Department of Health and Human Services

**DEPARTMENTAL APPEALS BOARD**

Civil Remedies Division

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| In the Case of: | ) | |
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| Bloomfield Health Care Center, | ) | |
| (CCN: 07-5138), | ) | Date: June 20, 2007 |
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| Petitioner, | ) | |
| | ) | |
| - v. - | ) | Docket No. C-03-428 |
| | ) | Decision No. CR1610 |
| Centers for Medicare & Medicaid | ) | |
| Services. | ) | |
| | ) | |

## DECISION

Petitioner, Bloomfield Health Care Center, Bloomfield, Connecticut, did not violate 42 C.F.R. § 483.25(j),[1] on October 7, 2002. Accordingly, there is no basis for the imposition of an enforcement remedy.

## I. Background

CMS notified Petitioner by letter dated February 26, 2003, that Petitioner was not in compliance with federal participation requirements based upon the findings of the Connecticut Department of Public Health, Division of Health Systems Regulation (the state agency), which completed a complaint survey of Petitioner's facility on January 28, 2003. CMS proposed to impose remedies against Petitioner, including termination of Petitioner's provider agreement effective July 28, 2003, denial of payment for new admissions effective April 28, 2003, and a per instance civil money penalty (PICMP) of $1000.

[1] All references are to the revision of the Code of Federal Regulations (C.F.R.) in effect at the time of the survey, unless otherwise indicated.

Petitioner requested a hearing by an administrative law judge (ALJ) by a document dated April 21, 2003. The request was docketed and assigned to me for hearing and decision on May 28, 2003.

A hearing was held in this case on February 11, 2004, in Hartford, Connecticut. CMS was represented by Joyce E. McCourt, Assistant Regional Counsel, Office of the General Counsel, Department of Health and Human Services. Petitioner was represented by Patricia C. Thomas, National Health Care Associates, Inc. CMS offered and I admitted CMS exhibits (CMS Ex.) 1 through 23 as evidence. Transcript page (Tr.) 14. Petitioner offered and I admitted Petitioner's exhibits (P. Ex.) 1 through 12 as evidence. Tr. 16, 148-49. CMS presented the testimony of Patricia Gannon, R.N. (the state agency surveyor), and Albert L. Geetter, M.D. Petitioner presented the testimony of Rolf Knoll, M.D., Carolyn Wendrow, Leslie Lindenberg, M.D., and Chidinma Anosike-Byron, R.N. The parties filed post-hearing briefs (CMS or P. Br.) and post-hearing reply briefs (CMS or P. Reply).

## II. Discussion

### A. Findings of Fact

The following findings of fact are based upon the exhibits admitted. Citations to exhibit numbers related to each finding of fact may be found in the analysis section of this decision if not indicated here.

1. Petitioner, located in Bloomfield, Connecticut, is authorized to participate in the federal Medicare program as a skilled nursing facility (SNF) and the state Medicaid program as a nursing facility (NF). Tr. 18; CMS Ex. 2.

2. Petitioner admitted Resident 2, a 72-year-old woman, into its facility from Hartford Hospital on September 20, 2002. Tr. 20; CMS Exs. 13, 15.

3. Resident 2 had diagnoses of, among other conditions, congestive heart failure (CHF), hypertension, cancer of the colon and breast, chronic renal failure, atrial fibrillation, deep vein thrombosis with a vena cava filter in her left side, and she had an ileostomy. Tr. 20-21; CMS Exs. 13, 15.

4. Resident 2's physician noted in his hospital discharge summary that managing her care would be difficult, specifically noting that her "[f]luid balance will also be somewhat problematic . . . because if she is to[o] dry her creatinine will rise and if she is over hydrated she is apt to develop congestive heart failure." CMS Ex. 13, at 4.

5. Resident 2's physician did not order monitoring of her input and output. CMS Ex. 20; Tr. 125, 163.

6. After experiencing vomiting and bowel difficulties, Resident 2 was returned to the hospital on September 21, 2002. Tr. 20; CMS Ex. 19; P. Ex. 3, at 2, 9.

7. Resident 2 was readmitted to Petitioner's facility on September 26, 2002. Tr. 20; P. Exs. 4-6.

8. Petitioner assessed Resident 2 upon her admission on September 20, 2002, and upon her readmission on September 26, 2002. CMS Exs. 15, 21, 22.

9. Petitioner care planned for Resident 2's dehydration risk. CMS Exs. 16, 21, 22, at 2-3; P. Ex. 1.

10. Petitioner monitored Resident 2's dehydration risk, implementing Resident 2's care plan. Tr. 37-44, 64-65; CMS Ex. 22, at 2-3; P. Ex. 3, at 11-14.

11. On October 5, 2002, Resident 2 experienced some vomiting. Tr. 22.

12. On October 6, 2002, Resident 2 continued to have some nausea. Tr. 22.

13. On October 7, 2002, Resident 2 was readmitted to the hospital after vomiting 450 ccs of a dark brown foul smelling emesis and exhibiting other signs of distress, including slight generalized abdominal pain, and becoming diaphoretic and pale. Tr. 22; CMS Ex. 23, at 5; P. Ex. 3, at 14.

14. At the hospital, Resident 2 received six liters of fluids intravenously over four hours and then went into CHF. Tr. 22-23; CMS Ex. 2, at 5; CMS Ex. 23, at 9, 11.

15. At the hospital, Resident 2 was diagnosed as suffering from mesenteric ischemia. CMS Ex. 11, at 6; P. Ex. 3, at 14.

16 The evidence does not show that Resident 2 was dehydrated at the time of her delivery to the emergency room on October 7, 2002.

17. On January 28, 2003, the state agency conducted a complaint survey of Petitioner's facility. CMS Exs. 1, 2.

18. On February 26, 2003, CMS notified Petitioner that it was imposing various remedies, including a PICMP of $1000, based on Petitioner's failure to comply with the participation requirement at 42 C.F.R. § 483.25(j) (Tag F327 in the January 28, 2003 survey). CMS Exs. 1, 2, 5.

19. On April 21, 2003, Petitioner requested a hearing.

**B. Conclusions of Law**

1. Petitioner's request for hearing was timely and I have jurisdiction.

2. The regulation at 42 C.F.R. § 483.25(j) requires a facility to provide each resident with sufficient fluid intake to maintain proper hydration.

3. Petitioner was not in violation of 42 C.F.R. § 483.25(j) on October 7, 2002, with respect to Resident 2.

4. The remedies proposed by CMS are not reasonable because there is no violation of participation requirements and no basis for the imposition of an enforcement remedy.

**C. Issues**

The issues presented in this matter are:

Whether there is a basis for the imposition of an enforcement remedy; and,

Whether the remedy imposed is reasonable.

**D. Applicable Law**

Petitioner is a long-term care facility located in Bloomfield, Connecticut, participating in the federal Medicare program as a SNF and in the Connecticut Medicaid program as a NF. The statutory and regulatory requirements for participation by a long-term care facility are found at sections 1819 and 1919 of the Social Security Act (the Act) and at 42 C.F.R. Part 483. Sections 1819 and 1919 of the Act vest the Secretary of Health and Human Services (Secretary) with authority to impose CMPs against a long-term care facility for failure to comply substantially with federal participation requirements.

Pursuant to the Act, the Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility that is not complying substantially with federal participation requirements. Facilities that participate in Medicare may be surveyed on behalf of CMS by state survey agencies in order to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-488.28, 488.300-488.335. Pursuant to 42 C.F.R. Part 488, CMS may impose a PICMP or a per day CMP against a long-term care facility when a state survey agency concludes that the facility is not complying substantially with federal participation requirements. 42 C.F.R. §§ 488.406; 488.408; 488.430. The regulations in 42 C.F.R. Part 488 also give CMS a number of other remedies that can be imposed if a facility is not in compliance with Medicare requirements. *Id.*

The regulations specify that a CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP, of from $3050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents, and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i), (d)(2). The lower range of CMP, from $50 per day to $3000 per day, is reserved for deficiencies that do not constitute immediate jeopardy but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). There is only a single range of $1000 to $10,000 for a PICMP, which applies whether or not immediate jeopardy is present. 42 C.F.R. §§ 488.408(d)(1)(iv); 488.438(a)(2).

The Act and regulations make a hearing before an ALJ available to a long-term care facility against whom CMS has determined to impose a CMP. Act, section 1128A(c)(2); 42 C.F.R. §§ 488.408(g); 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *Anesthesiologists Affiliated, et al*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Cal Turner Extended Care Pavilion*, DAB No. 2030 (2006); *The Residence at Salem Woods*, DAB No. 2052 (2006). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); *see also* 42 C.F.R. §§ 488.330(e) and 498.3. However, the choice of remedies by CMS or the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance found by CMS if a successful challenge would affect the amount of the CMP that could be collected by CMS or impact upon the facility's nurse aide training program. 42 C.F.R. §§ 498.3(b)(14) and (d)(10)(i). CMS's determination as to the level of noncompliance "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). This includes CMS's finding of immediate jeopardy. *Woodstock Care Center*, DAB No. 1726, at 9, 38 (2000), *aff'd, Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board) has long held that

the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g., Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). Review of a CMP by an ALJ is governed by 42 C.F.R. § 488.438(e).

When a penalty is proposed and appealed, CMS must make a *prima facie* case that the facility has failed to comply substantially with federal participation requirements. "*Prima facie*" means that the evidence is "[s]ufficient to establish a fact or raise a presumption unless disproved or rebutted." *Black's Law Dictionary* 1228 (8th ed. 2004); *see also, Hillman Rehabilitation Center*, DAB No. 1611, at 8 (1997), *aff'd Hillman Rehabilitation Center v. U.S. Dep't. of Health and Human Services*, No. 98-3789 (D.N.J. May 13, 1999). To prevail, a long-term care facility must overcome CMS's showing by a preponderance of the evidence. *Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004); *Batavia Nursing and Convalescent Inn*, DAB No. 1911 (2004); *Emerald Oaks*, DAB No. 1800 (2001); *Cross Creek Health Care Center*, DAB No. 1665 (1998); *Evergreene Nursing Care Center*, DAB No. 2069, at 7-8 (2007).

**E. Analysis**

At the hearing the parties agreed that the only alleged deficiency at issue before me is the alleged violation of 42 C.F.R. § 483.25(j) (Tag F327) at a scope and severity level of G, an isolated incident of actual harm that did not constitute immediate jeopardy.[2] Tr. 19; CMS Ex. 1, at 1; CMS Ex. 2, at 4. The parties agreed that the only resident involved was Resident 2. Tr. 20. The parties further agreed that the alleged deficiency was corrected prior to hearing and that the only remaining remedy at issue is the $1000 PICMP. Tr. 23.

Petitioner admitted Resident 2, a 72-year-old woman, to its facility from Hartford Hospital on September 20, 2002. After experiencing vomiting and bowel difficulties, Resident 2 was returned to the hospital on September 21, 2002. She was then readmitted to Petitioner's facility on September 26, 2002. She was diagnosed with, among other conditions, CHF, hypertension, cancer of the colon and breast, chronic renal failure, atrial fibrillation, deep vein thrombosis with a vena cava filter in her left side, and she had an ileostomy. On October 5, 2002, she experienced some vomiting, and she continued to

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[2] Although CMS points out in its briefs that Petitioner had not completed a comprehensive assessment of Resident 2, the state agency did not cite Petitioner as deficient in this regard and I do not consider that issue. I note that under 42 C.F.R. § 483.20(b)(2)(i), Petitioner had 14 days to do a comprehensive assessment of Resident 2, and she was only in the facility for 10 days.

have nausea throughout October 6, 2002. On October 7, 2002, she was transferred back to the hospital after vomiting 450 ccs of a dark brown foul smelling emesis and exhibiting other signs of distress. Upon her readmission to the hospital, Resident 2 received six liters of fluids intravenously over four hours and then experienced CHF. It is undisputed that Resident 2 was at risk for dehydration during her time at the facility.

CMS imposed the PICMP based on its conclusion that Petitioner's care of Resident 2 violated 42 C.F.R. § 483.25(j), a subsection of the Quality of Care regulation at 42 C.F.R. § 483.25. The regulation provides that:

> 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.

CMS asserts that the facility failed to provide Resident 2 with sufficient fluid intake to maintain proper hydration and health, with the result that Resident 2 suffered actual harm. CMS maintains that Petitioner failed to assess and monitor Resident 2's fluid intake and output adequately while at the facility, in order to prevent Resident 2 from being under- or over-hydrated. CMS relies on findings made by Surveyor Gannon that, while Resident 2 was at risk for dehydration, Petitioner did not do "a dehydration risk assessment" for Resident 2; Resident 2's documented intake was less than her need as identified by the dietician; her resident care plan did not show interventions to maintain fluid level; Petitioner failed to consistently document Resident 2's fluid output; and Resident 2 was dehydrated on admission to the hospital on October 7, as evidenced by the fact that she received six liters of IV fluid in the emergency room. CMS Ex. 2, at 4-5.

The regulations do not specify how a facility is to provide the proper hydration. The regulation at 42 C.F.R. § 483.25(j) requires only that a facility provide "sufficient fluid intake." The State Operations Manual (SOM) sets out the investigative protocol for surveyors with regard to hydration, but does not require facilities to monitor resident input and output. The SOM provides that, when a facility undertakes monitoring a resident's input and output, the surveyor should use the input and output record to determine whether the resident's fluid goals or calculated fluid needs were consistently met. The SOM provides surveyors with the guidance that if the facility being surveyed

properly assessed a resident, care planned for the resident, implemented the resident's care plan, evaluated the resident's outcome, and revised the resident's care plan as needed, then the facility would be in compliance with the regulations. SOM App. PP at 41-43.

Petitioner's policy with regard to hydration, as reflected at CMS Ex. 10, at 2, indicates that a licensed nurse will perform a dehydration risk assessment within 24 hours of a resident's admission or readmission, annually, and upon a significant change in a resident's condition, in order to see if a resident has conditions predisposing them to a hydration risk. If a resident is at such risk, a care plan for the resident must be developed. If a resident's physician diagnosed a resident as dehydrated, Petitioner's protocol was to follow the physician's orders, document the resident's intake and output every shift, document in the nurse's notes every shift until symptoms resolved, and, if total fluid intake was below 1000 ccs in a 24-hour period, notify the resident's physician. The dietician would ensure that the resident receives his or her fluids of choice, if appropriate. CMS Ex. 10, at 3.

Resident 2's physician noted that Resident 2's hydration would be difficult to assess. However, he did not order any particular monitoring of her hydration, including ordering input and output monitoring. Petitioner's expert witnesses testified that had Resident 2's physician felt it necessary, he would have ordered monitoring input and output. Tr. 125. Resident 2's Admission Nursing Assessment, completed on September 20, 2002 (CMS Ex. 15), does not specifically state that it is addressing hydration, but it does reflect a "Nutritional Assessment." This Nutritional Assessment notes the resident is independent in her eating skills and that her intake by mouth is "good." CMS Ex. 15, at 3. Resident 2's Initial Care Plan indicates under "Nutrition/Hydration," as a problem area, "poor per Nausea" and notes that staff's approach should be to "monitor offer foods of choice." CMS Ex. 16. Resident 2's Admission Nursing Assessment dated September 26, 2002, did not include a nutritional or hydration assessment on that particular document. CMS Ex. 21. However, her Initial Care Plan from the September 26, 2002 readmission notes as a Nutrition/Hydration problem "Nausea/vomiting" and as a staff approach a regular diet as tolerated and encouragement of fluids per mouth as tolerated. CMS Ex. 21, at 8. A separate "Nutritional Assessment/Full" was done on October 1, 2002. Both Resident 2's nutritional and fluid needs were specifically assessed. CMS Ex. 22. The dietitian estimated Resident 2's daily fluid needs as a range of 1513-1815 ccs per day and noted that the resident stated her intake had been poor but was slowly improving. The dietician planned to provide Ensure, to monitor what Resident 2 was taking by mouth, to weigh her, and to follow her progress. CMS Ex. 22, at 2-3. Resident 2's fluid intake, ileostomy output, and vomitus amounts were recorded. Tr. 42-43, 63-64; CMS Ex. 3, at 12; CMS Ex. 17; P. Exs. 2, 3.

I find, based on the evidence presented, that Petitioner assessed Resident 2 (CMS Exs. 15, 21, 22), and care planned for Resident 2 (CMS Exs. 16, 21), and was implementing the care plan.[3] Although Petitioner's assessments and care plans for Resident 2 may not be models, the regulations and the SOM do not specify what the assessments and care plans are to look like or how detailed they are to be. The survey process is a result-oriented process and, if an adverse result is observed, in this case the alleged dehydration, then a presumption arises that inaction or deficient action by the facility was the cause. When such a presumption is triggered, CMS has met the prima facie case and the burden is then upon a petitioner to show it was actually in compliance or to rebut the presumption. In this case I find that Petitioner did assess Resident 2 and then developed and implemented a plan of care, although it was not perfectly documented or executed.

Furthermore, the evidence does not show that Resident 2 was dehydrated when she was sent to the emergency room on October 7, 2002. Resident 2 was in Petitioner's facility on her second admission from September 26, 2002, until early in the morning of October 7, 2002, a period of about 10 days. P. Ex. 3, at 5-14; Tr. 72. Surveyor Gannon clarified during her testimony that she cited Petitioner because Resident 2 was at risk, she was dehydrated, and Petitioner did not do a good job of monitoring her. Tr. 72-75. Surveyor Gannon agreed that her deficiency finding was premised significantly upon her belief that Resident 2 was dehydrated at the time she was received at the emergency room early in the morning of October 7, 2002, due to Petitioner's failure to appropriately monitor her. Tr. 45-47, 55-57, 74-75.

Surveyor Gannon pointed to Resident 2's blood urea nitrogen (BUN) and creatinine results on October 7, 2002, to show that Resident 2 was dehydrated on that date. Tr. 45-50, 56, 60. There is no dispute that both results were out of normal limits (CMS Ex. 23, at 7; Tr. 56). Resident 2's discharge summary from Hartford Hospital for the period October 7, 2002 through October 30, 2002, indicates a diagnosis of transient renal insufficiency (TRI), secondary to dehydration. CMS Ex. 11, at 5. The summary does not, however, indicate when the TRI arose, whether it existed upon admission on October 7, 2002, or whether it developed during her 23-day hospital stay. In fact, a progress note from the Hartford Hospital shows that on October 31, 2002, Resident 2's discharge from the hospital was delayed due to elevated creatinine and BUN, "probably due to

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[3] I note that while Resident 2's fluid intake was less than the dietician determined to be ideal on several days (CMS Ex. 2, at 5; P. Ex. 4), I do not infer that, because Resident 2's recorded intake was less than her assessed need, the facility's plan to encourage the intake of fluids by mouth was inadequate and required the facility to implement more aggressive measures, such as providing intravenous fluids, because Resident 2 was ambulatory, coherent, and able to take water/fluid as she felt the need.

dehydration" from Lasix and vomiting. P. Ex. 11; Tr. 59-60. No admissions summary is in evidence. Documents prepared by the hospital contemporaneously with Resident 2's admission on October 7, 2002, reflect a diagnosis of mesenteric ischemia but not dehydration. P. Ex. 8, at 1. The hospital records in evidence do not mention dehydration until the note of October 31, 2002 (P. Ex. 8, at 2; P. Exs. 9, 10, 11; CMS Ex. 23, at 1-14), a fact acknowledged by Surveyor Gannon on cross-examination. Tr. 60.

Surveyor Gannon did not make any personal observations of Resident 2 or her environment at the time of the alleged incident on October 7, 2002, as Resident 2 was no longer at the facility at the time of the complaint survey. Tr. 31, 33. The allegations on the statement of deficiencies are largely based upon Surveyor Gannon's review of facility and hospital records. Surveyor Gannon testified that she also spoke with the intensive care unit manager at the hospital and he indicated that Resident 2 was severely dehydrated. Tr. 55-57, 60, 68-69. I do not find the hearsay statement of the intensive care manager that Resident 2 was dehydrated on admission as reliable or credible as the hospital records made at the time of Resident 2's admission to the hospital which do not reflect a diagnosis of dehydration.

Petitioner offered two expert witnesses, Drs. Knoll and Lindenberg, to testify about whether Resident 2 experienced dehydration at the facility. I found their opinions more persuasive, given their credentials and experience, than the opinion of CMS's expert, Dr. Geetter. Dr. Knoll testified that Resident 2's hospitalization on October 7 was precipitated by an episodic manifestation of mesenteric ischemia, an event that mimics dehydration and causes laboratory values that look like those associated with dehydration. Tr. 113-14. Dr. Knoll further testified that this condition was not preventable by monitoring an individual's fluid input or output, as bowel ischemia is not caused by dehydration but by lack of blood flow to the bowel. Tr. 115-16. Dr. Knoll stated that when Resident 2 arrived at the emergency room and was found to have a blood pressure of 70 systolic, she was given the normal treatment of fluid resuscitation with large volumes of fluid to bring up her blood pressure. Tr. 116. Dr. Knoll further stated that his examination of Resident 2's records while she was at Petitioner's facility from September 26 through October 7 showed that Resident 2's fluid intake was sufficient, with the facility monitoring vital signs which indicated that she was receiving adequate fluids. Tr. 117-18. Dr. Knoll concluded that there was nothing that Petitioner could have done to prevent Resident 2 from developing the ischemia that resulted in her October 7 hospitalization. Tr. 119. Dr. Lindenberg testified that, from his review of the records at Petitioner's facility and the hospital to which Resident 2 was admitted, Resident 2's October 7 admission to the hospital was triggered by her becoming septic due to a bowel ischemia. Tr. 152. Dr. Lindenberg stated that the drop in Resident 2's blood pressure, the rise in her creatinine levels, and her BUN lab values at the hospital, were all the result of her ischemia, and not dehydration. Tr. 152-53. Dr. Lindenberg also agreed with Dr.

Knoll that this was an acute event that happened to Resident 2, not something that gradually occurred over several days, and that it was beyond Petitioner's ability to predict or prevent. Tr. 158. I note that CMS's expert, Dr. Geetter, agreed that administering six liters of fluid would lead to CHF in a person who was not dehydrated. Because he reviewed only select hospital records, Dr. Geetter was unaware that Resident 2 suffered CHF at Hartford Hospital after being administered the six liters of fluid. Tr. 89-91.

Based on the evidence before me, I find that Resident 2 suffered mesenteric ischemia on October 7, 2002, as reflected in her discharge summary's citation of mesenteric ischemia as a primary diagnosis (CMS Ex. 11, at 6) (of which diagnosis Petitioner had been informed by 6:30 a.m. on October 7, 2002, as reflected in Petitioner's Nursing Notes at P. Ex. 3, at 14). Petitioner's experts' opinion of the diagnosis of mesenteric ischemia, and their explanation of its impact and effect on Petitioner, is consistent with all the medical evidence and provides a credible explanation for Resident 2's signs and symptoms as reflected in the record. Petitioner's experts' testimony is also consistent with emergency room notes (CMS Ex. 23) that indicate six liters of fluid were given to get Resident 2's blood pressure to rise (CMS Ex. 23, at 11), which led to her CHF/pulmonary edema, which condition required that she be intubated (CMS Ex. 23, at 12). Moreover, the only person who actually saw Resident 2 on October 7, 2002, R.N. Anosike-Byron, testified that Resident 2 was not showing signs of dehydration. R.N. Anosike-Byron is a registered nurse, with a master's degree in nursing, and I have no cause to believe that her testimony is not credible. Tr. 165-68. Buttressing her testimony is that, at the emergency room on October 7, 2002, Resident 2's skin moisture was noted to be normal and her skin temperature was noted to be cool. CMS Ex. 23, at 3; CMS Ex. 10, at 1.

Considering all the evidence, I find no violation of 42 C.F.R. § 483.25(j). The evidence does not show that Resident 2 was dehydrated on October 7, 2002. Although Resident 2 had abnormal laboratory values that are often associated with dehydration, Petitioner has produced credible evidence that those laboratory values are more consistent with the diagnosis of mesenteric ischemia for which she was admitted to the hospital and treated. Furthermore, when Resident 2 was full of fluids she shortly thereafter experienced CHF, which the credible testimony reflects is inconsistent with the resident having been dehydrated. The evidence does not show that Resident 2 was dehydrated and no inference arises in this case that Petitioner failed to provide Resident 2 "with sufficient fluid intake to maintain proper hydration and health."

## III. Conclusion

For the foregoing reasons, I conclude that Petitioner did not violate 42 C.F.R. § 483.25(j) on October 7, 2002, and there is no basis for the imposition of an enforcement remedy.

/s/
Keith W. Sickendick
Administrative Law Judge