period, including the DPNA. He did not address the other noncompliance findings.

Claiborne appealed DAB CR1687 to the Board. The Board upheld the ALJ's noncompliance finding and imposition of remedies from the August survey but reversed the ALJ's noncompliance finding and imposition of remedies from the September revisit. Claiborne-Hughes Health Center, DAB No. 2179 (2008). The Board remanded the case to the ALJ to determine whether the two remaining September noncompliance findings supported the remedies imposed for that later period.

Upon remand, the ALJ upheld the September noncompliance finding under 42 C.F.R. § 483.15(g)(1), which concerns a facility's

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[1] We adopt the ALJ's exhibit citation convention by citing to both the exhibit number and to the Civil Remedies Division docket number prefix. For example CMS Exhibit 1 in Docket No. C-07-111 is cited as "07-111 CMS Ex. 1."

responsibility to provide social services. ALJ Decision at Finding of Fact and Conclusion of Law (FFCL) 1. He did not address the finding under section 483.25(j), which concerns hydration. He upheld the remedies imposed by CMS based on the September revisit. Id. at FFCL 2.

Claiborne now appeals the ALJ's decision on remand, arguing that it was in substantial compliance with sections 483.15(g)(1) and 483.25(j). It asks the Board to address both of these findings.[2]

Applicable law

The federal statute and regulations provide for surveys to evaluate the compliance of skilled nursing facilities with the requirements for participation in the Medicare and Medicaid programs and to impose remedies when a facility is found not to comply substantially. Sections 1819 and 1919 of the Social Security Act; 42 C.F.R. Parts 483, 488, and 498.[3]

"Substantial compliance" is defined as "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health and safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. "Noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." Id.

CMS may impose a CMP for the days on which the facility is not in substantial compliance. 42 C.F.R. §§ 488.404, 488.406, 488.408. Where the noncompliance poses less than immediate jeopardy but has the potential for more than minimal harm, CMS may impose a

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[2] Claiborne also asked the Board to review the six noncompliance findings in the August survey that the ALJ did not review in his original decision (DAB CR1687) or his decision on remand (DAB CR1815). Request for Review (RR) at 14. In DAB No. 2179, the Board determined that the noncompliance finding upheld by the ALJ in DAB CR1687 supported the remedies imposed by CMS pursuant to the August survey. Therefore, we decline Claiborne's request for a Board review of the remaining deficiencies from the August survey.

[3] The current version of the Social Security Act can be found at www.ssa.gov/OP_Home/ssact/comp-ssa.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.

CMP between $50 and $3,000 per day. 42 C.F.R. § 488.438(a)(1)(i). CMS may also impose a DPNA for each day that a facility is not complying substantially with participation requirements. 42 C.F.R. § 488.417(a).

Board precedent has established that a facility must prove by the preponderance of the evidence that it is in substantial compliance. Batavia Nursing and Convalescent Center, DAB No. 1904 (2004), aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson, 129 Fed.Appx. 181 (6th Cir. 2005). In order to put the facility to its proof, CMS must initially present a prima facie case of noncompliance with Medicare participation requirements. Once CMS has presented prima facie evidence as to any material disputed facts, the burden of proof shifts to the facility to show at the hearing that it is more likely than not that the facility was in substantial compliance.

Standard of review

Our standard of review on a disputed finding of fact is whether the ALJ decision is supported by substantial evidence on the record as a whole. Our standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. 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.

Substantial evidence is "more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Richardson v. Perales, 402 U.S. 389, 401 (1971), quoting Consolidated Edison Co. v. NLRB, 305 U.S. 197, 229 (1938). Under the substantial evidence standard, the reviewer must examine the record as a whole and take into account whatever in the record fairly detracts from the weight of the decision below. Universal Camera Corp. v. NLRB, 340 U.S. 474, 488 (1951).

Analysis

1. The ALJ erred in concluding that Claiborne was not in substantial compliance with 42 C.F.R. § 483.15(g)(1) from September 5, 2006 through September 17, 2006.

Section 483.15(g)(1) of 42 C.F.R. provides:

> The facility must provide medically-related social services to attain or maintain the highest practicable

> physical, mental, and psychosocial well-being of each resident.

The ALJ framed the issue as whether Claiborne was noncompliant because it "failed to inform [Resident # 5's] family that it had ordered and conducted a medical consultation in order to evaluate the resident for suitability for hospice care." ALJ Decision at 3.

Hospice "is a special way of caring for people who are terminally ill" in which the goal is "to manage [the person's] pain and other symptoms, not to cure their illness." 07-111 CMS Ex. 26, at 4; ALJ Decision at 3. Hospice can also provide services, such as counseling, to families of dying people. 07-111 CMS Ex. 26, at 4.

Resident # 5 was a 99-year old woman with, among other problems, advanced dementia. CMS Exs. 1, at 4; 7, at 8. When she was admitted to Claiborne in February 2002 she signed an "advanced directive/living will which clearly set out her wishes for comfort measures only in an end-of-life situation." RR 9, citing 07-111 CMS Ex. 7, at 4.

Claiborne's Dietary Manager testified that Resident # 5 had been identified as "at risk for nutritional and fluid imbalance due to poor intake, confusion, swallowing problems and cognitive impairment." 07-111 P. Ex. 7, at 2. The Director of Rehabilitation testified that Resident # 5 received "restorative" feeding services, but, despite these services, as of August 2006 Resident # 5's "food intake had steadily been decreasing to the point where we felt it was no longer sufficient to sustain her nutritional status." 07-111 P. Ex. 6, at 2. The Director of Rehabilitation talked with Resident # 5's daughter over the telephone in the presence of the Dietary Manager on August 21, 2006. Id. They discussed the Director and Manager's opinion that a feeding tube was necessary to ensure adequate nutrition. Id. The daughter objected to insertion of a tube and, that day, signed a refusal of treatment form for the feeding tube. Id.; 07-111 CMS Ex. 7, at 5. A nurse's note of August 22 stated: "[Resident's doctor] notified. Family here, signed paperwork for no Tube Feeding, Hospice Consult. Awaiting orders." 07-111 CMS Ex. 7, at 9.[4]

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[4] The ALJ indicated that this note meant that the nurse signed paperwork for no tube feeding and a hospice consult. ALJ Decision at 5. Since in fact the daughter signed the no tube

(continued...)

The surveyor did not file written direct testimony. Her notes quote the daughter as saying, that when the Director of Rehabilitation raised the question of a feeding tube with her on August 21, "I told her NO!". 07-111 CMS Ex. 7, at 3. The notes also state that the daughter told the surveyor –

> My mother is almost 100 years old. I don't know why anyone would even consider putting a tube feeding in a lady that old. She has no quality of life. If she takes two bites and a little liquid that's fine with us. My sister and I agree. I don't think my mother will make it to her birthday in November. She's really declining fast. I don't want my mother forced to eat or drink.

Id.

The Director of Rehabilitation and Dietary Manager also testified that hospice care was "introduced" and "discussed" in the call after the daughter declined the feeding tube and that the daughter stated that she "didn't really know how she felt about Hospice care for her mother" and "the family would have to think about it." 07-111 P. Exs. 6, at 2-3; 7, at 2. The surveyor's notes state that the daughter told the surveyor that "[t]hey did call me about the feeding tube but never mentioned anything to me about the Hospice." 07-111 CMS Ex. 7, at 3. CMS did not submit any written direct testimony from the daughter confirming this statement, however.

On August 22, Resident # 5's doctor ordered: "(1) No Tube Feeding (2) Hospice Consult." 07-111 CMS Ex. 7, at 6.

The Director of Rehabilitation testified that the hospice consult was "to determine whether [Resident # 5] even actually qualified for Hospice services." 07-111 P. Ex. 6, at 3. The Admissions Administrator told the surveyor –

> [Resident # 5] had been declining. We were just doing anything that we could to help the family. We got the

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[4](...continued)
feeding paperwork (07-111 CMS Ex. 7, at 5), we do not find that inference reasonable. The nurse's note suggests, rather, that the family was present and involved in both the tube feeding and hospice discussion, which led to the later doctor's order for the hospice consult.

> Hospice Consult just to see if the resident would qualify for Hospice.

07-111 CMS Ex. 7, at 2.

The hospice evaluation was performed. Ultimately the family refused hospice services because, according to the daughter, hospice "didn't offer any more services than the nursing home." 07-111 CMS Ex. 7, at 3.

The ALJ found that Claiborne failed to discuss the hospice consult with the family prior to the doctor's ordering it and concluded that Claiborne had therefore failed to comply substantially with the requirements of section 483.15(g)(1). ALJ Decision at 3. Claiborne argues that the ALJ's conclusion of law and finding of fact should be reversed because (1) section 483.15(g)(1) does not require it to have discussed the hospice consult with Resident # 5's daughter before the doctor ordered it and (2) substantial evidence in the record as a whole does not support a finding that it failed to consult with the daughter before the doctor ordered the hospice consult.

The ALJ rejected Claiborne's arguments about the regulatory requirement. He wrote:

> It is true that 42 C.F.R. § 483.15(g)(1) does not spell out the steps that a facility must take as a prerequisite to ordering hospice care or even a hospice suitability consultation for a resident. But, implicit in the regulations is that every resident of a facility – or that resident's guardian or representative – must be kept informed of every significant care decision by facility staff.

ALJ Decision at 4.

We disagree with the ALJ's attempt to read a notice requirement into section 483.15(g)(1). Specific regulations set forth requirements about when a facility must notify or consult with residents or their families.[5] CMS did not cite Claiborne as

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[5] For example, section 483.10(b)(11)(i) requires immediate notification of the family when there is an accident involving the resident, a significant change in the resident's status, a need to alter treatment significantly, or a decision to transfer the resident from the facility; section

(continued...)

noncompliant with any of those regulations. In contrast, section 483.15(g)(1) is an affirmative requirement that a facility provide medically-related social services and says nothing about family notification.

The ALJ reasoned that, because notice/consultation requirements are set forth in other regulations, they are also "implicit" in section 483.15(g)(1) when a facility (or in this case the treating doctor) acts to determine whether social services (such as hospice) are available or appropriate. Neither the ALJ nor CMS cited any supporting authority for this conclusion. See CMS Br. at 2-7. We see no reason to read some generalized notice requirement into section 483.15(g)(1) when CMS has elsewhere set forth explicit standards for determining when residents or families must be notified. By relying on an inferred and undefined notice obligation, CMS and the ALJ avoided addressing the standards CMS adopted in the notice regulations. For example, section 483.10(b)(ii)(i) requires notification when the resident's treatment needs to be changed "significantly." Under that standard, the ALJ would have to consider whether consulting about suitability or eligibility for hospice (as opposed to deciding whether to change from active treatment to hospice care) is a "significant" alteration in treatment. Moreover, we see nothing in the relevant section of the State Operations Manual (SOM), CMS's interpretive guidelines for surveyors and facilities, that supports the ALJ's inference of any notice obligation under section 483.15(g)(1), much less a notice obligation under the circumstances of this case. See 07-111 P. Ex. 11 (SOM, App. PP-60-61).

Finally, nothing in prior Board decisions on section 483.15(g)(1) supports the ALJ's conclusion; rather those cases address whether a facility failed to provide social services, not whether it informed a family about a consultation regarding whether such services should or could be provided. See, Brookshire Health Care Center, DAB No. 2190 (2008); Park Manor Nursing Home, DAB No. 2005 (2005); Harmony Court, DAB No. 1968 (2005); Vandalia Park, DAB No. 1939 (2004); Ivy Woods Health Care and Rehabilitation Center, DAB 1933 (2004); Milpitas Care Center, DAB

[5](...continued)
483.10(b)(11)(ii)(A) requires prompt notification of the family when there is a change in roommate or room assignment; section 483.12 requires prior (with limited exceptions) notice to the resident and family of a planned transfer or discharge.

No. 1864 (2003). Therefore, we hold that the ALJ's conclusion that section 483.15(g)(1) required prior notice and consultation under the circumstances in this case is over broad and erroneous.[6]

To the extent that a discussion with the family about whether Resident # 5 should receive hospice care might be viewed as itself a social service (see CMS Br. at 5), the record shows that Claiborne provided that service. The Director of Rehabilitation testified that she "personally spoke with [the] daughter regarding Hospice on numerous occasions." 07-111 P. Ex. 6, at ¶ 5. Social progress notes of August 26 and 31 by the facility's social worker state that "daughters are currently discussing whether or not to elect hospice and will make decision soon" and that hospice services were declined because the "daughters feel that the facility is adequately meeting [Resident # 5's] needs." 07-111 P. Ex. 7, at 13-14.

Where a family has expressed uncertainty, gathering information through a hospice consult to better inform the family what hospice might offer is arguably an aspect of providing medically-related social services to address that uncertainty. We therefore disagree with the ALJ's characterization of the hospice consult as provided "in the face of knowledge that the family might not want hospice care for Resident # 5." ALJ Decision at 4, citing 07-111 P. Ex. 6, at 2-3. The ALJ does not explain, moreover, why the mere fact that the daughter expressed some uncertainty about choosing hospice care would have imposed an obligation on the facility to obtain the family's permission before getting a hospice consult. The family's conclusion that hospice was not needed because Claiborne provided all that hospice could offer was a result of, not a rejection of, the information provided through the consult. The ALJ's analysis blurs the distinction between the process of considering whether

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[6] We reach no conclusion here about when or if other regulations may require consultation with a family prior to even a consultation with a hospice provider to determine suitability for such services. The ALJ suggested (ALJ Decision at 4) that a resident or family member might wish to choose a different hospice provider even for the consultation (which does not limit the resident's choice of provider should hospice be selected (07-111 CMS Ex. 26, at 7, 11)). Under other regulations, the possibility that hospice has not previously been discussed or represents a significant change in condition may be relevant. Here, however, the parties involved all understood that Resident # 5 was dying and wanted only comfort care, and hospice had been previously raised as an alternative.

hospice services could benefit a resident and the process of deciding on the actual provision of hospice services by a particular hospice provider.

Because we find Claiborne did not violate section 483.15(g)(1), we do not address whether the ALJ's finding (that Claiborne failed to discuss the hospice consult with the daughter on August 21) is supported by substantial evidence in the record as a whole.

2. Claiborne failed to show that it was in substantial compliance with 42 C.F.R. § 483.25(j) by the preponderance of the evidence.

The ALJ did not reach the noncompliance finding that CMS made pursuant to 42 C.F.R. § 483.25(j). Given our reversal of the finding under section 483.15(g)(1), we must reach the section 483.25(j) finding. To avoid delay from a second remand, we review this noncompliance finding ourselves in the first instance. 42 C.F.R. § 498.88(f)(1)(iii); Ross Health Care Center, DAB No. 1896, at 13 (2003). We review this noncompliance finding under the de novo standard that the ALJ would have applied.

Section 483.25(j) requires:

> A facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.

The Statement of Deficiencies (SOD) relied on findings as to two specific residents (# 8 and # 4) and a group of residents, some of whom were on Claiborne's Focused Hydration List. We conclude that, for Resident # 8, Claiborne showed that it met the regulatory requirements of section 483.25(j). We conclude that Claiborne failed to rebut the findings as to Resident # 4 and other residents on its Focused Hydration List and that the potential for harm was more than minimal. Therefore, we conclude that Claiborne was not in substantial compliance with section 483.25(j).

a. Resident # 8

For the following reasons, we conclude that the preponderance of the evidence shows that Claiborne's care of Resident # 8 complied with section 483.25(j).

Resident # 8 had multiple diagnoses, including Alzheimer's, congestive heart failure and chronic renal insufficiency. 07-111

P. Ex. 16, at 1. Since January 2005, she had had a feeding tube for nourishment and hydration and had received nothing by mouth. 07-111 CMS Ex. 1, at 5; 07-111 P. Ex. 16, at 1-3. CMS relies on the following findings made by the surveyor (CMS Br. at 3-5):

> No intake Record was found on the medical record . . . . Review of the nursing notes dated 8-15-06 through 8-17-06 revealed the Resident was sent to the hospital at 6:30 [P.M.] on 8-17-06 for increased congestion, "gurgling", and an elevated temperature. The Resident returned to the facility on 8-22-06 with a diagnosis of Aspiration Pneumonia. Review of the discharge summary from the hospital revealed the Resident had been "significantly dehydrated" and had required several liters of free water to correct the problem. Review of the medical record since the Resident's return from the hospital revealed there continued to be no documentation of intake on the chart.

07-111 CMS Ex. 1, at 5. CMS argues that these findings show noncompliance because Claiborne has not documented that, prior to the hospitalization, its staff "assessed Resident 8's fluid needs." CMS Supplemental Br. at 5. CMS further alleges that Claiborne "has pointed to no document which indicates how the staff were going to ensure that Resident 8 received those fluids" or "which indicates that Resident 8 did in fact receive the required fluids." Id. at 5.

CMS's description of the record is incorrect. Claiborne submitted Resident # 8's Dietary Progress Notes beginning with the January 2006 "Annual Review" that documented the dietician's consideration of Resident # 8's nutrition and hydration needs including calculation of the number of cubic centimeters (cc's) of fluid Resident # 8 required daily. 07-111 P. Ex. 16, at 18-20. The notes show regular assessment by the dietician of those needs, including Resident # 8's weight changes, her protein values, her skin condition, and her risk of fluid retention. Id. Claiborne also documented that it ensured that Resident # 8 received what was ordered by requiring staff to record the nutrients and fluids Resident # 8 received on the Medications Administration Record (MAR). Id. at 26-30. Finally, the MAR showed that Resident # 8 was given what was ordered for her during the relevant time periods. Id.

CMS relies on the hospital's determination that Resident # 8 was dehydrated when she was admitted August 17.[7] CMS Supplemental Br. at 3. In response, Claiborne cites Community Skilled Nursing Centre, DAB No. 1987 (2005), in which the Board stated that 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." RR at 52. Relying on the testimony of a nurse expert, Claiborne asserts that its care was consistent with such standards. RR at 52-53. The nurse expert reviewed the dieticians' assessment of Resident # 8's needs and testified that the nurses' notes "show that the resident did not exhibit [] clinical symptoms of dehydration, such as dry skin and mucous membranes, cracked lips, poor skin turgor, fever, or abnormal lab values." 07-111 P. Ex. 8, at ¶ 22. She noted that on August 17, after communication with Resident # 8's doctor about her continuing congestion and culture of her sputum, Claiborne began increasing Resident # 8's fluids pursuant to her doctor's orders. 07-111 P. Ex. 8, at ¶ 22. She concluded:

> By following the scheduled hydration protocol as developed by the facility's registered dietician, constantly monitoring the resident's clinical condition and documenting it in the nurses' notes, and increasing the resident's hydration rate as ordered by the physician, Claiborne acted consistently with the professional standards of care.

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[7] In its final brief, Claiborne challenges for the first time on appeal whether the evidence supports CMS's assertion that Resident # 8 was "significantly dehydrated" on admission to the hospital. P. Reply to CMS Supplemental Br. at 9. We find that the evidence supports a finding of dehydration but not the degree of dehydration. While the surveyor wrote in the SOD that the hospital discharge summary stated that Resident # 8 was "significantly dehydrated" and required "several liters of free water" (07-111 CMS Ex. 1, at 5), the record does not contain the quoted hospital summary. However, Claiborne's dietician's notes stated that the hospital discharge summary reported that Resident # 8 "required 'several' liters of free water and increased PEG tube flushes to correct her sodium." 07-111 P. Ex. 16, at 20. This evidence supports a finding that Resident # 8 was dehydrated, not that she was "significantly" dehydrated.

07-111 P. Ex. 8, at ¶ 23. CMS offered no contrary expert testimony, not even the testimony of the surveyor. Based on this record, we conclude that the preponderance of the evidence establishes that Claiborne met professional standards of quality for preventing dehydration in someone of Resident # 8's condition.

b. Resident # 4

For the following reasons, we conclude that Claiborne did not show, by a preponderance of the evidence, that Claiborne's care of Resident # 4 met the requirements of section 483.25(j).

Resident # 4 was a frail 80 year-old woman with multiple diagnoses including Peripheral Vascular Disease and Alzheimer's. 07-111 CMS Ex. 1, at 6, 15. For several months prior to the September revisit, she had been treated for a antibiotic resistant urinary tract infection (UTI) and was on antibiotics for the UTI on August 30, 2006. Id.

The surveyor made the following findings. As of August 30, 2006, Resident # 4 had been placed on Claiborne's Focused Hydration List "to provide extra fluids for Residents with a history of or currently having a UTI, and for Residents at risk for dehydration." 07-111 CMS Ex. 1, at 6. Resident # 4's "Diet Flow Sheet" stated that her "daily hydration need" was 1500 cc's of fluid. Id.; 07-111 CMS Ex. 10, at 1. Resident # 4's Diet Flow Sheets for August 30, 31 or September 1 failed to show that her fluid intake met her estimated daily need of 1500 cc's. 07-111 CMS Ex. 1, at 6. A nurse's note of September 1, 2006 at 2:00 A.M. stated that Resident # 4 had "an elevated temperature of 99 degrees axillary (actual 100 degrees)." Id. The Licensed Practical Nurse/Night Supervisor who wrote the note told the surveyor that he "had encouraged extra fluids for the Resident that night, and then would have retaken the temperature to see if it came down." Id. However, there was no documentation that the LPN retook the temperature. Id.

Claiborne makes a number of arguments in response to these findings, none of which establish that it was in substantial compliance.

First, Claiborne argues that it did document that it "did in fact provide this resident with sufficient fluid intake to maintain proper hydration." P. Reply to CMS Supplemental Response at 10. It complains that CMS has failed to take into consideration fluid intake documented on records other than the Diet Flow Sheets. It states:

> The diet flow sheets are not the only place fluid intake is recorded, nor are they intended to be inclusive of all intake provided to residents. Rather, they are part of an overall intervention plan to monitor, encourage and document significant changes. These sheets do not account for additional fluids taken by the resident throughout the day when encouraged by the staff on their rounds and they do not account for supplements administered by the nurses and recorded on the MAR.

RR at 49.

The diet flow sheets show fluid consumption at meals of 460 cc's on August 30, 840 cc's on August 31, and 930 cc's on September 1, all well under the 1500 cc's minimum. 07-111 CMS Ex. 10, at 1, 2. We accept Claiborne's assertion that the daily flow sheets were only part of its hydration monitoring system. However, as discussed below, the remainder of the records fail to show that Resident # 4 drank 1500 cc's of fluid each of these days and fail to show how Claiborne could have known or evaluated whether her fluid intake over these days was sufficient to maintain proper hydration and health.

- In addition to amounts recorded on the Diet Flow Sheets, Claiborne relies on the fact that Resident # 4 had a doctor's order for 120 cc's of liquid dietary supplement three times a day. P. Reply to CMS Supplemental Response at 10. It cites Resident # 4's MAR for September 1, which documents the administration of 360 cc's of supplement that day. The record does not contain the August 2006 MAR, so there is no documentation that this supplement was given on August 30 and 31. However, even assuming Resident # 4 actually consumed 360 cc's of supplement on all three days, she was still well short of her 1500 cc's minimum daily need.

- Claiborne points to the order on the MAR to "crush medications and put in ice cream." P. Reply to CMS Supplemental Response at 10, citing 07-111 CMS Ex. 6, at 28. It then argues that the Diet Sheet indicates that "a single dish of ice cream is equivalent to another 120 cc of fluid" (id. citing 07-111 P. Ex. 15, at 3) and asserts that Resident # 4 took medications "several times a day" (id.). However, even if we accept ice cream as a fluid, there is no way to know how much ice cream Resident # 4 ate with medication and no reason to

assume she ate a whole dish of ice cream with medications.

- Claiborne also points to the Activities of Daily Living (ADL) Flow Sheets (07-111 P. Ex. 15, at 4), MAR (id. at 17), and nurses' notes (id. at 1) to support it claim that the resident was offered fluids in other ways. P. Reply to CMS Supplemental Response at 10-11. Entries on these records indicate that staff offered fluids to Resident # 4 on September 1. We see no ADL sheets or MARs for August. With one exception in which a nurse also wrote "taken well" in a nurses' note (07-111 P. Ex. 15, at 17), the entries do not indicate whether Resident # 4 actually drank any (or how much) of the offered fluids. Moreover, they provide no basis on which Claiborne could have assessed Resident # 4's intake and risk of dehydration over these three days.[8]

Therefore, we agree with CMS that Claiborne's records do not show that Resident # 4 drank at least 1500 cc's of fluid on August 30 or 31, or September 1, 2006.

Claiborne also argues that "failing to document [fluid consumption] is **not** sufficient by itself to warrant a violation" of section 483.25(j) because "failure to document the complete intake of a resident on its diet flow sheet is not evidence that a facility failed to properly hydrate a resident." P. Reply to CMS Supplemental Response at 9.

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. Here, CMS's prima facie case rests on Resident # 4's assessed hydration need (by Claiborne) for 1500 cc's of fluid a day and the absence of documentation over a three-day period showing that her intake met this need. Claiborne had an opportunity to show

[8] Moreover, we note that there is reason to question the reliability of the entries on the September "ADL Flow Record" (07-111 CMS Ex. 6, at 37). The form had entries for all categories (such as eating, transfers, toilet use, fluids) for all shifts on September 3, including the 3 P.M. to 11 p.m. shift. For example, it indicated that Resident # 4 had been offered fluids "3" times on the 3 P.M. to 11 P.M. shift. However, this is impossible since Resident # 4 was found dead at 11:45 that morning. Over this "3" and all other entries for this shift, someone then superimposed an "H."

that it did provide sufficient fluid intake. It could make this showing 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.

Claiborne cites the testimony of the night LPN Night Supervisor who recorded Resident # 4's elevated temperature at 2:00 A.M. on September 1. He testified that for temperatures "100 or lower, our standard treatment is to push/encourage fluids and monitor the patient. This is exactly what I did that night for Resident 4." 07-111 P. Ex. 9, at ¶ 4. However, this testimony does not cure the problem that Claiborne has failed to show that it provided Resident # 4 with sufficient fluid intake or that it had a means of evaluating Resident # 4's fluid intake in relation to her needs on the three days in question even though she was on its Focused Hydration List, was on antibiotics for a UTI, and had an elevated temperature during this time.

c. Other Residents on Focused Hydration List

Of the 22 residents reviewed in the survey, the surveyor found that 20 lacked full documentation of fluid intake. 07-111 CMS Ex. 1, at 7. Claiborne responded that there was no requirement to document fluid intake of all residents. RR at 53. However, of the 20 without full documentation of intake, Residents # 3, 5, 7, 11, 12, 13, 14 and 16 were on the Focused Hydration List. 07-111 CMS Exs. 2 and 9. Claiborne does not deny that these residents were assessed as at risk for dehydration and therefore being monitored for adequate hydration. Claiborne argues, however, that no specific documentation is required to show hydration. RR at 53; P. Reply to CMS Response at 12-13; 14-15.

This argument is unpersuasive since Claiborne's "Hydration Program Guidelines" for residents at risk of dehydration provides for recording (on different forms), totaling, and reviewing intake amounts. 07-111 P. Ex. 17. Specifically, the Guidelines state that the "Night Shift Supervisor will be responsible for calculating total resident intake from Activity, Hydration and Meal Tray daily to determine resident hydration compliance and needs." 07-111 P. Ex. 17. The surveyor reported, and Claiborne did not deny, that the LPN Night Supervisor indeed stated that he was responsible for totaling the fluid intake recorded on different facility records but the surveyor found that no such daily fluid totals were recorded. 07-111 CMS Ex. 1, at 6-7. In response, Claiborne argues that the regulations do not require it to "tally such totals as part of [residents'] provision of sufficient fluid intake." P. Reply to CMS Response at 13.

A facility may chose different methods for assuring that it is providing sufficient fluid intake, but, having chosen a method, it cannot complain that CMS is relying on the facility's failure to implement its chosen method in determining whether the facility actually provided adequate hydration. Here, because Claiborne had not implemented this method, it has failed to show how it was determining that residents on its Focused Hydration List were provided sufficient fluid intake to maintain proper hydration and health.

Claiborne also argues that it should be found to be in substantial compliance because CMS has failed to prove that Resident # 4 (or other residents) were actually dehydrated or that Claiborne in fact failed to provide them with sufficient fluid intake. See RR at 49-50, 53; P. Reply to CMS Supplemental Response at 2, 14. This argument is without merit. Here the record shows that Claiborne itself determined that Resident # 4 and other residents were at risk of dehydration and required monitoring. Yet Claiborne had no means to determine whether Resident # 4 drank sufficient fluids over three days to meet her daily hydration need as calculated by the facility. The documentation methods Claiborne adopted to assure sufficient intake had also not been implemented for other residents on the Focused Hydration List. Moreover, it is undisputed that elderly sick people are at increased risk of dehydration and that such dehydration can result in serious adverse consequences, including increased susceptibility to infection and death. 07-111 CMS Exs. 28, at 1, 2; 29, at 1-2; 07-31 CMS Ex. 14, at ¶¶ 15-23. All of these factors support our conclusion that Claiborne residents were at risk of not being provided with sufficient fluid intake to maintain proper hydration and health and that this risk posed a potential for more than minimal harm.

For the preceding reasons, we conclude that Claiborne has failed to show that it was in substantial compliance with section 483.25(j).

3. The CMP imposed for September 5, 2006 through September 17, 2006 is reduced from $100 per day to $50 per day.

Pursuant to 42 C.F.R. § 488.438(a)(1)(i), CMS imposed a CMP of $100 per day from September 5, 2006 through September 17, 2006, based on the SOD findings of three deficiencies each constituting noncompliance at the low end of scope and severity scale. 07-111 CMS Ex. 1; 42 C.F.R. § 488.404. CMS may impose a CMP in the range of $50 to $3,000 per day for deficiencies that do not pose

immediate jeopardy. Pursuant to 42 C.F.R. § 488.417, CMS imposed a DPNA from August 20, 2006 through September 17, 2006.

Claiborne objects to these remedies on the ground that it was in substantial compliance with the cited regulations (RR at 54), an argument that we have rejected as to 42 C.F.R. § 483.25(j). Alternatively, Claiborne argues that the ALJ failed to explain "the basis for his conclusion that the $100 per day CMP resulting from this survey was reasonable as opposed to the minimum of $50.00." Id.

In this decision and in DAB No. 2179, we reversed two of three noncompliance findings on which CMS relied in determining the amount of the CMP. The hydration noncompliance that we sustain was cited at a severity/scope level of a pattern causing no actual harm with only the potential for more than minimal harm. Therefore, we reduce the CMP to more reasonably reflect the lower level of noncompliance we have found. The CMP is reduced to $50 per day because the regulations require CMPs to be set in $50 increments and $50 is the minimum applicable amount.

Conclusion

For the reasons explained above, we reverse the ALJ's conclusion in FFCL 1 that Claiborne was not in substantial compliance with 42 C.F.R. § 483.15(g)(1); we conclude that Claiborne was not in substantial compliance with 42 C.F.R. § 483.25(j); we modify ALJ FFCL 2 by reducing the amount of the CMP from $100 per day to $50 per day but uphold the imposition of the DPNA.

/s/
Judith A. Ballard

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member