Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Del Rosa Villa
Docket No. A-12-22
Decision No. 2458
May 8, 2012

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Del Rosa Villa (Del Rosa), a California skilled nursing facility (SNF), appeals a decision by Administrative Law Judge (ALJ) Richard J. Smith, *Del Rosa Villa*, DAB CR2435 (2011) (ALJ Decision). The ALJ upheld a determination by the Centers for Medicare & Medicare Services (CMS) that Del Rosa was not in substantial compliance with 42 C.F.R. § 483.25(h)(2), which states that a SNF must ensure that each resident receives "adequate supervision" and assistance devices to prevent accidents. The ALJ also upheld the $10,000 per-instance civil money penalty (CMP) that CMS imposed on Del Rosa for its noncompliance.

For the reasons stated below, we affirm the ALJ Decision.

General Background

To participate in Medicare, a SNF must at all times be in "substantial compliance" with the requirements in 42 C.F.R. Part 483. On June 12, 2009, the California Department of Public Health (CDPH) began an onsite survey of Del Rosa to determine whether it had complied with those requirements in caring for a 52 year-old male resident, identified as Resident 1, who was admitted to Del Rosa on May 22, 2009 and committed suicide there during the early morning of June 11, 2009. CMS Ex. 1, at 1. Based on its survey findings, CDPH concluded, and CMS concurred, that Del Rosa was not in substantial compliance with section 483.25(h)(2). *Id.* at 1-2, 7-8; CMS Ex. 40.

Del Rosa requested a hearing on that determination. In early July 2010, it asked the ALJ to postpone the hearing, contending that a criminal investigation into Resident 1's death was interfering with its ability to challenge CMS's noncompliance determination. *See* RR at 2 n.2. The ALJ granted the postponement (over CMS's objection) and scheduled the hearing to begin on December 6, 2010. However, in November 2010, Del Rosa asked

for an additional postponement. The ALJ denied the request, and Del Rosa filed an interlocutory appeal to overturn that ruling. The Board denied the interlocutory appeal,[1] and the evidentiary hearing proceeded as scheduled.

Del Rosa put on three witnesses at the three-day hearing: Gary Hoyes, a health care consultant; Thomas Woodbury, M.D., Del Rosa's Medical Director; and Randolph Noble, M.D. (an expert in psychiatry). Other than Dr. Woodbury, Del Rosa did not call any of its employees to testify. CMS, on the other hand, proffered the testimony of Wendy Myers, R.N. (a nursing home surveyor who interviewed several Del Rosa employees during the relevant survey) and Barbara Ziv, M.D. (an expert in psychiatry).

On April 14, 2011, four months after the hearing – and in the midst of the post-hearing briefing process – Del Rosa filed a Motion to Supplement the Record. The motion sought the admission of six pages of medical records from Resident 1's hospitalization at Arrowhead Regional Medical Center (Arrowhead). The ALJ admitted those records as Petitioner's Exhibit 132, and the parties filed supplemental briefs concerning the records' evidentiary significance.

The ALJ's Decision

The ALJ found several facts relating to Resident 1's stay at Del Rosa, and the ones material to our decision are undisputed.

On April 21, 2009, prior to his admission to Del Rosa, Resident 1 unsuccessfully attempted suicide by jumping into the path of a moving car. ALJ Decision at 8. He was hospitalized at Arrowhead from April 21 to May 22, 2009, where he received treatment for a broken leg. *Id.* at 8-9. For a period of time during that hospitalization, Resident 1 was subject to involuntary confinement under California law, the authorities having determined that he was a danger to himself due to his mental condition. *See id.* at 8.

On May 8, 2009, Resident 1 was evaluated by a psychiatrist, who concluded that he "'remain[ed] unpredictable with intermittent thoughts of suicide'" and "'at risk of harming himself if he were discharged to the community.'" ALJ Decision at 8 (quoting P. Ex. 126). Hospital records from May 16 to May 20, 2009 show an order for a "1:1 sitter," a person whose sole task was to monitor him. *Id.* His medication in the hospital included Clozaril, a powerful anti-psychotic drug that is prescribed to treat schizophrenia. *Id.*

On May 22, 2010, Resident 1 was discharged from Arrowhead and admitted to Del Rosa. ALJ Decision at 9. Del Rosa's admission records show that Resident 1 had multiple

[1] *Del Rosa Villa,* Ruling No. 2011-2 (Dec. 2, 2010).

diagnoses, including a repaired leg fracture, paranoid schizophrenia, and suicidal ideation (thoughts of suicide). *Id.*; *see also* P. Ex. 87, at 5. Those records also show that Resident 1 was taking Clozaril "to address his history of self harm, suicidal ideation, delusions, and hallucinations related to his schizophrenia." ALJ Decision at 9. In addition, the admission records show a physician order directing Del Rosa to monitor Resident 1 for and document the occurrence of delusions, hallucinations, or "responding to inner stimuli." *Id.*

Resident 1 was a smoker. *See* ALJ Decision at 9. On May 22, Del Rosa's staff determined that he was capable of safely smoking and did not require supervision while smoking. *Id.*

On May 30, 2010, Anthony Shin, M.D., Del Rosa's staff psychiatrist, evaluated Resident 1. ALJ Decision at 9. "Dr. Shin found [Resident 1]'s mood to be stable, and noted that he was positive for delusions and positive for auditory and visual hallucinations."[2] *Id.* "Dr. Shin scored [Resident 1] an 18/30 on a mini-mental status exam, which, according to CMS's expert witness, Dr. Ziv, indicates dementia." *Id.*

Two days later, on June 1, 2009, the nursing staff completed Resident 1's Minimum Data Set (MDS) assessment. ALJ Decision at 10. The MDS indicates that Resident 1 had moderately impaired cognitive skills for daily decision-making, was easily distracted, and had periods of altered perception or awareness of surroundings, episodes of disorganized speech, and mental functioning that varied over the course of the day. *Id.* Because of his injured leg, Resident 1's "primary mode of locomotion" was a wheelchair. *Id.*

Licensed vocational nurse T.Y. performed a more intensive assessment of Resident 1's mental status, recording her findings in a Resident Assessment Protocol (RAP) summary dated June 1, 2009. ALJ Decision at 10. Nurse T.Y. noted in the RAP summary that Resident 1 had diagnoses of depression, schizophrenia, and suicidal ideation; talked to himself or "imaginary others"; tended to ramble or talk nonsensically; had a short attention span and difficulty completing his thoughts; and needed assistance with decision-making. *Id.* Nurse T.Y. also reported that Resident 1 had a "'[history] of responding to inner stimuli by self harm, delusion, hallucinations and suicide attempts in past'" but had not exhibited those behaviors since his admission to Del Rosa. *Id.* (citing P. Ex. 106, at 15). She stated that Resident 1's mental condition "'does tend to vary [at] times, sometimes better and/or worse'" and that he was "'[at] risk for decline.'" *Id.* (quoting P. Ex. 106, at 11).

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[2] When Dr. Shin wrote that Resident 1 was "positive for" delusions and hallucination, P. Ex. 89, at 2, it is unclear whether he was speaking about Resident 1's history of mental illness, or about Resident 1's presentation during the May 30th evaluation.

In addition to preparing the RAP summary, Nurse T.Y. wrote a care plan for Resident 1 on June 1, 2009. ALJ Decision at 10. In relevant part the plan instructed:

> Notify MD if [Resident 1's] mood or behaviors interfere [with] his functions, safety or medical needs. **Suicide watch [at] all times.**

Id. (quoting P. Ex. 94, at 3, 8) (emphasis added). The phrase "suicide watch [at] all times" was written on the plan in red ink. *Id.*

On June 5, 2009, an interdisciplinary team (IDT) composed of the Director of Nursing (DON), Nurse T.Y., and two others participated in a "resident care conference" concerning Resident 1. ALJ Decision at 11. The participants reviewed Resident 1's diagnoses, physician orders, MDS, and plan of care. *Id.* No changes were made to the care plan as a result of the June 5th conference. *Id.*

Late on June 5, 2009, the nursing staff began to notice Resident 1 bouncing on his bed in a sitting position. ALJ Decision at 11. A nurse notified his physician, Wilson Gomer, M.D., of the behavior, and he responded by prescribing the anti-anxiety drug Ativan. *Id.* Despite this medication, Resident 1's bouncing resumed early on June 6th. *Id.* Nursing notes for that day state that Resident 1 displayed "'much confusion'" and "'could not hold still.'" *Id.* (quoting CMS Ex. 3, at 77). Dr. Gomer increased the Ativan dosage and instructed Del Rosa to send Resident 1 to the hospital if his anxiety or restlessness persisted or worsened. *Id.* It did worsen (apparently), and Resident 1 was transferred to St. Bernadine Medical Center (SBMC) at 2:00 p.m. on June 6th. *Id.* at 12. Resident 1 became calmer in the emergency room, and SBMC discharged him back to Del Rosa during the late evening of June 6th with an information sheet about anxiety and panic attacks and with an instruction to follow up with his primary care physician within two days. *Id.*

On June 7, 2009, the nursing staff reported that Resident 1 was exhibiting less anxiety and bouncing. ALJ Decision at 13. However, the staff also reported, on a "Medication Administration Record" (MAR), that Resident 1 had had delusions and hallucinations during the 7:00 a.m. to 3:00 p.m. shift. *Id.* Staff also reported that he "respond[ed] to inner stimuli" during the 11:00 p.m. to 7:00 a.m. and the 7:00 a.m. to 3:00 p.m. shifts on June 7th. *Id.*

Also on June 7th, the nursing staff completed a short-term plan of care to address what the plan called Resident 1's "'mania m/b [manifested by] bouncing & repetitive action.'" ALJ Decision at 13 (quoting P. Ex. 102, at 1). The short-term plan called on the staff to "monitor [Resident 1] for 72 [hour] charting," provide medication "as ordered," encourage him to participate in activities, and notify his physician of any changes of condition or adverse reactions. *Id.*

According to the MAR, Resident 1 had delusions and hallucinations and responded to inner stimuli on June 8, June 9, and June 10, 2009. ALJ Decision at 13. On June 9th, Resident 1's sister telephoned Del Rosa to report that her brother had called her and said that he "'had homosexual microchips planted in his head, please come save me.'" *Id.* (quoting P. Ex. 95, at 2). The nurse who took the sister's telephone call wrote in Resident 1's chart that he was "'currently resting comfortably in bed, had not stated any of this [referring to his microchip delusion] to staff when asked about it,'" and told the inquiring nurse that he was "'OK.'" *Id.* (quoting P. Ex. 95, at 2); *see also* CMS Ex. 42, at 14.

On June 10, 2009, a Behavioral Management Team met to discuss Resident 1. ALJ Decision at 13. The team planned to have Resident 1's physician assess him and noted that he had "'0 expressions of suicidal ideation at this time.'" *Id.* at 14 (quoting P. Ex. 90). That same day, Del Rosa's DON spoke with Resident 1's sister and with Dr. Shin, who increased Resident 1's morning dosage of Clozaril. *Id.*

The other relevant events are recounted by the ALJ as follows:

> 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. 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. 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. 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. The nurse called Dr. Gomer again around 12:15 a.m, just a few minutes past midnight.
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> Quite soon after the call to Dr. Gomer, at around 12:30 a.m. in the very early morning of June 11, [Resident 1] 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. According to Surveyor Myers, [Certified Nurse Assistant D.J.] told her that [Resident 1] 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. D.J. said that R1 always stayed in bed at night.

> Around 12:50 a.m., [Resident 1] was found hanging by his own belt on the perimeter fence of the parking lot. Staff performed CPR and called 911. [Resident 1] died shortly thereafter at St. Bernardine.

ALJ Decision at 14 (citations omitted).

Based on these and other findings, as well as on his evaluation of the parties' competing expert witness testimony, the ALJ concluded that Del Rosa had failed to supervise Resident 1 adequately, noting that its staff failed to implement a suicide watch, as called for in his plan of care, and rejecting Del Rosa's argument that a suicide watch was an excessive or inappropriate intervention. ALJ Decision at 14-35. The ALJ also found that in view of the "bizarre and disturbing features of [Resident 1's] conduct and condition" on the evening of June 10, 2009, Del Rosa ignored or overlooked an "obvious and foreseeable" risk of harm by allowing him to go outdoors unsupervised that evening. *Id.* at 32-33.

Del Rosa now contends, in this appeal, that "the evidence, taken as a whole, shows that [its] staff did properly admit, assess, plan for his care, and adequately supervise" Resident 1. Request for Review (RR) at 40.

Standard of Review

The Board's standard of review on a disputed finding of fact is whether the decision is supported by substantial evidence on the record as a whole. *Guidelines, Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs,* http://www.hhs.gov/dab/divisions/appellate/guidelines/index.html (Guidelines). The Board's standard of review on a disputed conclusion of law is whether the ALJ's decision is erroneous. *Id.*

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

Discussion

Although Del Rosa's appeal raises several evidentiary and procedural issues, this case is at heart a simple one, resolved by the undisputed facts. Based on its comprehensive assessment of Resident 1, Del Rosa itself identified as a problem that he was at risk of self-harm and listed "suicide watch" as an intervention to address this risk. Whether or

not a suicide watch was an appropriate intervention or had a specific meaning in the context of nursing facility care, Del Rosa was obligated under section 483.25(h)(2) to provide Resident 1 a level of supervision consistent with his care plan to meet the identified need. Yet, Del Rosa does not claim to have implemented any structured plan for supervision of Resident 1, much less to have implemented a "suicide watch" or any level of supervision that reasonably could be considered adequate to meet the identified risk.

This alone is sufficient to establish noncompliance with section 483.25(h)(2), yet the undisputed facts and evidence also show larger problems with the care and services Del Rosa was providing. The undisputed fact that key staff members were unaware of Resident 1's risk for suicide and of his care plan calling for a suicide watch has implications for the quality of care provided to all residents, which is to be based on the resident assessment and care plan. Moreover, despite other risks to Resident 1's safety that should have been evident when his condition deteriorated (including the risk of harm from his "bouncing" behavior and from smoking), staff let him go out in the middle of the night, not only unaccompanied, but with no plan for periodic checks on his welfare.

Below, we first discuss in more detail how the undisputed facts and evidence amply support the ALJ's conclusions regarding what supervision Resident 1 needed and how the supervision provided was inadequate. We then discuss Del Rosa's arguments on appeal.

1. *Substantial evidence supports the ALJ's conclusion that Del Rosa was noncompliant with 42 C.F.R. § 483.25(h)(2).*

Section 483.25(h)(2) states a SNF must "ensure" that each resident receives "adequate supervision and assistance devices to prevent accidents."[3] The requirements in section 483.25(h)(2) are part of a SNF's overall obligation under section 483.25 to provide each resident with "the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the [resident's] comprehensive assessment and plan of care." The Board has held that section 483.25(h)(2) requires a SNF to eliminate or reduce a known or foreseeable "risk" of accident "to the greatest degree practicable." *Clermont Nursing & Convalescent Center*, DAB No. 1923, at 9-10 (2004), *aff'd, Clermont Nursing & Convalescent Ctr. v. Leavitt,* 142 F. App'x 900 (6th Cir. 2005); *see also Woodstock Care Ctr.* v. *Thompson,* 363 F.3d 583, 590 (6th Cir. 2003) (a SNF must take "all reasonable precautions against residents' accidents").

[3] The term "accident" is construed by CMS to mean "any unexpected or unintentional incident, which may result in injury or illness to a resident," a definition broad enough to include an act of self-harm by a resident. State Operations Manual, CMS Pub. 100-07, Appendix PP (guidelines for F323), available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html.

Substantial evidence supports the ALJ's conclusion that Del Rosa did not meet its obligation to provide "adequate supervision" to Resident 1. As noted, section 483.25(h)(2) requires a SNF to take reasonable measures to minimize foreseeable risks of harm. There is no dispute that when Resident 1 was admitted to Del Rosa on May 22, 2009, the nursing staff knew or should have known that he was at **some** risk of self-harm. Resident 1 was admitted to Del Rosa with diagnoses of schizophrenia, a depressive disorder, and suicidal ideation. P. Ex. 87, at 5. Hospital records received by the facility prior to or upon Resident 1's admission show that he had recently attempted suicide. *See* CMS Ex. 42, at 15; P. Ex. 124, at 1-2; Tr. at 49-50, 56-58. In addition, Resident 1 arrived at Del Rosa with a prescription for Clozaril, a powerful anti-psychotic drug that is ordinarily prescribed for persons with schizophrenia who have not been helped by other drugs and who have tried to commit suicide or are likely to harm themselves. Tr. at 271. Product information from Clozaril's manufacturer states that "people with schizophrenia are at a much greater risk of suicide" than those in the "general population," and that "[a]lthough suicidal behavior is difficult to predict, research scientists have found several factors that can increase the risk of suicide in people with schizophrenia," including "symptoms of depression, hopelessness, and worthlessness"; hallucinations ("imagined but untrue ideas, visions, or voices that the person believes are telling him/her to commit suicide"); and "[r]ecent discharge from the hospital." CMS Ex. 43, at 7. According to the parties' expert witnesses (Dr. Ziv and Dr. Noble), Resident 1's April 21st suicide attempt was also a risk factor for another attempt. Tr. at 265, 596.

Del Rosa concedes that Resident 1 "was seriously mentally ill," that his mental illness and other factors "made the *risk* that he might attempt suicide after his previous apparent attempt greater than that of a person who did not have similar characteristics," and that this risk "created *some* 'supervision' obligation." RR at 3, 4 (italics in original). To her credit, Nurse T.Y., who had at least 25 years of experience working at Del Rosa, assessed Resident 1 as needing supervision to prevent self-harm and wrote a plan of care that purported to address that problem. Tr. at 181, 184-89; CMS Ex. 3, at 28 ("Prob. # 11," mentioning Resident 1's "depressive disorder," schizophrenia, and history of responding to inner stimuli "M/B [manifested by] self harm"); CMS Ex. 48, at 10, 44. She told Surveyor Myers during the survey that she had determined that a suicide watch was necessary for Resident 1 after thoroughly reviewing his psychiatric history and MDS assessment. Tr. at 202. Nurse T.Y. further indicated that she wrote the plan of care believing that Resident 1 required "heightened monitoring" and that staff needed "to keep an eye on him" and be "aware of where he was at all times" (the quoted words are Surveyor Myers' characterization of Nurse T.Y.'s interview statements). Tr. at 78, 206-07.

"Ensuring" that a resident receives "adequate supervision" involves (among other things) devising and implementing a plan of supervision to minimize the hazards or risks facing the resident. *See* State Operations Manual (SOM), CMS Pub. 100-07, Appendix PP (guidelines for F323). The record shows at least three interrelated shortcomings in this area.

First, and foremost, Del Rosa does not point to any evidence that its staff carried out, **in any form or to any degree,** the plan of care's instruction for a suicide watch. The Board has said that accident precautions contained in a resident's plan of care represent a SNF's judgment about what measures are necessary to keep the resident safe, and that failure to implement such precautions supports a conclusion that the SNF did not meet its obligation under section 483.25(h)(2) to provide adequate supervision. *St. Catherine's Care Center of Findlay, Inc.*, DAB No. 1964, at 13 n.9 (2005); *Cedar Lake Nursing Home*, DAB No. 2288, at 6-11 (2009), *aff'd, Cedar Lake Nursing Home v. U.S. Dep't of Health & Human Servs.*, 619 F.3d 453 (5th Cir. 2010). Consequently, Del Rosa's failure to implement a suicide watch supports the ALJ's conclusion that the SNF did not provide adequate supervision.

The second problem, pointed out by the ALJ, is that prior to Resident 1's death, the nurses and CNAs who cared for Resident 1, including those who were on duty the night he committed suicide, were unaware (or claimed to have been unaware) that his plan of care called for a suicide watch.[4] ALJ Decision at 18; Tr. at 85-86. Nurse T.Y. stated in a survey interview that her typical practice for instituting a suicide watch was to place at the nurse's station a form on which the resident's monitoring would be documented but that she did not follow that procedure for Resident 1. Tr. at 79; *see also* CMS Ex. 42, at 30. Licensed vocational nurse K.M., the nurse who supervised the overnight shift on June 10th, stated in her survey interview that she was supposed to acquaint herself with a resident's history and plan of care but did not have the time to do that for Resident 1,

[4] Not only were they unaware of the suicide watch intervention, most of the nurses or CNAs who were interviewed during the survey, including those who were on duty on the night of June 10th, were unaware of Resident 1's psychiatric history and recent suicide attempt. CMS Ex. 42, at 17, 18, 21, 25, 26, 32. Even Del Rosa's DON lacked accurate or complete information about that event. During her interview, the DON stated, in error, that Resident 1's suicide attempt was a "long time ago," and that she did not know when the attempt occurred. CMS Ex. 42, at 6-7. Common sense dictates that caregivers – from supervisors to CNAs – possess information about a resident's history sufficient for understanding the nature and magnitude of the risks they are obligated to help lessen. *See* Tr. at 346-47 (testimony of Dr. Ziv questioning "How can [one] treat a patient without knowing [his] entire history?" and further stating that "every person who was involved in this patient's care has an obligation to understand the entirety of the patient, from doctor on down to nurse, and you take responsibility for that part of that care that you are responsible for").

stating that this failure was "my fault." CMS Ex. 42, at 21. Licensed vocational nurse C.M., who performed Resident 1's MDS assessment, stated during her survey interview that nurses are expected to review and know what is in a resident's plan of care, and that nurses and CNAs are expected to carry out the plan. *Id.* at 27.

A third problem is that Resident 1's June 1, 2009 plan of care did not specify – and the nursing staff made no effort to clarify – what a "suicide watch" involved or required in Resident 1's circumstances. The plan does not specify the frequency, duration, or intensity of Resident 1's monitoring or describe how staff would carry it out. CMS Ex. 3, at 27. Daily nursing notes do state that the staff was "monitoring" Resident 1 or would "continue to monitor" him, *see, e.g.*, P. Ex. 95, at 5, but it is unclear how or under what circumstances the monitoring was performed.

Del Rosa points to testimony by Dr. Woodbury that the phrase "suicide watch at all times" in Resident 1's care plan was actually intended by Nurse T.Y. to mean that the staff should be alert for "suicidal ideation" or other "alarming statements or behaviors," rather than as a call for constant one-on-one monitoring, a measure appropriate for a patient who is an "active suicide risk." RR at 27-28 (citing Tr. at 494-95); Reply Br. at 14. Del Rosa overlooks testimony by Surveyor Myers, based on an interview of Nurse T.Y., that Nurse T.Y. intended the suicide watch to involve visual tracking of Resident 1's whereabouts. Tr. at 78, 206-07. Furthermore, Dr. Woodbury did not say that he ever spoke personally with Nurse T.Y. about this issue or explain how he came to his understanding of her intent. Tr. at 494-95. However, if the plan of care did not reveal the actual, intended meaning of the term "suicide watch," as Dr. Woodbury's testimony seems to imply, then Del Rosa had an obligation to clarify that meaning so that Resident 1's caregivers could implement the intended intervention. There is no indication that Del Rosa ever made such a clarification.

The care planning and implementation failures we have just described are sufficient to support the ALJ's conclusion that Del Rosa was not in substantial compliance with section 483.25(h)(2). Having determined during its own comprehensive assessment process that Resident 1 was at risk of self-harm, Del Rosa needed to (1) make a professional judgment about the level of supervision he required and that was reasonable under all the circumstances; (2) care plan that supervision; and (3) communicate to the staff their role and responsibility to implement the care plan. *Golden Age Skilled Nursing & Rehabilitation Center*, DAB No. 2026, at 11 (2006); SOM, Appendix PP (guidelines for F323).

Ensuring adequate supervision also involves modifying a plan of supervision to deal with changed circumstances. SOM, Appendix PP (guidelines for F323). As the ALJ found, Resident 1's mental condition began deteriorating on June 5, 2009. ALJ Decision at 21. Yet, Del Rosa failed to show that it adequately re-assessed Resident 1's need for

supervision, modified his plan of care, or intensified supervision. A short-term plan of care created on June 7th called for staff to "monitor [Resident 1] for 72 [hour] charting," but the plan was focused only his "bouncing" and "repetitive action"; it did not reflect concern about the other psychotic symptoms that began to manifest themselves after June 6th. CMS Ex. 3, at 33. Moreover, the plan did not say how Resident 1 would be monitored. It is also unclear whether "72-hour charting" was different from the monitoring that Dr. Gomer ordered when Resident 1 was admitted to Del Rosa. *See* P. Ex. 87, at 6; Tr. at 144-45. There is, in any event, no documentary evidence of increased monitoring of Resident 1 on or after June 7th. *See* CMS Ex. 3, at 63-65; P. Ex. 95, at 5-10; Tr. at 347-50.

The only other evidence of an effort to re-assess Resident 1's need for supervision is the record of the June 10th meeting of Del Rosa's Behavioral Management Team (BMT). P. Ex. 90. Although the BMT acknowledged that Resident 1 had been recently hospitalized in response to "bizarre behavior" and "fidgeting," and although his MAR showed that he had been exhibiting psychotic symptoms during each shift beginning on June 7th, there is no evidence that the BMT considered whether or how he should be supervised (or supervised more closely) in light of these developments. The BMT's only "plan for action" was for "MD to assess." P. Ex. 90. It is true that Del Rosa's DON conferred with Dr. Shin on June 10th about the "microchip" delusion reported by Resident 1's sister on June 9th, but there is no evidence that the DON talked with Dr. Shin about how, if at all, Resident 1 should be monitored.

Finally, we agree with the ALJ that events on the night of June 10th constitute sufficient evidence of noncompliance, regardless of the content of Resident 1's plan of care. Nurse K.M. was one of the nurses on duty that night. CMS Ex. 42, at 19. When her shift started at around 11:00 p.m., she went to Resident 1's room, saw him bouncing "quietly" up and down in his wheelchair, but thought he "seemed OK otherwise." *Id.* Shortly after leaving the room, however, she heard a crash and went back to the room, where she learned (from Resident 1's roommate) that Resident 1 had bounced out of his wheelchair and where she saw Resident 1 on the floor next to his overturned wheelchair. *Id.* Evidently concerned about Resident 1's safety, Nurse K.M. recorded the event in an "incident log" and paged Dr. Gomer. *Id.* After the crash, Resident 1 came up to the nurses' station to ask for a lighter but Nurse K.M. (or another nurse) refused, telling him that it was time to sleep, not smoke. *Id.* at 19-20. Nurse K.M. recalled in her survey interview that, after Dr. Gomer failed to answer his page, she wanted to page him again but became busy with other duties. *Id.* at 20. She later saw Resident 1 rolling his wheelchair toward the laundry room door (from where he left the building) and recalled assuming that he had found a lighter. *Id.*

Regardless of Resident 1's suicidal tendencies, the incident which triggered Nurse K.M.'s call to Dr. Gomer on June 10th demonstrated that Resident 1 could unintentionally injure himself while bouncing in his wheelchair. Del Rosa presented no evidence that after that incident, its staff reasonably thought that Resident 1's bouncing – and underlying anxiety – were under sufficient control to allow him to leave the building alone while he was in his wheelchair.[5] The Ativan Resident 1 took at 8:00 p.m. on June 10th had not relieved his anxiety enough to prevent the bouncing that caused his fall shortly after 11:00 p.m. Yet, the staff took no precautions to protect him while waiting for instructions from Dr. Gomer about what else to do.

The staff also allowed Resident 1 to leave the building without verifying that he was, in fact, an independent smoker.[6] Two employees who saw Resident 1 leave the building or head toward the exit (Nurse K.M. and CNA D.J.) admitted they were ignorant of whether Resident 1 had been assessed as needing supervision when he smoked. CMS Ex. 42, at 20, 24.

During the evidentiary hearing, Dr. Noble was asked whether it was necessary for a nurse to accompany Resident 1 outdoors to supervise his smoking. Tr. at 587-88. He responded that such supervision was unnecessary "based on what we know about [Resident 1's] mental state and past behavior at Del Rosa" because Resident 1 "had not expressed any intention to harm himself"; because he had previously gone outside to smoke; and because his smoking probably had a calming influence on him. Tr. at 588. The ALJ found this testimony to be not credible – "disingenuous" was the ALJ's word – because it overlooked or "ignored" the fact that Resident 1's mental state had "obviously worsened" during the previous three days and that "a little over an hour before going outside, [Resident 1] had been bouncing so violently that he fell out of his wheelchair and collapsed, shattered leg and all, to the ground." ALJ Decision at 31. The Board does not disturb an ALJ's findings concerning the credibility of, or the weight assigned to, witness testimony unless there are "compelling" reasons to do so. *Carrington Place at Muscatine*, DAB No. 2321, at 19 (2010). Del Rosa has not articulated a sound reason, much less a compelling one, to disturb the ALJ's weight and credibility findings regarding any of its witnesses, including Dr. Noble. In rejecting Dr. Noble's opinion, the

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[5] It unclear whether the night shift nurses were aware of the DON's consultation with Dr. Shin earlier in the day, the reason for that consultation, or the fact that Dr. Shin had increased his Clozaril dosage.

[6] There is conflicting evidence about whether the nursing staff regarded Resident 1 as a safe smoker. The ALJ found, and the record shows, that on May 22, 2009, Rosewood's staff assessed Resident 1 to be an "independent smoker" – that is, a person who "[did] not require supervision while smoking." CMS Ex. 3, at 27. But there is also evidence that some Del Rosa employees regarded Resident 1 as an unsafe smoker. Tr. at 63, 65; CMS Ex. 42, at 18. Moreover, there is no indication that the staff reconsidered its initial smoking assessment in light of the agitation and other symptoms that Resident 1 began experiencing on June 5th.

ALJ articulated the reasonable view that even if the nursing staff could not have predicted that Resident 1 was going outside to commit suicide, he needed supervision to ensure that his agitation – which had caused him to bounce out of his wheelchair, and which the staff had no reason to believe was under reliable control – did not cause another accident with resulting physical harm.

2. *Del Rosa's arguments concerning the necessity of a suicide watch are unpersuasive.*

Del Rosa's appeal briefs contain several lines of argument, but most revolve around the provision in Resident 1's plan of care calling for a suicide watch. According to Del Rosa, a suicide watch refers to strict, intensive monitoring that is typically provided in a psychiatric hospital (or other similar institution) to an actively or imminently suicidal patient by persons trained to recognize and evaluate symptoms of psychiatric illness. The term has little relevance to nursing home care, argues Del Rosa, because any person who might require a suicide watch (as Del Rosa defines it) would not be properly housed in a SNF but, instead, in a psychiatric hospital or other facility that specializes in treatment of severe mental illness. Del Rosa asserts that Resident 1 was never judged by a physician to be "actively" or "imminently" suicidal while at Del Rosa, and it points out that Nurse T.Y. was reprimanded for including a suicide watch in Resident 1's plan of care. For these reasons, Del Rosa maintains that it should not be faulted for failing to implement a suicide watch. *See* RR at 2, 4-5, 20-26, 39; Reply Br. at 2-4, 9, 12-15.

We are unpersuaded by this argument. As a preliminary matter, the record does not establish that the term "suicide watch" was unfamiliar to Del Rosa's employees or regarded as necessarily inappropriate in these circumstances. To the contrary, the term is found in one of Del Rosa's own resident care policies. The document entitled "Suicide Threats Policy and Procedures" instructs the staff to report immediately "[a]ll resident threats to commit suicide" and further instructs the staff to commence a "suicide watch" when ordered by the facility's Medical Director or the resident's attending physician. CMS Ex. 9, at 1. The policy states that a suicide watch involves "check[ing] the resident's status periodically (every hour, every fifteen minutes, or continuously) as ordered by the Medical Director or the attending physician." *Id.*

Del Rosa's Medical Director, Dr. Woodbury, testified that Nurse T.Y.'s call for a suicide watch was contrary to "policy." Tr. at 493-94. However, Del Rosa's Suicide Threats policy did not prohibit the staff from instituting a suicide watch without a physician's order if it determined that the measure was necessary in view of the resident's history, diagnoses, symptoms, and behavior. Nurse C.M. told surveyors that a suicide watch was a "nursing measure" that required no physician order, and stated that while she was unaware that Resident 1's plan of care included that measure, she should have known about it. CMS Ex. 42, at 27.

Dr. Woodbury also testified that a suicide watch was, in fact, unnecessary, Tr. at 494, but the ALJ gave little or no weight to that testimony because of Dr. Woodbury's lack of expertise in psychiatry and his non-involvement in Resident 1's care during May and June 2010. ALJ Decision at 28. Those were perfectly sound reasons, and we note that Dr. Woodbury did not support his opinion with any discussion or evaluation of the clinical evidence.

In mentioning Nurse T.Y.'s reprimand (which occurred after Resident 1's suicide), Del Rosa implies that the ALJ should have discounted her judgment about Resident 1's need for close supervision. We see no good reason for the ALJ to have done so, however. As the ALJ found, the DON and other members of Resident 1's IDT reviewed the care plan during a June 5th conference, discussed what changes (if any) were needed, but left the plan intact. Tr. at 89-91; P. Ex. 105, at 1 (expressly indicating the plan of care was reviewed by the IDT). The ALJ reasonably inferred from these facts that the DON would have rescinded the suicide watch had she thought the measure unnecessary.

Furthermore, Nurse T.Y.'s judgment was objectively reasonable based on this record. Resident 1 arrived at Del Rosa with multiple risk factors for suicide. *See* Tr. at 265-66. Only one month had elapsed since his suicide attempt by a method that had a high chance of success. His admission records indicated that suicidal ideation was an "active" problem. Tr. at 286. He was on Clozaril, a medication prescribed for persons with recurrent suicidal tendencies, and he was taking the maximum recommended dosage (300 mg per day) of that drug. Tr. at 270-73; CMS Ex. 43, at 4. In addition, Resident 1 had received a dose of Haldol, an anti-psychotic drug, the night before his admission to Del Rosa. Tr. at 270-71. Dr. Ziv testified that this fact indicated that Resident 1's mental condition was not yet stable. Tr. at 327. Dr. Ziv also testified that the report in Nurse T.Y.'s June 1st RAP Summary that Resident 1 was talking to himself and to "imaginary others" was some indication that he was continuing to have delusions and hallucinations. Tr. at 292; CMS Ex. 3, at 49. Thus, the ALJ reasonably rejected Del Rosa's suggestion that a suicide watch was unnecessary or inappropriate. *See* ALJ Decision at 19-20.

3. *The hospital records in Petitioner's Exhibit 132 do not undercut the ALJ's finding of noncompliance*

According to Del Rosa, the Arrowhead records in Petitioner's Exhibit 132 "undercut many of CMS' assertions that support its finding of noncompliance" and "obliterate" many of the expert opinions expressed by CMS's psychiatric expert, Dr. Ziv. RR at 2. Those records, which were admitted after the hearing, consist of reports of psychiatric consultations on April 21, April 28, May 8, and May 13, 2009 as well as an April 23, 2009 report by Dr. Tran, Resident 1's "attending" physician at Arrowhead. The report of the May 8th consultation was part of the record prior to the evidentiary hearing. *See* P. Ex. 126. Except for the May 8th report, the records in Petitioner's Exhibit 132 were not reviewed by either party's witnesses prior to the hearing.

The report of the April 21st consultation states that Resident 1 had a long history of schizophrenia, that he had been living at a "board & care" home for 12 years, that he was usually treated with Clozaril and other drugs, that he had been feeling depressed, and that "voices" had told him to attempt suicide. P. Ex. 132, at 5. The report also states that Resident 1 was still "very psychotic & expressing SI [suicidal ideation]." *Id.*

On April 23rd, Dr. Tran wrote that Resident 1 was "overtly psychotic, responding to [auditory hallucinations] and has suicidal thoughts." P. Ex. 132, at 4. Dr. Tran also noted that Resident 1's Clozaril dosage would be increased. *Id.*

The report of the April 28th consultation states that Resident 1 had been "off Clozaril" because of surgery and "has become increasingly psychotic." P. Ex. 132, at 3. The report also included a plan to increase his Clozaril dosage gradually. *Id.*

On May 8th, Dr. Baudhu evaluated Resident 1 to determine whether his involuntary commitment order (the "5250 hold") should be lifted and to recommend post-hospital placement. P. Ex. 132, at 2. Dr. Baudhu found that Resident 1 "remains unpredictable with intermittent thoughts of suicide." *Id.* He further found that Resident 1 was "not suitable or appropriate for BH [a boarding home]" and recommended that he be sent to a SNF. *Id.*

On May 13th, Dr. Baudhu re-evaluated Resident 1. P. Ex. 132, at 1. He recommended discontinuing the commitment order, found Resident 1 "ready for D/C [discharge]" to the SNF, and ordered a "continu[ation] [of] current psychotropic meds." *Id.* Dr. Baudhu commented that Resident 1 had been "treated by a private psychiatrist on Clozaril for 14 years." *Id.*

The ALJ did not discuss the records in Petitioner's Exhibit 132, but he was not required to do so because they do not detract from the substantial evidence supporting his conclusion that Del Rosa failed to supervise Resident 1 adequately. *Lake Park Nursing and Rehabilitation Center*, DAB No. 2035, at 17 (2006); *Universal Camera*, 340 U.S. at 488 ("The substantiality of evidence must take into account whatever in the record fairly detracts from its weight."). We agree with CMS that Petitioner's Exhibit 132 merely corroborates or duplicates evidence of Resident's underlying psychiatric condition, his recent suicide, and his need for medication to control the symptoms of his schizophrenia. *See* Response Br. at 12.

Del Rosa contends that the Arrowhead records undermine a key factual premise supporting the determination of noncompliance. Del Rosa asserts that the determination that Resident 1 received inadequate supervision was based on the premise that he was "actively suicidal" at Del Rosa (and thus in need of more supervision than he actually received). However, says Del Rosa, the Arrowhead records establish that Resident 1 was no longer actively suicidal by the time he arrived at Del Rosa on May 22, 2009, his

doctors having earlier released him from involuntary commitment. Furthermore, says Del Rosa, no physician judged him to be actively suicidal while he was at Del Rosa. Consequently, Resident 1 did not require "acute intervention" or any supervision that was "closer" than what he actually received, according to Del Rosa. *See* RR at 5-6, 8, 13-19, 21-22, 25.

This argument is unpersuasive. First, we are uncertain what Del Rosa means by "actively suicidal." We presume the term means having a present intention to commit suicide in the near future as well as a specific plan to do so by lethal means. Whatever the meaning, the ALJ did not find that Resident 1 was "actively suicidal" upon admission to Del Rosa, or that Del Rosa failed to provide supervision designed to safeguard an actively suicidal resident. Rather, the ALJ found Del Rosa noncompliant because it failed without good reason to implement an intervention that its own staff had deemed necessary to meet Resident 1's assessed need for supervision, failed to reassess Resident 1's need for supervision after his mental condition began to deteriorate on June 5th, and failed to intensify supervision on June 10th after he demonstrated an ability to injure himself while bouncing in his wheelchair.

Del Rosa asserts that Dr. Ziv based her criticism of the nursing staff's performance on the assumption that Resident 1 was actively suicidal or an imminent danger to himself from the moment he arrived at Del Rosa and remained so during his stay. RR at 5-6, 17-20. However, Dr. Ziv never testified that Resident 1 was "actively suicidal" or should have been recognized by Del Rosa as such. She testified only that "suicidal ideation" was an "active problem" (since it was identified as an admission diagnosis) and that Resident 1 showed signs in the facility of being "actively psychotic." Tr. at 285-86, 290.

Del Rosa contends that Dr. Ziv might have "softened her critiques" of the nursing staff had she known that a psychiatrist had released Resident 1 from involuntary commitment, as the Arrowhead records show. Reply Br. at 8. Del Rosa also asserts that both expert witnesses "could have addressed . . . the effect on the Resident's risk of suicide of his *fourteen year* history of the use of Clozaril noted in the documents." *Id.* (italics in original). Speculation about what the experts might have said had they seen the Arrowhead records in Petitioner's Exhibit 132 is irrelevant because Del Rosa never asked the ALJ to recall Dr. Ziv or Dr. Noble after those records were admitted. In addition, Del Rosa's speculation that the witnesses would have given favorable testimony is not, on this record, well-founded. Del Rosa does not point to testimony indicating that Dr. Ziv predicated her opinions on an assumption that Resident 1 had not been released from involuntary confinement. Del Rosa also fails to explain precisely how Resident 1's long-time use of Clozaril might have affected witnesses' opinions about the risk of harm.

Del Rosa asserts that Petitioner's Exhibit 132 shows that "close supervision" was unnecessary because none of the psychiatrists whose reports are found in that exhibit stated that supervision would be necessary in the nursing home or "raised any concerns about any ongoing danger to self." RR at 18-19; Reply Br. at 8. However, none of the psychiatric evaluations documented in Petitioner's Exhibit 132 occurred at or near the point Resident 1 was discharged from Arrowhead (on May 22, 2009), so it is unlikely that the physicians who made those evaluations were contemplating or making recommendations about post-hospitalization supervision. Furthermore, there is no evidence that any of the physicians were asked about the need for such supervision. Dr. Baudhu, the psychiatrist who released Resident 1 from involuntary commitment on May 13th, indicated that he performed his May 13th evaluation to assess Resident 1's need for further involuntary confinement and in response to a request for orders for "treatment," a term that most likely refers to medication (not supervision). P. Ex. 132, at 1. The fact that Resident 1 no longer needed involuntary confinement – a measure that is appropriate when there is reason to believe that the detainee is an **immediate** danger to himself or others (*see* Tr. at 556-57) – does not necessarily mean that the chance of another suicide attempt was negligible. Nor does it prove that Resident 1 could be safely left unsupervised, particularly in view of Nurse T.Y.'s unquestioned assessment that he was at continuing risk for self-harm.

4. *Del Rosa's other arguments concerning the noncompliance determination are meritless.*

Noting that the physicians who evaluated or treated Resident 1 never ordered Del Rosa's nursing staff to implement a suicide watch, one-to-one monitoring, or any other level of systematic visual monitoring, Del Rosa contends that it relied on physician judgment concerning the need for such monitoring and should not be faulted for not implementing an intervention that no physician saw fit to order. RR at 6; Reply Br. at 4-5. This line of argument is unpersuasive. A SNF has an independent obligation under section 483.25(h)(2) to determine the type and level of supervision necessary in light of the resident's history and comprehensive assessment; in other words, the SNF is ultimately responsible for ensuring that the level of supervision is adequate to meet the resident's needs. That is not to say that a SNF's reliance on physician judgment concerning a resident's supervision would never, under any circumstances, suffice to demonstrate substantial compliance with section 483.25(h)(2). At minimum, however, a SNF must show that it actually relied on a physician's judgment and that such reliance was reasonable.

Here, Del Rosa failed to show that it actually or reasonably relied on physician advice or judgment about Resident 1's needs. In fact, we see no evidence that any of Resident 1's physicians rendered a judgment about the level of supervision he needed while in the

SNF. Physician orders and reports are simply silent about the issue. *See* CMS Ex. 3, at 3-13. One cannot reasonably infer anything from that silence because there is no evidence that Del Rosa asked the physicians about what type or level of supervision Resident 1 needed.

Del Rosa also argues that its staff had no reason to foresee that Resident 1 would commit suicide when he went outdoors to smoke early on June 11th, pointing to testimony that suicide attempts are essentially unpredictable. RR at 5-6; Reply Br. at 11, 18-20. However, the staff's inability to predict when or how that event might occur is irrelevant because "[i]t is not a prerequisite to finding noncompliance under section 483.25(h)(2) that any actual accident have occurred or be caused by [a SNF's] inadequate supervision[.]" *Briarwood Nursing Center*, DAB No. 2115, at 11 (2007). The proper inquiry is whether the SNF took reasonable steps to "meet assessed needs" and to mitigate "foreseeable risks of harm." *Id.* The unpredictability of how or when an adverse event may occur does not mean the absence of a foreseeable risk that such an event will occur.

When Resident 1 entered Del Rosa, its staff assessed Resident 1 as at "risk" for self-harm. One may quarrel, as Del Rosa does, about the immediacy or magnitude of the risk. But given the severity of Resident 1's mental illness and the fact that he had attempted suicide just one month before his admission to Del Rosa, that risk of harm was both foreseeable (Nurse T.Y. recognized it) and high enough to warrant careful thought and planning about how to minimize it. The ALJ clearly focused on how Del Rosa responded to the risk of harm and Resident 1's assessed need for supervision.[7]

Del Rosa also complains that the ALJ did not address what it calls "CMS's allegation that Petitioner's noncompliance *caused* the Resident's death[.]" RR at 2 (italics in original). We are not certain that CMS actually alleged a causal link between the noncompliance and Resident 1's death,[8] but the issue is irrelevant in any event because the occurrence of an accident (with resulting physical harm) is not a prerequisite for finding noncompliance

[7] Del Rosa contends that "*[i]n retrospect*, it is of course easy to argue that had the nurse stopped the Resident rather than simply engaging him in a conversation he would not have killed himself when he did. But we do not know – and there is no way to know – whether he would simply have returned to his room and hanged himself there." Reply Br. at 4. This contention focuses on the unpredictability of a specific course of events, not on whether the staff took reasonable measures to meet Resident 1's assessed need for supervision and to minimize an apparent threat of physical harm (including a fall or crash from his wheelchair). Furthermore, it is foreseeable that the risk of an unobserved, untoward event is greater when a resident is outdoors alone in the middle of the night.

[8] The SOD states that Del Rosa's noncompliance "resulted" in Resident 1 "going outside of the facility on 6/11/09 at 12:30 AM unaccompanied by facility staff where he" committed suicide. CMS Ex. 1, at 8.

with section 483.25(h)(2).[9] As the Board explained in *Clermont Nursing & Convalescent Center*, whether a SNF complied with section 483.25(h)(2) depends on whether it took all "reasonable" or "practicable" measures – consistent with a resident's assessment and plan of care – to identify, evaluate, and reduce or eliminate the foreseeable "risk" of an accident. DAB No. 1923, at 20-22 (citing and quoting other Board decisions). As the Sixth Circuit Court of Appeals recognized in affirming *Clermont*, this "risk-oriented analysis" eliminated the need for CMS to prove accident causation. 142 F. App'x at 904.

Finally, Del Rosa contends that the ALJ should have overturned the determination of noncompliance because CMS failed to offer evidence of a standard of care specifying the type or level of monitoring that was necessary and appropriate for Resident 1 during his residency at Del Rosa. RR at 3-5; Reply Br. at 2-3, 20. Del Rosa asserts that because a "suicide watch" does not and cannot mean the same thing in both the psychiatric hospital and nursing home settings, it was CMS's obligation to define what that term meant in determining whether Del Rosa met its care planning and other obligations under section 483.25(h)(2). Reply Br. at 14.

CMS had no obligation to determine, in hindsight, precisely how much or what kind of supervision Resident 1 needed. Section 483.25(h)(2) required Del Rosa to make that judgment based on its own assessment of the resident, then to formulate and implement a plan calculated to ensure that Resident 1 received the needed level of supervision. *Josephine Sunset Home*, DAB No. 1908, at 15 (2004). Based on its assessment of Resident 1, Del Rosa determined that a "suicide watch" (of some kind) was appropriate. We agree with the ALJ that the inclusion of that intervention in the plan of care should have signaled to the staff that Resident 1 needed to be watched closely and regularly, if not to minimize an imminent threat of self-harm, then (1) to ensure that a deterioration in his mental condition was promptly detected and assessed, and (2) to increase the likelihood that a suicide attempt would be detected in time to prevent physical harm or death. If there were any doubts about the appropriateness, feasibility, or effectiveness of that intervention, Del Rosa was obligated to resolve them during the care planning process, in consultation, if necessary, with Resident 1's physicians.

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[9] Causation may be relevant in assessing CMS's determination that Del Rosa's noncompliance was at the level of "immediate jeopardy," but the Board is authorized to review that determination only if it would affect the "range of civil money penalty amounts that CMS could collect" (or under other circumstances not present here). 42 C.F.R. § 498.3(b)(14); *Wisteria Care Center*, DAB No. 1892, at 15-16 (2003). In this case, CMS imposed a "per-instance" CMP for Del Rosa's noncompliance. When CMS elects to impose a per-instance CMP for a SNF's noncompliance, the penalty amount must be in the range of $1,000 to $10,000 per instance, regardless of whether the noncompliance constitutes immediate jeopardy. 42 C.F.R. §§ 488.438(a)(2), 488.408(d)(i)(iv). Consequently, the immediate jeopardy finding in this case did not and could not affect the CMP range, and the Board lacks the authority to review the immediate jeopardy finding for that reason. *Fort Madison Health Center*, DAB No. 2403, at 12-13 (2011).

We emphasize that Del Rosa was noncompliant not because it failed to institute any particular monitoring regime, such as one-on-one supervision. It was noncompliant because it failed to specify clearly in the plan of care the precise level of monitoring required to meet Resident 1's assessed need for supervision, to communicate to staff what it was expected to do, and to implement any systematic monitoring of Resident 1.

5. *There was no impropriety by CMS and no prejudice to Del Rosa stemming from the belated admission of the Arrowhead records.*

Del Rosa alleges misconduct by CMS or CDPH relating to the post-hearing admission of Petitioner's Exhibit 132. *See* RR at 1. As noted in the Background, the ALJ admitted that exhibit – containing six pages of medical records from Arrowhead – in response to Del Rosa's April 14, 2011 (post-hearing) Motion to Supplement the Record. According to that motion, Del Rosa obtained the Arrowhead records from CDPH in March 2011 as a result of a discovery request it made during the judicial appeal of a state enforcement citation. Motion to Supplement (MTS) at 4.

Del Rosa now contends that CDPH had possession of the Arrowhead records prior to the December 2010 evidentiary hearing. RR at 1; Reply Br. at 7-8. Del Rosa further asserts that CMS or CDPH "decided to withhold" those records from Del Rosa, the ALJ, and its own expert witness (Dr. Ziv); that CMS questioned its expert witness (Dr. Ziv) based on a record it knew was materially incomplete; and that the ALJ "declined even to investigate" whether CMS or CDPH possessed or failed to turn over the documents prior to the hearing. RR at 2; Reply Br. at 7-8. According to Del Rosa, these circumstances "fatally taint[ ]" the ALJ Decision and "implicate[ ] the integrity of the survey and enforcement process." RR at 2.

These contentions have no merit. In general, an allegation of impropriety in the nursing home survey and enforcement process, such as the one Del Rosa seems to be making here, is irrelevant.[10] The issue before the ALJ (and the Board) is the validity of CMS's determination of noncompliance, and a resolution of that issue "hangs on the ALJ's de novo review of the evidence" relating to that determination, and not on the conduct (by CMS or the state) of the survey and enforcement process. *Northlake Nursing and Rehabilitation Center*, DAB No. 2376, at 10 (2011). Allegations of errors or irregularities in the survey and enforcement process will not upset a determination of noncompliance when reliable evidence submitted during the ALJ proceeding (such as the SNF's own records) supports that determination. *North Carolina State Veterans Nursing*

[10] Such an allegation might be relevant if it implicated a SNF's due process rights or called into question the authenticity of documentary evidence in the record, but, as we explain later, there was no due process violation relating to the admission of Petitioner's Exhibit 132, and Del Rosa did not challenge the admission of any of CMS's documentary evidence.

Home, Salisbury, DAB No. 2256, at 23 (2009). Thus, the ALJ committed no error in not investigating why the Arrowhead documents were not obtained or disclosed by CMS or CDPH prior to the December 2010 hearing.[11]

Furthermore, the Arrowhead records are not, as Del Rosa asserts, material to the outcome, as our discussion in section 3 (above) makes plain. Hospital documents that Del Rosa did not have when it admitted Resident 1 and did not rely upon in assessing his supervision needs while in the facility are irrelevant to the noncompliance issue presented in this case.

To the extent that Del Rosa is claiming a denial of due process in the administrative hearing process, we find no such denial. In its post-hearing motion to supplement, Del Rosa asked for the following:

> At a minimum, the record must be reopened to add [the Arrowhead] documents to the record. Then, assuming that CMS does not decide to modify or withdraw any of its findings, the [ALJ] should permit the parties to submit amended Posthearing Briefs that address the context and significance of this evidence.

MTS at 7. The ALJ granted these requests in an April 25, 2011 order. He admitted the Arrowhead documents into the record and permitted the parties to submit supplemental briefs to "address the [documents'] context and significance." The April 25th order states that the ALJ denied a request (apparently made during a teleconference) for an opportunity to submit written statements from medical experts, ruling that such evidence would be "irrelevant, needlessly cumulative, and having the obvious potential for impeding the speedy conduct of this appeal." Del Rosa does not challenge that ruling. We would not consider that ruling to be an error or abuse of discretion in any event because Del Rosa did not proffer any written statements or ask the ALJ to recall any witnesses to testify about the Arrowhead records. Its motion to supplement merely "suggest[ed]" that a conference "may be appropriate to address whether" whether some witnesses should be recalled. MTS at 7.

We note that despite the prominence Del Rosa gives to this subject, it failed to show any impropriety by CMS or CDPH. Del Rosa suggests that CMS made a deliberate or conscious decision to withhold the Arrowhead records from its witnesses or the ALJ and that CMS examined Dr. Ziv knowing that the record was materially "incomplete." *See*

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[11] Del Rosa's motion to supplement did not ask the ALJ to conduct such an inquiry; Del Rosa merely "suggest[ed] that it "may be appropriate for the [ALJ] to inquire into the circumstances under which the State Survey Agency obtained these documents, and why they were not produced to the parties before now . . . ." MTS at 7 (emphasis added).

RR at 1-2. But there is no evidence that CMS saw or obtained the Arrowhead documents prior to the hearing; in fact, Del Rosa conceded in its motion to supplement that it "had no reason to believe that CMS had possession of, or deliberately withheld" the Arrowhead documents. MTS at 6. Even if CMS were aware of the Arrowhead documents prior to the hearing, it is unclear why CMS would have been obligated to produce or rely on them. Del Rosa does not contend that nondisclosure violated any statute, regulation, or pre-hearing order, or was inconsistent with a pre-hearing representation or commitment by CMS. There is some evidence that CDPH obtained the Arrowhead documents prior to the December 2010 hearing,[12] but CDPH was not obligated to turn them over absent a subpoena or other valid legal demand. The ALJ's December 8, 2009 order concerning "pre-hearing exchanges" did not impose on CMS an obligation to produce all relevant records in CDPH's possession, and at no time prior to the December 2010 hearing did Del Rosa ask for, or the ALJ refuse to issue, a subpoena for documents held by Arrowhead or CDPH. *See* 42 C.F.R. § 498.58 (authorizing an ALJ to issue subpoenas for the production of relevant documents).

6. *Del Rosa does not dispute the ALJ's conclusion that the criminal investigation of Resident 1's death did not unfairly hinder its challenge to the federal noncompliance finding.*

In addition to upholding CMS's determination of noncompliance, the ALJ revisited Del Rosa's claim, first raised in a July 6, 2010 motion and later in Del Rosa's interlocutory appeal to the Board, that a state criminal investigation of Resident 1's death had prevented employees from testifying on its behalf (or giving other assistance) in this administrative proceeding. ALJ Decision at 34-35. The ALJ rejected that claim, finding that Del Rosa had almost one year to research and prepare its case before the advent of the state criminal investigation and that during that one-year period, "[e]very 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." *Id.* at 34. The ALJ also found that Del Rosa "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." *Id.* at 35. The ALJ further found "no reason that [Del Rosa] could not have attempted a concrete, detailed proffer of what it might show if the showing were unimpeded by the state investigation" and that "[s]uch a proffer could easily have been made on the basis of written witness statements obtained early in Petitioner's own preparation of its case." *Id.*

The ALJ asserted that "[i]t is very, very difficult to see [Del Rosa'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." *Id.*

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[12] *See* Declaration of Wendy Myers, attached to CMS's Objection to Petitioner's Motion to Supplement Record (dated April 20, 2011).

In short, the ALJ found that Del Rosa had received a fair opportunity to mount its challenge to the noncompliance determination and failed to show that the outcome of the administrative proceeding would have been different had the hearing been postponed beyond December 2010. Del Rosa made no effort to contest those findings in its request for review. It merely asserted, in a footnote, that it was "preserv[ing] for judicial appeal" the claim rejected by the Board in the interlocutory appeal "that the ALJ should have postponed the hearing in this case pending clarification of the status of a related grand jury investigation, which made it impracticable for most of [the facility's] staff to participate in this hearing." RR at 2 n.2. Because Del Rosa did not ask us to review the ALJ's findings concerning the timing of the evidentiary hearing, we affirm them without further discussion.

7. *Del Rosa does not challenge the reasonableness of the $10,000 per-instance CMP.*

When appealing a finding of noncompliance, a SNF may contend that the amount of the CMP imposed for that noncompliance is unreasonable. *Capitol Hill Community Rehabilitation and Specialty Care Center*, DAB No. 1629, at 5 (1997). The ALJ concluded that the CMP amount was reasonable (ALJ Decision at 35-36), and Del Rosa does not challenge that conclusion in this appeal. For that reason we affirm that part of the ALJ Decision without further discussion.

Conclusion

The ALJ's conclusion that Del Rosa was not in substantial compliance with section 483.25(h)(2) is affirmed.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Judith A. Ballard
Presiding Board Member