Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Del Rosa Villa,
(CCN: 55-5195),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket Nos. C-10-45, C-10-54

Decision No. CR2435

Date: September 21, 2011

DECISION

I sustain the determination of the Centers for Medicare and Medicaid Services (CMS) to impose remedies against Del Rosa Villa (Petitioner or facility) for failure to comply substantially with Medicare program participation requirements. For the reasons that follow, I uphold the per instance civil money penalty (CMP) of $10,000.

I. Background

Petitioner, located in San Bernardino, California, is authorized to participate in Medicare as a skilled nursing facility (SNF). The California Department of Public Health (the state survey agency) conducted a survey of Petitioner that was completed on July 2, 2009, and found Petitioner not in substantial compliance with program participation requirements. CMS notified Petitioner by letter dated August 11, 2009, that it was imposing the following enforcement remedies: a per instance CMP of $10,000; termination of Petitioner's provider agreement by no later than January 2, 2010, if substantial compliance was not promptly achieved

and maintained; and withdrawal of Petitioner's authority to conduct a Nurse Aide Training and Competency Evaluation Program (NATCEP). CMS Exhibit (CMS Ex.) 40, at 1-5.

On July 10, 2009, CMS conducted a Federal Comparative Monitoring Survey of Petitioner and found Petitioner not in substantial compliance with program participation requirements. CMS notified Petitioner by letter dated August 13, 2009, that it was imposing the following enforcement remedies: a denial of payment for new admissions (DPNA) effective August 27, 2009; a CMP of $250 per day, effective July 10, 2009; termination of Petitioner's provider agreement by no later than January 2, 2010, if substantial compliance was not promptly achieved and maintained; and withdrawal of Petitioner's authority to conduct a NATCEP. CMS stated that the DPNA and CMP would continue until Petitioner returned to substantial compliance or termination was effectuated.

Petitioner requested a hearing to appeal the findings of the July 2, 2009 survey by letter dated October 9, 2009. The request for hearing was docketed as C-10-45 and assigned to me for hearing and decision on October 22, 2009.

Petitioner requested a hearing to appeal the findings of the July 10, 2009 survey by letter dated October 9, 2009. The request for hearing was docketed as C-10-54 and assigned to me for hearing and decision on October 22, 2009.

By letter dated November 18, 2009, CMS requested that Docket No. C-10-54 be consolidated with Docket No. C-10-45. In the absence of objection and for good cause shown, I issued an Order Consolidating Cases on November 19, 2009.

On November 24, 2010, Petitioner filed a Notice of Withdrawal of Hearing Request as to 7/10/09 Federal Survey Only.

I convened a hearing in San Francisco, California on December 6-8, 2010. CMS offered, and I admitted, CMS Exs. 1-10, 13, 36-43, 47, and 48. Transcript (Tr.) at 27, 252-53. Petitioner offered, and I admitted, Petitioner Exhibits (P. Ex.) 1, pgs. 22-26; 32-35, 46-48, 86-131. Tr. at 30, 31, 603. CMS called two witnesses, Surveyor Wendy Myers, R.N., and Barbara Ziv, M.D. Petitioner called the following witnesses: Gary Hoyes, Thomas Woodbury, M.D., and Randolph Noble, M.D. The parties filed post-hearing briefs (CMS Br. and P. Br.) and post-hearing reply briefs (CMS Reply and P. Reply).

Procedural History:

The specifically-discussed Orders below are not the only ones issued over the course of this litigation, but they are the ones significant in illuminating the unusual and protracted period of prehearing development in this case.

Order Denying Motion to Continue, dated June 11, 2010: This Order contains a summary of the procedural history of the case up to that date, and reflects the resolution of then-pending disputes concerning the date and location of the hearing, which at that point was to be September 7, 2010 in Santa Ana, California.

Order Regarding CMS's Request for Subpoena, dated June 14, 2010: This Order addresses CMS's request for a subpoena, and states that Petitioner had filed an objection. I directed Petitioner to comply with one of two alternatives in lieu of issuing the subpoena, but ruled that if Petitioner did not avail itself of either alternative, I would grant CMS's request for a subpoena.

Order Granting Petitioner's Request for Subpoenas, dated June 14, 2010: This Order addresses Petitioner's request for subpoenas, states that CMS had filed an objection, and that Petitioner had filed an unauthorized response to CMS's objection. I granted Petitioner's request for subpoenas.

Order Following Prehearing Conference, dated July 29, 2010: This Order followed a July 27, 2010 telephone prehearing conference, at which the principal matter discussed was the effect of an ongoing criminal investigation by state authorities into events that are part of the background of this case. After hearing additional comment and argument from the parties (both sides having already explained their positions prior to the conference), I found it necessary to vacate the September 7, 2011 hearing date because of the criminal investigation. I directed the parties to suggest new hearing dates. At the conference, I also resolved certain evidentiary issues and granted the parties' unopposed pending motions by which they sought to amend their final exchanges.

Notice of Rescheduled Hearing Date, dated August 13, 2010: This Notice announced a new hearing date of December 6, 2010, with the location to be announced at a later date.

Notice of Location of Hearing, dated November 10, 2010: This Notice announced the specific location of the hearing scheduled to begin on December 6, 2010.

By Direction Letter, dated November 17, 2010: This letter informed the parties that Petitioner's request for a postponement of the hearing, as set forth in an email dated November 17, 2010, was denied. In the email, Petitioner stated that the

parties had "settled the federal survey portion of this appeal." Petitioner stated further that it would be requesting a postponement of the hearing on the state survey currently scheduled to begin on December 6, 2010. Petitioner represented that CMS took no position on Petitioner's request, as long as the hearing was rescheduled to a date in the first half of 2011.

On November 19, 2010, Petitioner sought the intervention of an appellate panel of the Departmental Appeals Board (Board) in this case by filing its "Request for Review of ALJ's Denial of Petitioner's Motion for Stay." The Board's appellate panel denied Petitioner's request in its Ruling No. 2011-2 on December 2, 2010. Petitioner's representations are fully set out in its pleading and require no further discussion here except to note that they raise the same arguments concerning a state criminal investigation that had been raised earlier to me. Similarly, the Board's detailed analysis of Petitioner's request, its careful discussion of the legal and factual context of the situation, and its determination not to intervene in the case, are all set out in its Ruling. They require no additional discussion.

By Direction Letter, dated November 24, 2010: This letter informs the parties that, in order to accommodate Petitioner's counsel's and witnesses' travel (see Petitioner's email dated November 23, 2010), the hearing would begin in the afternoon instead of the morning of December 6, 2010.

Order of December 3, 2010: This Order states that Petitioner, in a series of emails, renewed its efforts to win a postponement of the hearing, and that CMS responded by email. I denied Petitioner's motion. I found that Petitioner's arguments offered in support of its motion failed to demonstrate good cause for vacating the setting of the hearing, particularly in light of the Board's December 2, 2010 Ruling No. 2011-2. I informed the parties that I would provide a more formal oral ruling at the hearing. Tr. at 14-23.

Order of April 25, 2011: This Order followed a telephone conference held on April 25, 2011, which addressed Petitioner's Motion to Supplement Record, dated April 15, 2011, and CMS's Objection to Petitioner's Motion to Supplement Record, dated April 20, 2011. I noted the importance of resolving this issue expeditiously in this case, which has been marked by repeated delays, while at the same time ensuring that each side's right to a full and complete discussion of all the evidence is preserved. Accordingly, I granted Petitioner's motion and permitted Petitioner to submit a set of lately-discovered documents as P. Ex. 132 for admission to the record, and allowed each side to file supplemental briefs addressing the documents' content. Both parties filed their supplemental briefs on May 13, 2011, and with those filings, the record closed.

II. Issues

The issues before me are:

(1) whether the facility was in substantial compliance with 42 C.F.R. § 483.25(h) at the time of the July 2, 2009 survey; and

(2) if the facility was not in substantial compliance, whether the penalty imposed, a $10,000 per-instance CMP, was reasonable.

III. Applicable Law and Regulations

The statutory and regulatory requirements for participation by a long-term care facility are found at sections 1819 (SNF) and 1919 (NF) of the Social Security Act (Act) and at 42 C.F.R. Part 483.[1] Section 1819(h)(2) of the Act vests the Secretary of Health and Human Services (Secretary) with authority to impose enforcement remedies against a SNF for failure to comply substantially with the federal participation requirements established by sections 1819(b), (c), and (d) of the Act.[2] Pursuant to 1819(h)(2)(C), the Secretary may continue Medicare payments to a SNF not longer than six months after the date the facility is first found not in compliance with participation requirements. Pursuant to 1819(h)(2)(D), if a SNF does not return to compliance with participation requirements within three months, the Secretary must deny payments for all individuals admitted to the facility after that date – commonly referred to as the mandatory or statutory DPNA. In addition to the authority to terminate a noncompliant SNF's participation in Medicare, the Act grants the Secretary authority to impose other enforcement remedies, including a discretionary DPNA, CMPs, appointment of temporary management, and other remedies such as a directed plan of correction. Act § 1819(h)(2)(B). 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. "*Substantial compliance* means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301 (emphasis in original). A deficiency is a violation of a participation requirement established by sections 1819(b), (c), and (d) of the Act or the Secretary's regulations at 42 C.F.R. Part 483, subpart B.

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[1] All references are to the 2010 version of the Code of Federal Regulations (C.F.R.), which was in effect at the time of the survey, unless otherwise indicated.

[2] Section 1919(h)(2) of the Act gives similar enforcement authority to the states to ensure that NFs comply with their participation requirements established by sections 1919(b), (c), and (d) of the Act.

State survey agencies on behalf of CMS may survey facilities that participate in Medicare to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-.28, 488.300-.335. The regulations specify the enforcement remedies that CMS may impose if a facility is not in substantial compliance with Medicare requirements. 42 C.F.R. § 488.406.

CMS may impose a CMP for the number of days a facility is not in substantial compliance or for each instance of noncompliance. 42 C.F.R. § 488.430(a). 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 a CMP, $3,050 per day to $10,000 per day, is reserved for deficiencies that pose 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). "*Immediate jeopardy* means a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301 (emphasis in original). The lower range of a CMP, $50 per day to $3,000 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). A per instance CMP may range from $1,000 to $10,000, and the range is not affected by the presence of immediate jeopardy. 42 C.F.R. § 488.438(a)(2).

The Act and regulations make a hearing before an administrative law judge (ALJ) available to a long-term care facility against which CMS has determined to impose an enforcement remedy. Act §§ 1128A(c)(2), 1866(h); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *The Residence at Salem Woods*, DAB No. 2052 (2006); *Cal Turner Extended Care*, DAB No. 2030 (2006); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Anesthesiologists Affiliated*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); 42 C.F.R. §§ 488.330(e), 498.3. However, the choice of remedies, or the factors CMS considered when choosing remedies, is not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance that CMS determined, if a successful challenge would affect the range of the CMP that may be imposed or impact the facility's authority to conduct a NATCEP. 42 C.F.R. § 498.3(b)(14), (d)(10)(i). The CMS determination as to the level of noncompliance, including the finding of immediate jeopardy, "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2); *Woodstock Care Ctr.*, DAB No. 1726, at 9, 38 (2000), *aff'd*, 363 F.3d 583 (6th Cir. 2003). 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). ALJ review of a CMP is subject to 42 C.F.R. § 488.438(e).

The standard of proof, or quantum of evidence required, is a preponderance of the evidence. CMS has the burden of coming forward with the evidence and making a *prima facie* showing of a basis for imposition of an enforcement remedy. Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense. *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd*, 129 F. App'x. 181 (6th Cir. 2005); *Batavia Nursing & Convalescent Inn*, DAB No. 1911 (2004); *Emerald Oaks*, DAB No. 1800; *Cross Creek Health Care Ctr.*, DAB No. 1665 (1998); *see Hillman Rehab. Ctr.*, DAB No. 1611 (1997), *aff'd*, No. 98-3789, 1999 WL 34813783 (D.N.J. May 13, 1999).

IV. Findings of Fact, Conclusions of Law, and Discussion

I make two findings of fact and conclusions of law to support this decision. I set them forth below as separate headings in bold type and then discuss each in detail.

1. Petitioner failed to comply substantially with the requirement at 42 C.F.R. § 483.25(h) (Tag F323).

CMS's allegations of noncompliance with 42 C.F.R. § 483.25(h) concern the care provided to Resident 1 (R1). With respect to this citation, the Statement of Deficiencies (SOD) alleges that an unannounced visit was made to Petitioner's facility on June 12, 2009, at 8:40 a.m. to investigate an entity self-reported incident (that is, an incident reported by the facility itself) regarding the suicide of R1. The SOD alleges that, based upon interview and record review, Petitioner failed to provide adequate supervision for R1 to prevent accidents by failing to supervise and monitor R1 for suicide watch at all times from June 1, 2009 through June 11, 2009. CMS Ex. 1, at 1. The SOD alleges further that Petitioner's failure to supervise and monitor R1 for "suicide watch at all times" resulted in R1 going outside of the facility at 12:30 a.m. on June 11, 2009, unaccompanied by staff, where he hanged himself with his belt on the perimeter fence. CMS Ex. 1, at 7. According to the SOD, "[t]hese violations presented either an imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result and was a direct proximate cause of the death of" R1. CMS Ex. 1, at 8.

(a) Facts

R1, a 52-year-old male, had a long history of psychiatric troubles, and on or about April 21, 2009, he attempted suicide by jumping into the path of a moving car. CMS Ex. 8. He was injured badly, and was admitted to Arrowhead Regional Medical Center (Arrowhead) for treatment of his injuries, which included a fractured left leg. CMS Ex. 8. During R1's stay at Arrowhead, on May 8, 2009, an orthopedist requested that R1 be evaluated by a psychiatrist. The orthopedist noted that R1 was "[m]edically cleared for d/c [discharge]" and stated "[p]lease evaluate to remove 5250 hold and recommend where pt can be sent."[3] P. Ex. 126; CMS Ex. 8, at 3. Later that day, R1 received a psychiatric evaluation from Dr. Ndlela. In his consultation note, Dr. Ndlela stated:

> [R1] remains depressed and unable to take care of himself. Remains unpredictable with intermittent thoughts of suicide. He is at risk of harming himself if he were discharged to the community. Pt is currently not suitable or appropriate for BH [behavioral health or mental health facility] due to the level of care he needs.

P. Ex. 126; CMS Ex. 8, at 3. Dr. Ndlela recommended that the resident be sent to a SNF; "cont[inue] [with] current psych meds in the SNF;" and "SW [Social worker] eval for placement." P. Ex. 126; CMS Ex. 8, at 3.

On May 15, 2009, R1 was prescribed Clozaril, an antipsychotic medication used for the treatment of schizophrenia.[4] Tr. 96; P. Ex, 120, at 4.

According to an Arrowhead inpatient progress note dated May 16, 2009, an "ortho student" examined R1, found that he was "doing well/stable," and wrote the following plan: "continue 1:1 sitter, psych meds titration;" "continue non WB [weight-bearing], reinforce this to pt;" "D/C [discharge] planning, placement per CM-SNF eval monday." P. Ex. 125, at 5. The order for "1:1 sitter" appears in inpatient progress notes dated May 17, May 18, May 19, and May 20, 2009. P. Ex. 125, at 1-4.

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[3] A "5250 hold" is an extension, for up to fourteen days, of a "5150 hold," which is the involuntary confinement of a person when a person is deemed to be a danger to others or himself or herself as a result of a mental disorder. The two types of holds refer to Sections 5150 and 5250 of the California Welfare and Institutions Code. See Tr. at 464-67 (testimony on "5150" and "5250" holds from Petitioner's witness, Dr. Woodbury).

[4] The generic name of Clozaril is Clozapine.

On May 22, 2009, Arrowhead's staff discharged R1 to Petitioner's facility. P. Ex. 86, at 1; CMS Ex. 3, at 1. According to Arrowhead's discharge orders, R1 was to continue on Clozapine, among other medications. P. Ex. 117.

The admission documents created by Petitioner's facility state that R1's primary diagnoses were fracture of the left tibia and fibula, diabetes, and hypothyroidism, and his secondary diagnoses were back pain, depressive disorder, schizophrenia, and suicide ideation.[5] P. Ex. 86, at 1; CMS Ex. 3, at 1. R1's physician, Dr. Wilson Gomer, gave orders stating, among other things, that Resident 1 "may have psych, podiatry, vision, dental and auditory consult." P. Ex. 87, at 9.

R1's medication orders on admission included Clozaril, 100 mg. by mouth at 9:00 a.m. and 200 mg. by mouth at 9:00 p.m., to address his history of self harm, suicidal ideation, delusions, and hallucinations related to his schizophrenia. P. Ex. 108, at 1; CMS Ex. 3, at 4. The medication record also reflects orders dated May 22, 2009, to monitor R1 each shift for delusions, hallucinations, and responding to inner stimuli, and the method for charting the frequency of these behaviors was to "tally by hatchmarks."[6] P. Ex. 87, at 6; P. Ex. 108, at 1; CMS Ex. 3, at 4.

In an initial care plan dated May 22, 2009, Petitioner's staff addressed R1's diagnoses of diabetes, his broken left leg and back pain, and hypothyroidism. P. Ex. 94, at 1-2, 5-6.

Petitioner's staff completed a smoking assessment on May 22, 2009. P. Ex. 130; CMS Ex. 3, at 27. According to the assessment, R1 was physically capable of safely conducting the activity of smoking, and did not require supervision while smoking.

On May 30, 2009, Dr. Anthony Shin, Petitioner's staff psychiatrist (Tr. at 482-83), evaluated R1. In his notes, Dr. Shin stated that R1 had a history of schizophrenia. Dr. Shin found R1's mood to be stable, and noted that he was positive for delusions and positive for auditory and visual hallucinations. Dr. Shin scored R1 an 18/30 on a mini-mental status exam, which, according to CMS's expert witness, Dr. Ziv, indicates dementia. P. Ex. 89, at 2; CMS Ex. 3, at 14; Tr. at 290-91. According to the record, this was Dr. Shin's only examination of Resident 1.

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[5] CMS's expert witness, Dr. Ziv, testified that "suicidal ideation refers to somebody's thoughts of killing themselves." Tr. at 285.

[6] Dr. Ziv testified that the order to monitor for delusions, hallucinations, and responding to inner stimuli was "redundant" because "internal stimuli are delusions and hallucinations." Tr. at 290.

On June 1, 2009, Petitioner's staff completed R1's initial Minimum Data Set (MDS) assessment. The MDS indicated that R1 had long-term memory problems, moderately impaired cognitive skills for daily decision-making, was easily distracted, had periods of altered perception or awareness of surroundings, had episodes of disorganized speech, and had mental functioning that varied over the course of the day. P. Ex. 106, at 3; CMS Ex. 3, at 41. In the area of physical functioning, the MDS indicated that R1 needed extensive assistance with walking, and that he needed limited assistance with locomotion off the unit. P. Ex. 106, at 4; CMS Ex. 3, at 42. R1's primary mode of locomotion was his wheelchair, and in addition to wheeling himself, he also used a cane/walker/crutch. P. Ex. 106, at 5; CMS Ex. 3, at 43. The MDS noted that R1 had been receiving an antipsychotic medication for the past seven days. P. Ex. 106, at 7; CMS Ex. 3, at 45.

As a result of the MDS assessment, LVN Teresa Yoder prepared RAP (Resident Assessment Protocol) summaries dated June 1, 2009, that evaluated R1 further in certain problem areas, including cognitive, communication, and psychotherapies. P. Ex. 106, at 11-16; CMS Ex. 3, at 49-54. In the RAP summary for the cognitive area, LVN Yoder wrote, among other things, that R1 "has short attention span, lose [sic] interest easily, & is prone to forget. He needs much assist [with] decision making but cont[inues] to ignore speaker and do what he wants." P. Ex. 106, at 11; CMS Ex. 3, at 49. LVN Yoder stated further that R1 "talks to self and/or imaginary others and his conversation can be rambling & nonsensical a [sic] time. His mental function does tend to vary [at] times, sometimes better and/or worse. He is [at] risk for decline . . . ." P. Ex. 106, at 11; CMS Ex. 3, at 49. In the RAP summary for communication, LVN Yoder noted, among other things, that he "has some difficulty completing his thoughts . . . [h]e does not like to participate in a conversation, does not initiate one . . . what little he does say is nonsensical & rambling." P. Ex. 106, at 12; CMS Ex. 3, at 50. In the RAP summary for psychotherapies, LVN Yoder noted that R1 had diagnoses of depression, schizophrenia, and suicidal ideation. LVN Yoder stated that the resident has a "[history] of responding to inner stimuli by self harm, delusion, hallucinations and suicide attempts in past. Since his admit he has not voiced or shown [signs or symptoms] of delusions, hallucinations, or suicide ideation." P. Ex. 106, at 14-15; CMS Ex. 3, at 52-53. LVN Yoder stated further that "[h]e will remain on suicide watch." P. Ex. 106, at 15; CMS Ex. 3, at 53.

On June 1, 2009, LVN Yoder also wrote care plan interventions for R1 that addressed different problem areas. P. Ex. 94; CMS Ex. 3, at 28-29. Among other things, LVN Yoder wrote "[n]otify MD if his mood or behaviors interfere [with] his functions, safety or medical needs. Suicide watch [at] all times." P. Ex. 94, at 3, 8; CMS Ex. 3, at 28-29. LVN Yoder wrote the phrase "[s]uicide watch [at] all times" in red ink on the care plan. CMS Ex. 3, at 28.

The nurses' weekly progress note dated May 27, 2009, indicates that R1 was on Clozaril, that he had had no episodes of responding to inner stimuli or delusions/hallucinations that week, and that the medication was effective. The note indicates that there was no change in his behavior. P. Ex. 96, at 3. With respect to "suicide ideation," staff did not indicate whether R1 had manifested this behavior or whether the medication was effective, as no boxes were checked. P. Ex. 96, at 3. The nurses' weekly progress note dated June 3, 2009, states that R1 was on Clozaril, he had had no episodes that week of responding to inner stimuli, hallucinations/delusions, or suicidal ideations, and the medication was effective. P. Ex. 96, at 1.

On June 5, 2009, Petitioner's interdisciplinary team consisting of DON Kelly Powell, R.N., LVN Yoder, Anita McGowan, R.D., LVN Cindy Manzano, Social Services Director Molly Kingsley and the Activities Director (full name unknown) held a resident care conference review for R1. P. Ex. 105; Tr. at 90-91. According to the care conference document, they reviewed R1's diagnoses, physician's orders, his MDS/assessments, and his care plan. P. Ex. 105. The document explicitly states at the bottom of the page ("Summary of Conference Discussion") that the resident's care plan and chart were reviewed. P. Ex. 105.

The nursing notes dated June 6, 2009, at 2:30 a.m., indicate that, around the start of the shift — that is, some time around 11:00 p.m. on June 5 — the nurse saw R1 "bouncing up & down on his bed." The nurse called R1's physician, Dr. Gomer, around 1:00 a.m., and Dr. Gomer called back an hour later. The nurse observed that the resident was "still quietly bouncing in a sitting position." Dr. Gomer gave a new order for two mg. of Ativan by mouth, one dose.[7] The nurse administered the Ativan to R1. P. Ex. 95, at 7; P. Ex. 87, at 3; CMS Ex. 3, at 11, 77. A nursing note dated June 6, 2009, at 6 a.m., indicates that the medication was effective and the resident was sleeping. P. Ex. 95, at 7; CMS Ex. 3, at 77. According to an untimed nursing note, sometime during the morning of June 6, R1 was "awake alert . . . much confusion noted." The note states that R1 sat on his bed and bounced non stop for two hours, then got up, went out to smoke and have lunch. After lunch, he called his sister from the nurses' station. R1 "could not hold still," and he stood up and sat down in his wheelchair repeatedly. He went to the nurse's station, asked for his sister's phone number repeatedly, and was given the number. P. Ex. 95, at 6-7; CMS Ex. 3, at 77. The nurse stated that she called Dr. Gomer because R1's anxiety continued to increase. Dr. Gomer gave a new order for two mg. of Ativan every eight hours as needed and told staff to send the resident to the ER if he showed no change in behavior or if he worsened. P. Ex. 95, at 7; P. Ex.

[7] Ativan is a sedative. Tr. at 577. The generic name for Ativan is Lorazepam. Tr. at 591.

87, at 3; CMS Ex. 3, at 11. Around 2 p.m., R1 was given 2 mg. of Ativan "for severe anxiety [manifested by] bouncing & repetitive." P. Ex. 87, at 3; see CMS Ex. 7, at 4, 6. His bouncing continued, and he was sent to St. Bernardine Medical Center (St. Bernardine) via ambulance for evaluation. P. Ex. 95, at 6.

On the "Resident Transfer Record" that accompanied R1 to St. Bernardine, Petitioner's staff indicated that the "Reason for Transfer" was "Altered Mental Status," and described his diagnoses related to transfer as "shaking, repetitive motion & questioning." Under "Baseline Mental Status," Petitioner's staff noted that R1 "can't hold still." In the box "Other Pertinent Information," staff noted that R1 had been given 2 mg. of Ativan at 2 p.m. CMS Ex. 7, at 6.

On St. Bernardine's admission record, the hospital staff wrote that the "patient's description of the reason for admission" is "anxiety." P. Ex. 115.

The St. Bernardine ER triage assessment form notes that R1's triage status is "non urgent" and describes his chief complaint as "Pt agitated per staff (shaking/ - questions)." CMS Ex. 7, at 7. Under "past medical history," the triage nurse noted that R1 had "diabetes," "psych," "htn, [hypertension]," fracture of left leg, and, under "other," she wrote "schizo depression ↓ thyroid suicidal ideations." CMS Ex. 7, at 7. There is a "Suicide Screening" section on the form, which asks whether the patient meets "SAD PERSONS" criteria."[8] If the answer is yes, then the nurse is directed to fill out the "suicide risk tool." The nurse checked "No." CMS Ex. 7, at 8. St. Bernardine did not perform a suicide assessment of R1. A CT head scan was ordered, and the report stated that the resident's "brain is unremarkable without mass lesions or acute hemorrhage." CMS Ex. 7, at 20-21. The ER physician stated in his report that R1 had presented with "repetitive motion & shaking" and noted that he had schizophrenia. CMS Ex. 7, at 9. The physician stated, "[R1] has been lying comfortably in NAD [no acute distress] all ED stay. No tremor, no shaking." (emphasis in original). CMS Ex. 7, at 10. He wrote "agitation resolved," noted R1's condition was improved and stable, prescribed Ativan in the evening, and discharged R1 with an instruction sheet on anxiety and panic attacks. CMS Ex. 7, at 10; see CMS Ex. 7, at 1. R1 was instructed to follow up with his primary physician in two days. CMS Ex. 7, at 1; P. Ex. 114.

A nursing note dated June 7, 2009, at 6:00 a.m., states that R1 had returned to Petitioner's facility from St. Bernardine the previous night — that is, the evening of June 6 — around 11:10 p.m. P. Ex. 95, at 6. According to the nursing note, in

[8] "SAD PERSONS" criteria is a suicide assessment screening tool. At the hearing, Dr. Ziv testified that "SAD PERSONS" is a mnemonic, where each letter in "SAD PERSONS" represents a different risk factor for suicide. Tr. at 299-300.

the morning, the resident was up, propelling himself freely about the facility. The note states that R1 had "0 episodes of mania m/b [manifested by] bouncing or repetitive action" and that staff would continue to monitor. P. Ex. 95, at 6.

Later on June 7, Petitioner's staff completed a short term care plan to address the problem of "mania m/b [manifested by] 'bouncing' & repetitive action." P. Ex. 102, at 1; CMS Ex. 3, at 33. The objective was to have R1's bouncing behavior decrease in ten days. The plan stated the following approaches: monitor and chart R1's behavior for 72 hours, medicate as ordered, encourage him to participate in activities, redirect his focus, and notify his physician of any change in condition or adverse reactions. P. Ex. 102, at 1; CMS Ex. 3, at 33.

Another nursing note written on June 7, 2009, around 11:00 a.m., states that R1 was able to make his needs known, was confused, and tolerated his medications. The note indicates there was a decrease in R1's anxiety and repetitive motions. P. Ex. 95, at 5; CMS Ex. 3, at 78. According to a nursing note written that night around 11:20 p.m., no increased bouncing was noted on the shift, and the resident was sleeping most of the time. P. Ex. 95, at 5; CMS Ex. 3, at 78. On June 8, 2009, around 3:10 a.m., a nurse wrote that there were "0 episodes of ↑Bx [bouncing] this shift." P. Ex. 95 at 5; CMS Ex. 3, at 78. A nursing note later that morning, around 11:00 a.m., states, among other things, that the resident was confused and that a decrease in anxiety was noted. P. Ex. 95, at 5; CMS Ex. 3, at 78.

The Medication Administration Record (MAR) reveals that, on June 7, 2009, R1 exhibited delusions and hallucinations during the 7 a.m. to 3 p.m. shift. The resident also exhibited "responding to inner stimuli" during the 11 p.m. to 7 a.m. and 7 a.m. to 3 p.m. shifts. P. Ex. 108, at 1; Tr. at 97. The MAR shows that R1 also exhibited delusions, hallucinations, and "responding to inner stimuli" on June 8-10, 2009. P. Ex. 108, at 1; Tr. at 97.

According to the nursing notes, on June 9, 2009, R1's sister called the facility and reported to one of the nurses that her brother had called her and told her that he "had homosexual microchips planted in his head, please come save me." P. Ex. 95, at 2. The nurse checked on the resident, and stated in the nursing note that he was "resting comfortably in bed, has not stated any of this to staff when asked about it. He states I'm ok." P. Ex. 95, at 2. The nurse did not report the incident to R1's physician or psychiatrist.

On June 10, 2009, Petitioner's Behavioral Management Team met to discuss Resident 1. On their report, they noted that R1 was on Ativan and Clozaril. Under "Behavioral Problems," the team stated "recent trip to acute [hospital] [secondary to] bizarre behavior, fidgeting." P. Ex. 90. The team planned to have

R1's physician assess him, and noted that he had "0 expressions of suicidal ideation at this time." P. Ex. 90.

That same day, DON Powell spoke to R1's sister and also to Dr. Shin. P. Ex. 95, at 2. Dr. Shin gave a new medication order to increase the morning dosage of Clozaril to 150 mg. P. Ex. 87, at 2; CMS Ex. 3, at 12. DON Powell also noted that the resident requested to have regular meals for two days, and his diet was changed from a vegetarian diet to a regular diet. P. Ex. 95, at 2; P. Ex. 87, at 2; CMS Ex. 3, at 12.

R1's drug record shows that around 8:00 p.m. on June 10, R1 was given 2 mg. of Ativan because he exhibited severe anxiety. P. Ex. 108, at 6. The nursing notes indicate that around 11:20 p.m., R1 was bouncing again and bounced himself out of his wheelchair and crashed to the floor. P. Ex. 95, at 1; P. Ex. 98, at 2; CMS Ex. 3, at 79. He was found between the beds next to his overturned wheelchair. He was not injured. Petitioner's staff called Dr. Gomer around 11:35 p.m. According to the nursing notes, R1 was up and down several times, and he wheeled himself to the nurses' station and asked a nurse for a "light" for his cigarette. P. Ex. 95, at 1; CMS Ex. 3, at 79. The nurse told him she did not have a lighter and that he should be sleeping, not smoking. R1 went back to bed. In an interview with Surveyor Myers, the nurse said that R1 did not usually ask for cigarettes; he usually slept. CMS Ex. 42, at 20. The nurse called Dr. Gomer again around 12:15 a.m, just a few minutes past midnight.

Quite soon after the call to Dr. Gomer, at around 12:30 a.m. in the very early morning of June 11, R1 wheeled himself out the laundry room door, apparently to smoke. He was unaccompanied by staff but was seen by at least two nurses on his way out. CMS Ex. 42, at 20, 23. According to Surveyor Myers, one of the nurses, Dawnetta Jones, CNA, told her that R1 said "hello" to her, and she found this unusual because he never spoke to her and she had seen him go outside at night to smoke only once before. Ms. Jones said that R1 always stayed in bed at night. CMS Ex. 42, at 23.

Around 12:50 a.m., R1 was found hanging by his own belt on the perimeter fence of the parking lot. P. Ex. 95, at 1; P. Ex. 98, at 1; CMS Ex. 3, at 79. Staff performed CPR and called 911. R1 died shortly thereafter at St. Bernardine. P. Ex. 95, at 1, 3; CMS Ex. 3, at 79-80.

(b) Analysis

The general quality of care regulation, 42 C.F.R. § 483.25, requires that a facility ensure that each resident receives the necessary care and services to attain or maintain the resident's highest practicable physical, mental, and psychosocial

well-being, in accordance with the resident's comprehensive assessment and plan of care that the resident's care planning team developed in accordance with 42 C.F.R. § 483.20. The quality of care regulations impose specific obligations upon a facility related to accident hazards and accidents.

> The facility must ensure that—
>
> (1) The resident environment remains as free of accident hazards as is possible; and
>
> (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

42 C.F.R. § 483.25(h). The SOM, as amended in August 2007, instructs surveyors that the intent of 42 C.F.R. § 483.25(h)(1) and (2) is "to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents." The facility is expected to: identify, evaluate, and analyze hazards and risks; implement interventions to reduce hazards and risks; and monitor the effectiveness of interventions and modify them when necessary. SOM, app. PP, Guidance to Surveyors for Long Term Care Facilities, F323, Quality of Care (Rev. 27; eff. Aug. 17, 2007).

The Board has provided interpretative guidance for adjudicating alleged violations of 42 C.F.R. § 483.25(h)(1):

> The standard in section 483.25(h)(1) itself - that a facility "ensure that the environment is as free of accident hazards as possible" in order to meet the quality of care goal in section 483.25 -- places a continuum of affirmative duties on a facility. A facility must determine whether any condition exists in the environment that could endanger a resident's safety. If so, the facility must remove that condition if possible, and, when not possible, it must take action to protect residents from the danger posed by that condition. [Footnote omitted.] **If a facility has identified and planned for a hazard and then failed to follow its own plan, that may be sufficient to show a lack of compliance with [the] regulatory requirement.** In other cases, an ALJ may need to consider the actions the facility took to identify, remove, or protect residents from the hazard. Where a facility alleges (or shows) that it did not know that a hazard existed, the facility cannot prevail if it could have reasonably

> foreseen that an endangering condition existed either generally or for a particular resident or residents.

Maine Veterans' Home – Scarborough, DAB No. 1975, at 6-7 (2005) (emphasis added).

The Board has also explained the requirements of 42 C.F.R. § 483.25(h)(2) in numerous decisions. *Golden Living Ctr. – Riverchase*, DAB No. 2314, at 7-8 (2010); *Eastwood Convalescent Ctr.*, DAB No. 2088 (2007); *Liberty Commons Nursing and Rehab - Alamance*, DAB No. 2070 (2007); *Century Care of Crystal Coast*, DAB No. 2076 (2007), *aff'd*, 281 F. App'x 180 (4th Cir. 2008); *Golden Age Skilled Nursing & Rehab. Ctr.*, DAB No. 2026 (2006); *Estes Nursing Facility Civic Ctr.*, DAB No. 2000 (2005); *Northeastern Ohio Alzheimer's Research Ctr.*, DAB No. 1935 (2004); *Woodstock Care Ctr.*, DAB No. 1726 (2000), *aff'd*, 363 F.3d 583 (6th Cir. 2003). Section 483.25(h)(2) does not make a facility strictly liable for accidents that occur; however, it does require that a facility take all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents. *Woodstock Care Ctr. v. Thompson*, 363 F.3d at 589 ([A] SNF must take "all reasonable precautions against residents' accidents."). A facility is permitted the flexibility to choose the methods of supervision it uses to prevent accidents, but the chosen methods must be adequate under the circumstances. Whether supervision is "adequate" depends in part upon the resident's ability to protect himself or herself from harm. *Id.* Based on the regulation and the cases in this area, CMS meets its burden to show a *prima facie* case if the evidence demonstrates that the facility failed to provide adequate supervision and assistance devices to prevent accidents, given what was reasonably foreseeable. *Alden Town Manor Rehab. & HCC*, DAB No. 2054, at 5-6, 7-12 (2006). An "accident" is an unexpected, unintended event that can cause a resident bodily injury, excluding adverse outcomes associated as a direct consequence of treatment or care (e.g., drug side effects or reactions). SOM, app. PP, Tag F323; *Woodstock Care Ctr.*, DAB No. 1726, at 4.

There is no dispute that R1 was "seriously mentally ill, both before his admission to Petitioner's facility . . . and during his stay." P. Reply at 11. As stated above, R1 suffered from schizophrenia, a psychiatric disorder characterized by delusions and hallucinations. CMS Br. at 1; P. Br. at 11; Tr. 267. As stated above, on April 21, 2009, less than five weeks before his admission to Petitioner's facility, R1 attempted suicide by throwing himself in front of a moving car. A psychiatric evaluation on May 8, 2009, stated that R1 "remain[ed] depressed and unable to take care of himself . . . unpredictable with intermittent thoughts of suicide . . . at risk of harming himself if he were discharged to the community." P. Ex. 126; CMS Ex. 8, at 3. During his hospitalization at Arrowhead, R1 had an order for a

"1:1 sitter," which began at least as early as May 16, 2009, and continued at least through May 20, 2009. When R1 was admitted to Petitioner's facility on May 22, 2009, Petitioner's nurse had a suicide watch in place for R1. Beginning June 5, 2009, R1's psychiatric condition worsened and he became increasingly disturbed, exhibiting physical and emotional agitation, as well as auditory and visual delusions. Six days later, after wheeling himself out of the facility in the middle of the night, unaccompanied by staff, R1 hanged himself.

It is Petitioner's position that CMS has engaged in "retrospective second-guessing," essentially "work[ing] backward from the occurrence of a tragic event to assign blame to Petitioner." P. Reply at 11, 25, 29. Petitioner contends that its staff adequately supervised R1, and that his suicide, while tragic, was not reasonably foreseeable or avoidable. Petitioner argues that its staff responded appropriately to R1's behavioral changes at all times and consulted with his physician. Moreover, Petitioner maintains that its staff was alert for any "red flags" for suicide, and asserts that none of R1's behaviors or statements during the days preceding his death indicated that he was at increased risk of suicide. (P. Br. at 37-38).

Petitioner also repeatedly contends that, had any physician or psychiatrist determined that R1 was worsening and required greater supervision, R1 would have been transferred out of its facility to a psychiatric facility. CMS characterizes this argument as circular reasoning, and I agree with that characterization. Petitioner is essentially arguing that because R1 was not transferred to another facility, R1's condition did not warrant a higher level of supervision. However, as CMS points out, Petitioner's argument assumes that it was adequately supervising R1. CMS Reply at 9. As I discuss below, the evidence does not support Petitioner's claims. Despite the fact that R1 exhibited increasing and more frequent signs of severe destabilization, Petitioner's staff failed to take appropriate measures to supervise him adequately and protect him from foreseeable risks, in violation of 42 C.F.R. § 483.25(h).

At the outset, CMS points to R1's suicide attempt and his schizophrenia as risk factors for suicide that cannot be ignored. Citing the American Psychiatric Association Practice Guidelines: Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors (Published in November 2003) (APA Guidelines), as well as Dr. Ziv's testimony, CMS asserts that "a history of past suicide attempts is one of the most significant risk factors for suicide." CMS Ex. 38, at 104; Tr. at 265-66. CMS notes, additionally, that suicide rates are ten times higher in schizophrenics than in the general population. Tr. at 266-67. CMS notes that the APA Guidelines specifically state that "suicidal ideation and suicide attempts are common among individuals with schizophrenia and need to be identified and addressed in the assessment process." CMS Ex. 38, at 113.

In arguing that R1 required close supervision in light of his psychiatric history, CMS references both the "1:1 sitter" order in place while R1 was hospitalized at Arrowhead, and the "suicide watch" intervention written by LVN Yoder on his care plan when he was admitted to Petitioner's' facility. With respect to the "1:1 sitter" order, CMS alleges that Petitioner's staff failed to include this as a care plan intervention. [9] CMS contends that R1 continued to require a "1:1 sitter" after leaving Arrowhead as a precaution against another suicide attempt, and the omission of this crucial intervention demonstrates a failure by Petitioner to appropriately address his risk of suicide.

CMS alleges further that Petitioner failed to implement and communicate to staff the suicide watch intervention contained in R1's care plan. I have noted above that LVN Yoder wrote the words "suicide watch at all times" in red on R1's care plan. P. Ex. 94, at 3, 8; CMS Ex. 3, at 28-29. In her interview with Surveyor Myers, LVN Yoder stated that she wrote the suicide watch intervention because she had reviewed R1's records from Arrowhead and believed that R1's history of psychiatric issues and a recent suicide attempt warranted heightened monitoring. Tr. 77-78. As testified by Surveyor Myers, no one on Petitioner's staff who provided direct care to R1, with the exception of LVN Yoder, was aware that R1 had an intervention for a suicide watch or that he needed more supervision related to his prior suicide attempt. Tr. at 85; CMS Ex. 42, at 17-18, 21, 24; CMS Br. at 12. Surveyor Myers noted that not even the two staff persons who observed R1 leaving the facility on the night he committed suicide knew that he was on a suicide watch. CMS Ex. 42, at 21, 24.

In addressing the "1:1 sitter" order, Petitioner claims that CMS's interpretation of it is not reasonable. According to Petitioner, Arrowhead's "1:1 sitter" order was an order for one-on-one supervision of R1 to prevent him from ambulating on his broken leg, and was not meant as one-on-one monitoring because of risk for suicide. P. Br. at 18, 45. Petitioner asserts that the fact that Arrowhead's hospital progress notes (dated May 16, May 18, and May 20, 2009) were written by someone in the orthopedics department (the "ortho student" could have been an intern, a resident, or simply a student) shows that the "1:1 sitter" order was unrelated to R1's psychiatric condition. Moreover, Petitioner, citing Dr. Noble's testimony, contends that an orthopedic student is not qualified to order psychiatric interventions. P. Br. at 18; Tr. at 563-64.

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[9] Dr. Ziv testified that "[a]n order for one-to-one sitter means that there is one person assigned to one patient. That means that if I'm a sitter and I'm assigned to you, that my responsibility is to keep you safe and nobody else." Tr. at 277-78.

I cannot find Petitioner's characterization of Arrowhead's "1:1 sitter" order even marginally plausible. I cannot imagine how Arrowhead could have intended to limit the "sitter" order to the simple monitoring of R1 so that he stayed off his broken leg. At the hearing, when asked why a patient would be put on a one-to-one sitter, CMS's expert witness, Dr. Ziv, explained, "Because they are not reliable to keep themselves safe, with a less restrictive setting, meaning with just nursing observation or observation in a milieu." Tr. at 278. Arrowhead's staff knew that R1 had attempted suicide by throwing himself in front of a car and that he remained suicidal. According to the psychiatric consultation, R1 remained depressed and unpredictable with intermittent thoughts of suicide. It is clear that the requirement for a "1:1 sitter" was in response to R1's serious psychiatric issues, and was intended as a measure to keep him safe by minimizing any future suicide risk. To suggest that the "1:1 sitter" order was merely taking "precautions against weight bearing," as Petitioner claims, is, to be blunt, an absurdity.[10]

Petitioner also challenges CMS's understanding of the "suicide watch" intervention in R1's care plan, and attempts to downplay its meaning and significance. Petitioner contends that "the notation did not – and *could not* – mean the same in a nursing facility as it does in an acute psychiatric facility." P. Reply at 6 (emphasis in original). Petitioner asserts that the term "suicide watch" is used only in connection with a patient who is actively suicidal, and, in R1's case, there was "no indication in the record that any sort of intensive monitoring, whether called 'suicide watch,' 'one-to-one,' or anything else, ever actually was necessary based on [R1's] demeanor and behavior during his stay at Petitioner's facility." P. Posthearing Brief at 26. Moreover, citing the testimony of its witness Dr. Woodbury, Petitioner contends that only a physician can order a "suicide watch," and there was no such physician's order for this intervention. Tr. 493-94. Petitioner faults LVN Yoder for writing the "suicide watch" intervention, stating that she used "inartful" language and was "overzealous" since R1 had not shown any signs of being suicidal.[11] P. Br. at 25. According to Petitioner, LVN Yoder's intention in writing the intervention was not for staff to provide one-to-one supervision of R1 at all times, but for staff to be alert to any signs of suicidal ideation. (P. Brief at 46; P. Reply at 24.) To the extent that staff were to be responsive to such signs, Petitioner contends that this was carried out. As further support for its effort to mark the suicide watch intervention as inappropriate, Petitioner noted that CMS's expert witness Dr. Ziv herself testified that she could

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[10] Moreover, CMS notes that an Arrowhead social worker told Surveyor Myers that R1 was placed on this order because of his psychiatric issues. CMS Reply at 12.

[11] LVN Yoder was "counseled" by her supervisors at the facility — at some time after R1's suicide, of course — for writing the suicide watch intervention.

not recall having seen a patient on a "suicide watch" outside of a psychiatric facility. Tr. at 292-93. I shall discuss this point more particularly below.

Contrary to what Petitioner argues, I find that any "problem" with LVN Yoder having made the "suicide watch" notation in R1's care plan is an administratively- or heirarchically-derived "problem," not one of substance. After reviewing R1's records from Arrowhead, LVN Yoder identified R1 to be at risk for suicide, and wrote an intervention that addressed that risk. Regardless of whether her choice of words was "inartful" or precise and fitting, it is evident that LVN Yoder was concerned about R1's safety and wanted to make others aware that he needed close supervision. Had she not written the suicide watch intervention, she would have been derelict in her responsibilities to both R1 and to her professional caregiver colleagues. Even if LVN Yoder had never made such a notation, the circumstances of R1's admission to Petitioner's facility, combined with his increasingly severe symptoms of psychosis (which I describe further below), would have almost certainly required someone else at the facility to make a "suicide watch" notation. If this narrative has a hero, it is LVN Yoder.

CMS notes also that, during a Resident Care Conference Review for R1 on June 5, 2009, Petitioner's interdisciplinary team (DON Powell, LVN Yoder, SSD Kingsley, and LVN Manzano) reviewed documents, including R1's care plan, and left LVN Yoder's "suicide watch" intervention in place on the care plan, as written in red ink. Had there been any questions about the appropriateness of the wording, one would expect that the team would have addressed them. Since no changes were made, I cannot avoid the obvious conclusion that Petitioner's interdisciplinary team intended for this intervention to remain in effect as written in that red ink. Petitioner counters this by suggesting that "[a] more reasonable inference" is that the interdisciplinary team was more focused on R1's actual condition and behavior, than on the wording of the intervention. P. Reply at 24. According to Petitioner, because its team found that R1 was not exhibiting suicidal ideations or behavior, there was no need to change the care plan to reflect more intensive monitoring or to consider a transfer of R1 to a psychiatric facility. P. Reply at 24. I do not find Petitioner's explanation persuasive. It was incumbent upon the interdisciplinary team to review the care plan interventions as written, in conjunction with examining R1's condition and behavior. If Petitioner's team believed the suicide watch wording was unnecessary or inappropriate, it would have modified it, not ignored it. Because the intervention was left in place on R1's care plan, the "more reasonable inference" is that it was meant to be implemented by staff.

Although Petitioner acknowledges that R1 experienced "several changes of condition" beginning on June 6, it asserts that "none [were] related to suicidality." P. Brief at 27. Instead, Petitioner takes the position that many of R1's symptoms

were "typical manifestations of schizophrenia" (P. Reply at 20) and maintains that it provided interventions and supervision appropriate for R1's condition. Petitioner notes that its staff consulted with Dr. Gomer regarding R1's bouncing behavior, that Dr. Gomer sent R1 to St. Bernardine for evaluation, and that upon R1's return to the facility from the hospital, its staff completed a short term care plan on June 7, 2009, to address the "problem" of "mania [manifested by] 'bouncing' & repetitive action." P. Ex. 102, at 1. Petitioner asserts further that its staff monitored and charted R1's behavior for 72 hours, as directed by the care plan (P. Ex. 102, at 1), and documented that R1 "exhibited no more instances of mania or anxiety during that time." P. Br. at 28. In Petitioner's view, the series of events documented from June 6 up until the time of R1's suicide did not raise any red flags that R1 was suicidal or a danger to himself or others. P. Br. at 3, 43. According to Petitioner, at no time did anyone suggest "that more intensive supervision was necessary." P. Br. at 43.

Contrary to Petitioner's claim that R1's behavioral changes did not present any "red flags," there can be little question that beginning June 5, 2009, R1 exhibited signs indicating that he was severely destabilizing and headed for a crisis down a road marked with every imaginable warning sign. Those signs included a history of a recent and particularly-violent attempt at self-destruction, increasingly-erratic speech and behavior, a mounting state of physical agitation, and the onset of bizarre hallucinations. Over the course of several days, the nursing notes and medication records show all of these indicators of increased aggravation in R1's disturbed state. Yet, despite R1's behavioral changes and worsening condition, Petitioner's staff failed to take action and provide him with adequate supervision to keep him safe, with predictably-tragic consequences.

Around 11:00 p.m., on June 5, 2009, a nurse observed R1 "bouncing up & down" on his bed. R1 was "still quietly bouncing" at 2:00 a.m., when Dr. Gomer returned the nurse's telephone call and gave an order of two mg. of Ativan. P. Ex. 95, at 7. During the morning of June 6, 2009, R1 was described as confused and again showed agitation. According to the nursing note, R1 sat on his bed and again bounced nonstop for two hours, then got up, went out to smoke and have lunch. After lunch, he called his sister from the nurses' station. The nursing note states that R1 "could not hold still" and he stood up and sat down in his wheelchair repeatedly. P. Ex. 95, at 7; CMS Ex. 3, at 77. Because Resident 1's anxiety continued to increase, the nurse called Dr. Gomer, who gave a new order for two mg. of Ativan every eight hours as needed and to send the resident to the ER if he showed no change in behavior or if he worsened. P. Ex. 95, at 7; P. Ex. 87, at 3; CMS Ex. 3, at 11. Around 2 p.m., R1 was given 2 mg. of Ativan "for severe anxiety [manifested by] bouncing & repetitive." P. Ex. 87, at 3; see CMS Ex. 7, at 4, 6. His bouncing continued, and he was sent to the ER at St. Bernardine to be evaluated. P. Ex. 95, at 6.

In discussing the transfer of R1 to St. Bernardine, CMS argues that Petitioner failed to inform St. Bernardine of R1's complete psychiatric history, including his recent suicide attempt, and as a result, St. Bernardine's staff was unable to assess R1 adequately. Petitioner disputes this and asserts that its staff provided St. Bernardine with background information regarding R1's psychiatric history and that R1 received "a very thorough workup, including a CT scan" of his brain. P. Br. at 27. According to Petitioner, the nurse completing the admission assessment found no reason to do a suicide screening. P. Br. at 27. Moreover, Petitioner notes that the emergency department physician ultimately diagnosed a panic or anxiety attack and sent R1 back to Petitioner's facility the same day.

I find it reasonable to infer, based on the record, that Petitioner's staff failed to give a complete picture of R1's mental illness to St. Bernardine's medical personnel when he was transferred. Notwithstanding Petitioner's assertions, there is no evidence that anyone from the facility informed the hospital of R1's recent suicide attempt. On Petitioner's Resident Transfer Record, which accompanied R1 to St. Bernardine, Petitioner's staff indicated that the "Reason for Transfer" was "Altered Mental Status," described his diagnoses related to transfer as "shaking, repetitive motion & questioning" and noted his baseline mental status as "can't hold still." CMS Ex. 7, at 6. In the box "Other Pertinent Information," staff noted that R1 had been given 2 mg. of Ativan at 2 p.m. CMS Ex. 7, at 6. Nowhere on Petitioner's Resident Transfer Record does Petitioner's staff mention R1's recent suicide attempt.

The fact that R1 did not receive a suicide screening also strongly suggests that St. Bernardine did not receive all pertinent information about R1's psychiatric condition from Petitioner's staff. CMS, citing the testimony of Dr. Ziv, points out that, on St. Bernardine's suicide screening tool known as "SAD PERSONS" criteria, R1 met at least six criteria.[12] Specifically, R1 had had a previous suicide attempt, was psychotic, had no spouse or social supports, had medical illnesses, and suffered from depression. Tr. at 299-300. Dr. Ziv testified that when a person scores "at least six," that score represents a level of risk that warrants a suicide screening. Tr. at 299-300. Clearly, had St. Bernardine's medical personnel been informed of R1's recent suicide attempt, they would have assessed R1 using the SAD PERSONS criteria, which would have resulted in a suicide screening.

[12] According to Dr. Ziv, "SAD PERSONS" is a mnemonic device where each letter represents a risk factor for suicide. A point is assigned for each risk factor that a person meets. Tr. at 299.

It is also questionable whether the ER physician even knew about R1's suicide attempt. On his report, the physician wrote that R1 had presented with "repetitive motion & shaking" and noted that he had schizophrenia. CMS Ex. 7, at 9. He wrote "agitation resolved" (CMS Ex. 7, at 10), noted R1's condition was improved and stable, prescribed Ativan and discharged R1 with an instruction sheet on anxiety and panic attacks. The ER physician makes no mention about R1's recent suicide attempt, which suggests that he was unaware of it.

Further, I find no substance in Petitioner's assertion that R1's CT head scan is proof that St. Bernardine received R1's complete psychiatric history from Petitioner's staff.[13] R1's CT scan was performed to rule out certain neurological diagnoses and does not in any way demonstrate that St. Bernardine's staff was told of R1's recent suicide attempt or had a complete picture of his mental illness. In fact, when asked why a CT scan would have been performed on R1, both of Petitioner's expert witnesses, Dr. Noble and Dr. Woodbury, testified along similar lines. Dr. Noble testified that "certain tumors or conditions inside the brain can have an effect on behavior," and stated that a CT scan would be a way "to make sure that he hadn't fallen, struck his head, for example, a blood clot on it that was causing him to be agitated." Tr. at 578. According to Dr. Woodbury, the purpose of the CT scan would have been "[t]o determine if there was any anatomical abnormality, brain tumor, stroke, for the agitation that he had had at the nursing facility." Tr. at 508.

The record shows that after R1 returned to Petitioner's facility from St. Bernardine, he continued to show signs of severe emotional and physical agitation until his suicide. As documented in the medication record, from June 7 through 10, R1 manifested delusions, hallucinations, and "responded to inner stimuli." P. Ex. 108, at 1; CMS Ex. 3, at 63. On June 9, R1 called his sister and told her that he "had homosexual microchips planted in his head, please come save me." P. Ex. 95, at 2. When the nurse checked on R1 after being informed of this delusion by the sister, R1 said he was "ok." P. Ex. 95, at 2. The nurse did not report this incident to R1's physician or psychiatrist.

On June 10, 2009, Petitioner's Behavioral Management Team had a meeting to discuss R1. P. Ex. 90. That same day, Dr. Shin gave a new medication order to

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[13] On R1's CT scan report, the radiologist listed "Anxiety" under "Clinical data" and also stated "Indication: fall," which suggests that "anxiety" was being used to describe R1 clinically and that there was a chance he may have fallen. CMS Ex. 7, at 20. There is nothing in the report to suggest that the radiologist had any information about R1's recent suicide attempt.

increase the morning dosage of Clozaril to 150 mg. P. Ex. 87, at 2; CMS Ex. 3, at 12.

As I have noted above, events began moving swiftly toward their conclusion at the facility's fence. Around 8:00 p.m. on June 10, R1's narcotic record shows that he exhibited severe anxiety and was given 2 mg. of Ativan. P. Ex. 108, at 6. Later, at around 11:20 p.m., R1 was bouncing in his wheelchair and evidently became so agitated that, in spite of the multiple healing fractures of his left leg, he bounced himself out of his wheelchair and crashed to the floor. Despite the late hour, R1 did not go to sleep, but was up and down several times, and wheeled himself to the nurses' station and asked a nurse for a "light" for his cigarette. P. Ex. 95, at 1; CMS Ex. 3, at 79. The nurse told him she did not have a lighter and that he should be sleeping, not smoking. R1 went back to bed. Around 12:30 a.m. on the morning of June 11, R1 wheeled himself out the laundry room door, apparently to smoke. He was unaccompanied by staff and observed by at least two nurses on his way out. CMS Ex. 42, at 20, 23. Shortly thereafter, R1 hanged himself from the perimeter fence of the parking lot with a belt around his neck. P. Ex. 95, at 1; P. Ex. 98, at 1; CMS Ex. 3, at 79.

As support for its arguments that R1's mental state severely destabilized and that he required close supervision , CMS offered the testimony of its expert witness, Dr. Barbara Ziv, who is Board-certified in psychiatry and neurology. Tr. at 255-56. Dr. Ziv testified that R1 "had multiple risk factors for suicide." Dr. Ziv testified:

> The most robust risk factor is his recent serious suicide attempt. Other risk factors include his sex, the fact that he has a diagnosis of schizophrenia, the diagnosis of depression, poor social supports and . . . low socio-economic status was also associated with suicide risk.

Tr. at 265.

Dr. Ziv emphasized that "[t]he number one risk factor for a suicide attempt is the history of a suicide attempt" and that "anyone who has a serious suicide attempt . . . needs to be viewed . . . with great caution, in terms of their . . . evaluating them and following them from a psychiatric perspective." Tr. at 266. According to Dr. Ziv, suicide rates are higher in people with schizophrenia than in the general population, and estimated that the percentage is 10 times higher in the schizophrenic population. Tr. at 265, 266-67. Dr. Ziv testified that she strongly disagreed with Petitioner's Administrator's characterization that R1's suicide attempt "was in the past" and "not pertinent to . . . his residency" at Petitioner's facility. Tr. at 331; see Tr. at 87.

Dr. Ziv testified that when R1 was evaluated by the facility's staff psychiatrist, Dr. Shin, on May 30, he was described as having delusions and hallucinations, which indicated that R1 "was still actively psychotic at that time." Tr. at 289-90.[14] Dr. Ziv noted that Dr. Shin did not address whether R1 was suicidal or homicidal in his consultation note. Tr. at 330. Dr. Ziv also pointed out that Dr. Shin reported that R1's mini-mental status was 18 out of 30, which indicated dementia. Tr. at 291. When asked whether R1 was someone whom she expected would have expressed suicidal ideations, Dr. Ziv testified that R1 was "someone you would expect to demonstrate behaviorally, that he was getting worse and in fact, the records support that." Tr. at 289. According to Dr. Ziv, R1 was "not likely to be reliable" when asked whether he had suicidal thoughts. Tr. at 291. However, even given his unreliability, Dr. Ziv testified that she found no evidence in the record that Petitioner's staff ever asked him about suicidal ideations. Tr. at 291-92.

Dr. Ziv testified that R1 exhibited behavioral changes that indicated that he was destabilizing. According to Dr. Ziv, beginning at least on June 6, the date of R1's transfer to St. Bernardine's ER for his bouncing behavior, R1 "became increasingly unstable from a psychiatric point of view." Tr. at 294. She testified that R1's decreased sleeping from June 6 until his suicide was also a sign that he was destabilizing. Tr. at 295. Dr. Ziv testified that R1's "bouncing" behavior was what is known as "motor restlessness" or "psycho-motor agitation" and can be evidence of a "psychosis," "agitation," "anxiety" or "pain." Tr. at 294, 300. Dr. Ziv expressed her opinion that the emergence of this agitation warranted a psychiatric evaluation because it indicated that R1's symptoms were worsening and that he was not stable. Tr. at 300-01. Moreover, Dr. Ziv noted that, on the short term care plan developed after R1 returned to the facility from St. Bernardine's ER, Petitioner's staff described R1's problem as "mania." Tr. at 301. Dr. Ziv testified that "mania" is a psychiatric diagnosis, and the use of the term on the care plan was incorrect and made "no clinical sense" because R1 had not been documented as exhibiting manic behavior and had not been given such a diagnosis. Tr. at 301, 343-44.

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[14] Dr. Ziv testified that R1 was evaluated by the psychiatrist eight days after he was admitted to Petitioner's facility. In Dr. Ziv's opinion, this was an "unduly long period of time, given the fact that the patient's admission to the medical hospital was secondary to a suicide attempt" and that R1 "should have been evaluated by a psychiatrist from [Petitioner], either on the day of admission or prior to admission." Tr. at 313.

In testifying about R1's delusion of having a homosexual microchip implanted in his brain, Dr. Ziv characterized this as "evidence of a troubling delusion," noting that he had cried out for his sister to save him. Tr. at 295-96. On cross-examination, Dr. Ziv noted that Petitioner's DON had a communication with the psychiatrist after this incident, and the psychiatrist gave a telephone order to increase the dosage of Clozaril. Tr. at 353. When asked why a psychiatrist would have increased the dosage under those circumstances, Dr. Ziv response was that R1 was "increasingly psychotic." Tr. at 354. In Dr. Ziv's opinion, after learning about R1's delusion, Petitioner's staff had an obligation to speak with R1's physician and request that he examine R1 in person and not simply give an order over the telephone. Tr. at 357.

Dr. Ziv testified further that the presence or emergence of delusions or hallucinations were warning signs in the case of R1. Tr. at 302. Stressing the need to be aware of R1's "whole picture," Dr. Ziv testified:

> [R1] has a history of a serious suicide attempt. He has psychotic symptoms. He was not -- he was independent of a one-to-one sitter, before he came [to Petitioner's facility], and now, you know, less -- you know, about two weeks into it, he is becoming worse, from a psychiatric perspective. He is demonstrating a worsening of all of his psychotic symptoms, and you referred to the American Psychiatric Association. The treatment guidelines for hospitalization for psychiatric illness include the presence of psychosis or an exacerbation of psychotic symptoms in somebody who has a recent suicide attempt.

Tr. at 302-03; see Tr. at 332. In Dr. Ziv's opinion, R1 "demonstrated severe psychiatric disturbances" and worsened to the point that Petitioner's staff should have transferred him to a psychiatric facility so he could have received adequate treatment. Tr. at 306-07. On cross-examination, Dr. Ziv testified that she believed that R1's documented behaviors, including his microchip delusion, agitation, and his history, were "serious enough" that nursing staff should have said to the physician, medical director or the nursing home administrator, "[t]his patient needs a face-to-face evaluation." Tr. at 358.

With respect to the "suicide watch" wording on R1's care plan, Dr. Ziv testified on cross-examination that because "[s]uicide is a behavior that's associated with psychiatric illness," she believed that it was "inappropriate for a nursing home to put somebody on a suicide watch." Tr. at 359-60. Dr. Ziv testified that if a resident really needs a suicide watch, the resident should not be in a skilled nursing facility. Tr. at 361. On re-direct examination, Dr. Ziv stated that a suicide watch intervention would not be necessary for someone who had a remote history

of a suicide attempt and no current psychiatric symptoms. Dr. Ziv noted, however, that she did not agree with the characterization, attributed to the DON, of the suicide watch intervention being "unnecessary" for R1. Dr. Ziv testified that she believed the suicide watch "was necessary and inappropriate in this nursing home." Tr. at 363.

To rebut CMS's arguments, Petitioner offered the testimony of its expert witness Dr. Randolph Noble, who is Board-certified in internal medicine, pulmonary medicine, psychiatry, and in the past was also Board-certified in hyperbaric medicine. Tr. at 547. Dr. Noble testified that a previous suicide attempt is one of the major risk factors for suicide. Tr. at 596. He stated that there was "about a 10 percent risk of completed suicide with schizophrenia." Tr. at 551, 567, 596.

Dr. Noble testified that the fact that R1 may have been exhibiting delusions, agitation, or hallucinations did not indicate that R1 was actively suicidal. Tr. at 566-67. He testified that there is no correlation between agitation, such as R1's bouncing behavior, and the risk of suicide. Tr. at 554, 567. Dr. Noble opined that the exact cause of R1's bouncing behavior was unknown, but possible causes could have been an anxiety manifestation in the form of a panic attack, pain, delusion, or a drug side effect. Tr. at 554-55. When asked about the delusion R1 described to his sister in which he believed that a homosexual microchip had been implanted in his brain, Dr. Noble testified that the delusion was "very bizarre" and "very typical" of patients with paranoid schizophrenia. Tr. at 582; see Tr. at 549. In Dr. Noble's opinion, R1's delusion was not a sign that he was decompensating or becoming significantly worse because the type of delusion he had was "very common, and he expressed it to a family member, and this is not a harbinger of suicide, imminent suicidality." Tr. at 583. According to Dr. Noble, "[t]hese people live with those delusions" and "don't act out, in a suicidal fashion." Tr. at 567.

Dr. Noble expressed the opinion that, from June 7 through 10, there was no evidence that R1 had expressed any suicidal ideations or was agitated. Tr. at 584. According to Dr. Noble, R1's problems did not present any red flags, and Petitioner's staff had no reason to implement one-to-one supervision of R1 or enhanced monitoring of any sort. Tr. at 584-85.

As further support for its contention that R1's psychiatric condition did not present any red flags, Petitioner also offered the expert testimony of Dr. Thomas Woodbury, Petitioner's Medical Director.[15] Dr. Woodbury is Board certified in

[15] Dr. Woodbury testified that he is currently the medical director at eight or nine nursing facilities. Tr. at 461.

family practice, hospice and palliative care, and has a "qualification in geriatrics." Tr. at 461.

Dr. Woodbury testified that his role as Petitioner's Medical Director is "more of an oversight role" and that he no longer attends to patients at Petitioner's facility. Tr. at 462. Dr. Woodbury testified that he had not given any orders for R1 and that he "may have seen [R1] in years passed, but not at this time." Tr. at 463.

Dr. Woodbury testified that he does not "personally treat schizophrenia directly" and does not consider himself qualified to deal with someone with uncontrolled schizophrenia. Tr. at 521. Dr. Woodbury stated that he has a psychiatrist on any case involving a schizophrenic patient. Tr. at 521. According to Dr. Woodbury, Dr. Shin is Petitioner's staff psychiatrist, and in that role, Dr. Shin oversees the behavior management team. Tr. at 481-83.

Dr. Woodbury stated that there was nothing in the record from which to infer that R1 continued to be a danger to himself or others, after his psychiatric evaluation at Arrowhead on May 8. Tr. at 477. Moreover, he opined that nothing in the record shows that R1 was not appropriately supervised by Petitioner's staff. Tr. at 516. According to Dr. Woodbury, he saw no red flags in R1's record that made him concerned that R1 was exhibiting behaviors that could have been indicative of a potential suicide attempt. Tr. at 498, 499. Dr. Woodbury testified that R1's mania, rapid talking, and agitation were "red flags for uncontrolled schizophrenia." Tr. at 499. He opined that, "[a]sking to go out to smoke, having agitation is a very common problem in nursing facilities, in general." Tr. at 499.

I cannot find that Dr. Woodbury's opinions are entitled to be given any weight in the factual context of this case. Dr. Woodbury is not a psychiatrist. He gave no treatment orders for R1. By his own admission, he had not even seen R1 for many years. Dr. Woodbury was simply not qualified to provide credible testimony on R1's psychiatric condition. While he stated that there was nothing in the record from which to infer that R1 continued to be a danger to himself or others, and that he saw no red flags in R1's record that caused him to have concern that R1 was exhibiting behaviors that could have been indicative of a potential suicide attempt, his opinions were clearly based on speculation.

Petitioner also offered the expert testimony of Gary Hoyes, a health care services consultant. Tr. at 373-81. The thrust of Mr. Hoyes's testimony focused on the distinctions in admissions and discharge criteria of skilled nursing facilities and psychiatric facilities, the limitations of skilled nursing facilities in their ability to care for patients with serious psychiatric problems, and the appropriateness of R1's admission to Petitioner's facility.

I find that Mr. Hoyes' testimony has no bearing on the issues in this case. Mr. Hoyes has no medical background. He has never served as a permanent nursing home administrator, and he has served as an "interim nursing home administrator" twice, once for six months, and another time for a year. Tr. at 456-57. While he gave mostly hypothetical opinions, Mr. Hoyes has little practical experience in the areas about which he testified. For these reasons, I find that Mr. Hoyes' testimony is not entitled to be given any substantial weight.[16]

In evaluating the expert testimony offered by Dr. Noble and Dr. Ziv, I find that the opinions of Dr. Ziv are entitled to more weight when considered as a whole in light of other evidence in the record. Dr. Ziv's credible expert opinion is that R1 exhibited obvious signs that his mental health was deteriorating and that Petitioner's staff failed to take appropriate action. Her testimony indicates that despite Petitioner's claims that its staff could not have anticipated R1's suicide, his obvious and florid mental health problems were nevertheless serious enough to warrant further vigilance in his supervision. I am not persuaded by Dr. Noble's testimony that R1's problems presented no warnings of problems that would have required enhanced supervision or monitoring.

As discussed above, Dr. Ziv testified that R1's bouncing behavior for hours at a time, his lack of sleep, and his troubling "microchip" delusion were clear indications that R1 was further destabilizing. I note that, on cross-examination, even Dr. Noble admitted that if someone with schizophrenia exhibits hallucinations and delusions, he would be considered "actively psychotic." Tr. at 596. In Dr. Ziv's opinion, R1 exhibited behavioral signs of an increasingly disturbed mental state, which should have prompted Petitioner's staff to seek further psychiatric evaluation of R1. I find Dr. Ziv's opinion is consistent with the APA Guidelines. The APA Guidelines state:

> When treating individuals in long-term care facilities, the psychiatrist should be mindful of the need for follow-up assessments, even when initial evaluation does not show evidence of depression or increased risk for suicide or other self-injurious behaviors. To facilitate early intervention, safety and suicide risk should be reassessed with significant changes in behavior, psychiatric symptoms, medical status, and/or level of functional disability.

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[16] Although Mr. Hoyes testified on cross-examination that he had reviewed the exhibits in this case, it appeared that he was unfamiliar with the facts, for he testified on cross-examination that he did not see anything in the record that verified that the basis for R1's accident was a suicide attempt. Mr. Hoyes said that he had heard anecdotally that R1 had had an industrial accident. Tr. at 455-56.

CMS Ex. 38, at 124. I accept as credible and persuasive Dr. Ziv's expert opinion that, in the case of R1, his behavioral changes were serious and required follow-up psychiatric care, i.e. a "face-to-face evaluation." Tr. at 358.

Moreover, I find Dr. Ziv's testimony that R1's anxiety and agitation, as manifested by his bouncing behavior, were signs that his mental state was deteriorating and should have been viewed as more than symptoms associated with his baseline schizophrenia, consistent with the APA Guidelines and therefore credible. Dr. Ziv testified that R1's bouncing behavior, which began on June 6, indicated that R1 was becoming "increasingly unstable from a psychiatric point of view." I agree with CMS that Dr. Noble's opinion that there is no relation between agitation, as manifested by R1's bouncing behavior, and the risk of suicide, is contradicted by the APA Guidelines. As CMS points out, the APA Guidelines state:

> Anxiety appears to increase the risk for suicide . . . Specifically implicated has been severe psychic anxiety consisting of subjective feelings of fearfulness or apprehension, whether or not the feelings are focused on specific concerns. Clinical observation suggests that anxious patients may be more inclined to act on suicidal impulses than individuals whose depressive symptoms include psychomotor slowing. . . . In an inpatient sample, severe anxiety, agitation, or both were found in four-fifths of patients in the week preceding suicide.

CMS Ex. 38, at 116.

Petitioner argues that CMS has given an "incomplete" quote from the APA Guidelines, which is "at best misleading." P. Reply at 21. According to Petitioner, in an earlier section of the Guidelines, titled "Anxiety disorders," the APA states that there is "very little research" that shows a link between anxiety disorders and suicide. Petitioner states that the APA "reported that anxiety disorders may increase the rate of suicide in patients suffering from major depression, but the link to increased suicide rates is 'less clear' with other diagnoses." P. Reply at 21. Petitioner notes that where there is an increased risk of suicide, the APA stated that it may be associated with the comorbid diagnosis itself, and not the anxiety disorder. P. Reply at 21. Petitioner thus asserts that Dr. Noble is correct that R1's anxiety in the days preceding his suicide did not necessarily indicate an "increased risk beyond that associated with his baseline schizophrenia" or necessitate "increased suicide precautions." P. Reply at 21.

I find no merit in Petitioner's claims that the APA Guidelines excerpt quoted by CMS is "misleading" or ambiguous, or has limited value or meaning. CMS Ex. 38, at 116-17. In fact, at the end of the "Anxiety disorders" section of the APA

Guidelines relied upon by Petitioner, the APA states the following: "Nonetheless, suicide risk may be diminished by identifying masked anxiety symptoms and anxiety disorders that are misdiagnosed as medical illness as well as by explicitly assessing and treating comorbid psychiatric diagnoses in individuals with anxiety disorders." CMS Ex. 38, at 113. There can be little doubt that, according to the APA, there exists a correlation between anxiety/anxiety disorders and suicide risk.

Moreover, I find Dr. Noble's testimony that it was "appropriate" for Petitioner's staff to let R1 go outside to smoke in the middle of the night to be disingenuous. Dr. Noble testified that, based on R1's mental state, his past behavior at Petitioner's facility, and the fact that he had not expressed any intention to harm himself, there was no need to supervise R1 and no reason to be concerned. Tr. at 588. Dr. Noble appeared to contradict himself later, for, on cross-examination, he acknowledged that if someone with schizophrenia experiences hallucinations and delusions, "it would be fair to say" the person is "actively psychotic." Tr. at 596. Thus, based on Dr. Noble's own testimony, R1 would be considered "actively psychotic," for, in addition to his severe bouncing behavior, R1 also had delusions and hallucinations from June 7-10, 2009. P. Ex. 108, at 1; Tr. at 97. The most serious of these delusions occurred on June 9, 2009, when R1 called his sister and told her about his microchip delusion. Although Dr. Noble opined that R1's delusion was "very typical" of patients with paranoid schizophrenia and not a sign that R1 was decompensating, R1's psychiatrist, apparently after learning about R1's delusion from DON Powell the next day, ordered that R1's morning dosage of Clozaril be increased. Clearly, R1's psychotic symptoms were not under control. In testifying that there was no cause for concern when R1 went outside to smoke, Dr. Noble chose to ignore the fact that, a little over an hour before going outside, R1 had been bouncing so violently that he fell out of his wheelchair and collapsed, shattered leg and all, to the ground. R1 was an actively psychotic schizophrenic whose mental state had obviously worsened, and for Dr. Noble to opine that R1 required no supervision when he left the facility after midnight is not consistent with any reasonable standard of concern for R1's safety.

With respect to CMS's reliance on Dr. Ziv's testimony, Petitioner asserts that CMS has substituted Dr. Ziv's after-the-fact opinions for the contemporaneous judgments and first-hand assessments made by Petitioner's physicians and staff. P. Reply at 18-19. Petitioner notes that Dr. Ziv neither saw nor assessed R1, and drew inferences and conclusions from "only portions of the paper record." P. Reply at 9. Moreover, Petitioner asserts that Dr. Ziv disregards the fundamental distinctions between nursing facilities and psychiatric facilities.

Petitioner's arguments are unavailing. Dr. Ziv's expert opinions regarding R1 were based on careful review of the records, reflected her extensive experience with psychiatric patients, and were consistent with the APA Guidelines. Given

that none of Petitioner's witnesses who testified at the hearing had seen or assessed R1, the fact that Dr. Ziv did not personally examine R1 has little significance. Petitioner claims that Dr. Ziv reviewed only part of the record and thus had an incomplete picture of R1; however, she reviewed the same documents as Petitioner's witnesses, and I do not find that her testimony was credibly rebutted or refuted. I further find that whatever distinctions exist between nursing facilities and psychiatric facilities are irrelevant to my examination of the issues of this case.

The record and Dr. Ziv's credible testimony establish that, given R1's increasingly-severe decompensation, it was imperative that Petitioner's staff take necessary precautions to protect him from foreseeable accident hazards and to adequately supervise and monitor him. With the single exception of LVN Yoder, however, Petitioner's staff saw no urgency in the worsening of R1's psychiatric symptoms and failed to take appropriate action. Petitioner's failure to supervise and monitor R1 is nowhere more evident than on the night R1 left the facility, unaccompanied by staff, determined to end a night of increasing agitation and discomfort by ending his own life.

Petitioner inexplicably contends that R1's leaving the facility was a harmless event instead of recognizing the situation for what it plainly was -- an elopement. According to Petitioner, R1 wheeled himself out to have a smoke, and did not require any supervision since he had been assessed as a "safe smoker." Petitioner contends that there was nothing unusual about this and even asks what further actions should have been taken: "At most, CMS asserts that it was unusual for Resident #1 to be awake and wanting to smoke in the early morning hours, and that instead of simply noting the fact, the nurse on duty should have . . . done what?" P. Reply at 25.

Petitioner contends that R1's death was neither "foreseeable" *at that moment* nor "avoidable" by any reasonable intervention *at that time.* P. Br. at 38 (emphasis in original). According to Petitioner, its staff could not have been expected to anticipate the precise circumstances that led to R1's committing suicide. In its posthearing reply brief, Petitioner states, "In retrospect, it is obvious that had the nurse accompanied the Resident while he smoked, then perhaps he might not have responded to what must have been a sudden overwhelming impulse (or at least not then, or by hanging himself from the fence). But even in retrospect, it is hard to see how the nurse should have foreseen that specific risk, or the necessity to intervene immediately to prevent it." P. Reply at 25.

I find that Petitioner's attempt to portray R1's elopement as unremarkable demonstrates an extraordinary indifference to its duty to supervise and keep R1 safe from accidents. There can be no question that when R1 wheeled himself out

of the facility in the middle of the night, unaccompanied and unsupervised — and after the bizarre and disturbing features of his conduct and condition in the hours immediately preceding his elopement — the risks to him were obvious and foreseeable. I can conceive of no justification for Petitioner's allowing an actively psychotic schizophrenic with impaired decision-making abilities to wheel himself out of its facility unattended, after midnight, while in an obvious state of acute physical and emotional distress.

As discussed above, the duty of care owed by Petitioner to its residents under 42 C.F.R. § 483.25(h)(2) is not one of strict liability. However, Petitioner is required to provide *adequate* supervision and assistance devices to prevent accidents. *Crestview Manor*, DAB CR1350 (2005); *Windsor Health Care Ctr.*, DAB No. 1902, at 5 (2003). It is evident here that Petitioner failed to provide adequate supervision to R1; in fact, it provided no supervision at all.

While Petitioner's staff might not have been expected to foresee the tragic event that occurred, it could reasonably be expected to foresee that R1 was at risk of suffering harm or other injuries if not adequately supervised. *Batavia Nursing and Convalescent Ctr.*, DAB No. 1905, at 45 (2004). The Board defined the concept of "foreseeability" in the context of 42 C.F.R. § 483.25(h)(2) as follows:

> The Board has held that assessing foreseeability, simply requires looking at the "circumstances that were apparent or should have been apparent to the facility and then *evaluat[ing] whether those circumstances – which can often be unique* — were such that the facility could reasonably have anticipated the possibility of harm to the resident." *Lutheran Home at Trinity Oaks*, DAB No. 2111, at 17 (2007).

Briarwood Nursing Ctr., DAB No. 2115, at 13, n.9 (emphasis added) (2007). In *Josephine Sunset Home*, DAB No. 1908 (2004), the Board stated:

> The regulation speaks in terms of ensuring that what is "practicable" and "possible" to do is done. What is thus required of facilities is not prescience but reason and professional judgment in assessing what can be done to make residents (given their special needs) safe, through removing accident hazards, providing appropriate devices, and ensuring adequate supervision.

Josephine Sunset Home, at 14-15 (2004).

The Board's analysis is instructive in assessing the facts and context of what happened with R1. R1's history included a previous suicide attempt, he was a schizophrenic, he had an obvious tendency toward risky behavior, he was assessed to be cognitively impaired, and he showed signs of psychosis. Around 11:20 p.m, a little over an hour before his leaving the facility, R1 exhibited bouncing behavior so severe that he bounced himself out of his wheelchair and fell to the floor. It is apparent that there existed an irrational and potentially dangerous shortfall between his ability to assess risk and the real risks all around him. When R1 left the facility premises ostensibly to smoke unsupervised in the middle of the night, it was quite unlikely that he would have perceived the whole range of dangers to which he could possibly have been exposed — even if his self-immolation was not among them in that instant—and the facility staff had every reason to know that. Petitioner has pointed out that R1 was assessed as an independent smoker who did not require supervision, and while this may have been true when he was assessed on May 22, 2009, his psychiatric condition had clearly changed in the two critical weeks since then. One cannot imagine that, after R1 had crashed violently out of his wheelchair during another bouncing episode, he would have been assessed to be a "safe smoker." There is no question that R1 was engaging in behavior that put him at great risk when he wheeled himself outside, and it was Petitioner's duty to be proactive in its supervision of him.

I have no difficulty in concluding that when Petitioner's staff saw R1 leaving the facility, unaccompanied, they "could reasonably have anticipated the possibility" that he could somehow come to serious harm. Yet they did not stop him from going outside nor did they attempt to provide him with any supervision or protection. The Board in *Coquina Ctr.*, DAB No. 1860 (2002), concurred with the ALJ's opinion that, with a foreseeable risk that a facility could have practicably prevented, CMS did not have to show "that Petitioner foresaw the precise way in which harm would be visited upon residents as a result of its facility's failure to comply with participation requirements" in order to support a deficiency finding. *Coquina Ctr.*, DAB No. 1860 (2002), at 20, quoting *Coquina Ctr.*, DAB CR899 (2002), at 10. I find that Petitioner's staff fell far short in its duty to take all reasonable steps to ensure that R1 received supervision that met his assessed needs and mitigated foreseeable risks of harm from accidents, and thus violated 42 C.F.R. § 483.25(h). *Woodstock Care Ctr. v. Thompson*, 363 F.3d at 589 (a SNF must take "all reasonable precautions against residents' accidents").

Petitioner makes an additional argument that a state criminal investigation has somehow hindered its presentation of its case. However, from the time Del Rosa Villa was surveyed by the state agency to the time Petitioner claims it became aware of the state criminal investigation, it had almost a year to research and prepare its case. Every bit of evidence in its records, in the testimony of its staff, or in the records of third parties, was freely available to it without restriction.

Reduction of any oral testimony to written statements would have been an obvious measure in the most routine of situations. I regard it as particularly significant that although Petitioner had notice of the criminal investigation at least by May 20, 2010 (see B. Gluck Declaration attached to Petitioner's July 6, 2010 motion), Mr. Gluck delayed executing his declaration until June 18, 2010, and Petitioner did not bring the matter to my attention until its motion of July 6. Thus, at the outset and at the end of any discussion of this point must lie this realization: whatever evidence Petitioner now claims it was prevented from offering has, from the beginning, been within its own control, and was for a substantial period not the subject of criminal inquiry.

Petitioner has never offered any actual demonstration in fact of just how its case development was hindered, but has only posed such claims in purely speculative terms. There is no reason that Petitioner could not have attempted a concrete, detailed proffer of what it might show if the showing were unimpeded by the state investigation. Such a proffer could easily have been made on the basis of written witness statements obtained early in Petitioner's own preparation of its case. It is very, very difficult to see Petitioner's argument, continued as it was over weeks and months beginning in the summer of 2010, as supported by a real problem not of its own making.

2. The proposed per instance CMP of $10,000 is reasonable.

CMS determined to impose a per instance CMP of $10,000. CMS Ex. 40. The regulation authorizes the imposition of a per instance CMP ranging from $1,000 to $10,000. 42 C.F.R. § 498.438(a)(2). I must assess *de novo* the reasonableness of the CMP proposed by CMS based on the factors set forth at 42 C.F.R. § 488.438(f). In determining the amount of the CMP, the following factors specified at 42 C.F.R. § 488.438(f) must be considered: (1) the facility's history of non-compliance, including repeated deficiencies; (2) the facility's financial condition; (3) the seriousness of the deficiencies as set forth at 42 C.F.R. §488.404; and (4) the facility's degree of culpability. The CMS determination regarding the scope and severity of the deficiencies is not subject to my review, as the scope and severity of a deficiency has no effect on the range of per instance CMP which may be imposed. 42 C.F.R. §§ 498.3(b)(14), 488.438(a)(2); *see* 42 C.F.R. §§ 498.3(d)(10)(ii), 488.438(e).

CMS submitted evidence that shows that Petitioner was previously found in violation of 42 C.F.R. § 483.25(h) on each of its previous four re-certification surveys in 2005, 2006, 2007, and 2008. CMS Ex. 10, at 8. It is evident that Petitioner has a past history of noncompliance involving the failure to provide adequate supervision. Petitioner has not provided any evidence to show that its financial condition would preclude it from paying a $10,000 per instance CMP.

As discussed above, the deficiency citation is based upon an extremely serious incident. Despite Petitioner's insistence that what happened to R1 was not the result of unreasonable staff judgments, actions or omissions, I find that Petitioner's culpability was substantial. The term "culpability" is defined at 42 C.F.R. § 488.438(f)(4) to include, but to not be limited to, neglect, indifference, or disregard for a resident's care, comfort, or safety. Petitioner's staff exhibited indifference and disregard for R1's care and safety when they completely failed to provide any supervision or monitoring whatsoever to R1 when he wheeled himself out of the facility to his self-inflicted death, alone and in distress, in the middle of the night.

Based on my consideration of the regulatory factors listed in 42 C.F.R. § 488.438(f), I find that the per instance CMP of $10,000 is reasonable. Petitioner's staff's failure to supervise R1, who had become increasingly unstable mentally and exhibited severe psychotic symptoms, resulted in tragic consequences. Although the $10,000 amount is at the top of the range for a per instance CMP under the regulations, I find it to be authorized and appropriate as a mechanism to ensure future compliance and to protect Medicare beneficiaries.

V. Conclusion

For the foregoing reasons, I conclude that Petitioner failed to comply substantially with federal participation requirements and that the per instance CMP imposed against it is reasonable.

/s/
Richard J. Smith
Administrative Law Judge