Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Country Hills Health Care
(CCN: 55-5431),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-09-749

Decision No. CR2291

Date: December 13, 2010

DECISION

Petitioner, Country Hills Health Care, challenges the determination of the Centers for Medicare and Medicaid Services (CMS) that it was not in substantial compliance with program participation requirements. Petitioner also challenges CMS's imposition of a $10,000 per instance civil money penalty (CMP).[1] For the reasons discussed below, I find that the preponderance of the evidence establishes that Petitioner was in compliance with Medicare participation requirements at the relevant time. Thus, CMS is not authorized to impose remedies against Petitioner.

I. Background

Petitioner is a long-term care facility located in El Cajon, California, that participates in the Medicare and Medicaid programs. The California Department of Public Health (state agency) completed a complaint survey of Petitioner's facility on July 9, 2009. CMS

[1] Petitioner apparently also lost its authority to conduct a nurse aide training and competency evaluation program (NATCEP). CMS Pre-Hearing Brief (CMS PH Br.) at 3.

Exhibit (CMS Ex.) 1. The survey cited a deficiency under 42 C.F.R. § 483.25(h) (Tag F323, scope and severity level of J).[2] *Id*.

I conducted an in-person hearing in the case on July 12, 2010, in San Diego, California. Testifying for CMS was state agency surveyor Galen Gattis (Surveyor Gattis). Testifying for Petitioner were: Erin Chancler, Petitioner's administrator at the relevant time (Administrator Chancler); Carolyn Terry, a licensed vocational nurse for Petitioner (LVN Terry); José Palado, a certified nurse assistant for Petitioner (CNA Palado); Orlando Pérez, Petitioner's assistant maintenance supervisor (Mr. Pérez); Johanne Morales, Petitioner's environmental engineering supervisor (Ms. Morales); Gladys Ramos, a registered nurse for Petitioner (RN Ramos); and Jane Fontecha, a registered nurse and Petitioner's co-director of nurses (DON Fontecha).

I admitted CMS Exs. 1 through 12 and Petitioner's Exhibits (P. Exs.) 1 through 26. I also admit P. Ex. A.[3] Each party submitted a post-hearing brief (CMS Br. and P. Br., respectively). A 233-page transcript (Tr.) of the hearing was prepared.

II. Issues

The issues before me in this appeal are:

1. Whether Petitioner was in substantial compliance with participation requirements in the Medicare and Medicaid programs; and

2. Whether the remedies imposed are reasonable.

III. Controlling Statutes and Regulations

Sections 1819 and 1919 of the Social Security Act (Act) and the regulations at 42 C.F.R. Part 483 govern Petitioner's participation in Medicare and Medicaid. Sections 1819 and 1919 of the Act provide the Secretary with authority to impose remedies, including

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[2] A scope and severity level of J denotes an isolated deficiency that constitutes immediate jeopardy to resident health and safety. State Operations Manual (SOM), section 7400E; 42 C.F.R. §§ 488.301, 488.408.

[3] P. Ex. 1, entitled "Joint Stipulation of Undisputed Facts," was admitted to the record without the signature of CMS counsel. As an attachment to its post-hearing brief (Exhibit A), Petitioner submitted a copy of the "Joint Stipulation of Undisputed Facts" that CMS counsel signed. I am admitting Exhibit A to the record. Petitioner also submitted as attachments to its post-hearing brief Exhibits B through H, which consist, respectively, of abstracts of the testimony of: Administrator Chancler (Exhibit B): LVN Terry (Exhibit C); CNA Palado (Exhibit D); Mr. Pérez (Exhibit E); Ms. Morales (Exhibit F); RN Ramos (Exhibit G); and DON Fontecha (Exhibit H). They remain in the record as attachments to Petitioner's post-hearing brief, but I do not admit them into evidence.

CMPs, against long-term care facilities for failure to comply substantially with participation requirements.

The regulations define the term "substantial compliance" to mean:

> [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.

The Secretary has delegated to CMS and the states the authority to impose remedies against long-term care facilities not complying substantially with federal participation requirements. The applicable regulations at 42 C.F.R. Part 488 provide that state survey agencies, on behalf of CMS, may survey facilities participating in Medicare and Medicaid to ascertain whether the facilities are complying with participation requirements. 42 C.F.R. § 488.10-.28. The regulations contain special survey conditions for long-term care facilities. 42 C.F.R. § 488.300-.335. Under Part 488, a state or CMS may impose a CMP against a long-term care facility, if a state survey agency ascertains that the facility is not complying substantially with participation requirements. 42 C.F.R. §§ 488.406, 488.408, and 488.430. The CMP may begin to accrue as early as the date that the facility was first substantially out of compliance and may continue to accrue until the date the facility achieves substantial compliance, or until CMS terminates the facility's provider agreement. 42 C.F.R. § 488.440.

The regulations specify that if a CMP is imposed against a facility based on an instance of noncompliance, the penalty will be in the range of $1,000 to $10,000 per instance. 42 C.F.R. § 488.438(a)(2). When a CMP is imposed against a facility based on a per-day basis, it must fall into one of two broad ranges of penalties. 42 C.F.R. § 488.408, 488.438. The upper range of CMP, from $3,050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. § 488.438(a)(1)(i), (d)(2). The lower range of CMP, from $50 per day to $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). "Immediate jeopardy" is defined as:

> [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.

A facility may challenge the scope and severity that CMS cites only if a successful challenge would affect the range of CMP amounts that CMS imposed or would affect the facility's NATCEP. 42 C.F.R. § 498.3(b)(14), (d)(10)(i). CMS's determination as to the scope and severity of noncompliance "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). This includes CMS's finding of immediate jeopardy. *Woodstock Care Center*, DAB No. 1726, at 9 (2000), *aff'd, Woodstock Care Center v. U.S. Dept. of Health and Human Servs.*, 363 F.3d 583 (6th Cir. 2003).

The Departmental Appeals Board (Board) has long held that the net effect of these regulations is that a provider has no right to challenge the scope and severity 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).[4]

When a penalty is imposed and appealed, CMS has the burden of coming forward with evidence related to disputed findings that is sufficient, together with undisputed findings and relevant legal authority, to establish a prima facie case of noncompliance with a regulatory requirement. If CMS makes this prima facie showing, a petitioner must then carry its ultimate burden of persuasion by showing by a preponderance of the evidence on the record as a whole that it was in substantial compliance during the relevant period. CMS makes its prima facie showing if the evidence it relies on is sufficient to support a decision in its favor absent an effective rebuttal. An effective rebuttal of CMS's prima facie case would mean that the petitioner had shown that a preponderance of the evidence supported the facts on which it its case depended. *Evergreene Nursing Care Center*, DAB No. 2069, at 7 (2007). For the reasons enumerated below, I conclude that CMS did not make its prima facie showing here.

IV. Discussion

I make two numbered findings of fact and conclusions of law (Findings) to support my decision. I set them forth below as separate headings in bold and italic type and discuss each in detail.

1. Petitioner was in substantial compliance with the participation requirements at 42 C.F.R. § 483.25(h) at the relevant time.

42 C.F.R. § 483.25 requires that:

[4] Petitioner argues that CMS's finding of immediate jeopardy was clearly erroneous. Had I found Petitioner out of compliance with participation requirements, I would not have had the authority to consider the scope and severity of the deficiency, as CMS imposed only a per-instance CMP, and the range of CMP would not be affected. Although a NATCEP was apparently imposed as well, the imposition of a NATCEP was imposed based both on the imposition of the CMP, as well as CMS's finding of substandard quality of care. *See* CMS PH Br. at 2-4.

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

The subsection at 42 C.F.R. § 483.25(h) references accidents[5] and requires that:

> (h) *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.

In the case of *Meridian Nursing Center*, DAB No. 2265 (2009), the Board stated,

> Section 483.25(h)(1) requires that a facility address foreseeable risks of harm from accidents "by identifying and removing hazards, where possible, or where the hazard is unavoidable because of other resident needs, managing the hazard by reducing the risk of accident to the extent possible." Maine Veterans' Home – Scarborough, DAB No. 1975, at 10 (2005). Section 483.25(h)(2) requires 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." Briarwood Nursing Center, DAB No. 2115, at 11 (2007), citing Woodstock Care Ctr. v. Thompson, DAB No. 1726 (2000) (facility must take "all reasonable precautions against residents' accidents"), aff'd, Woodstock Care Ctr. v. Thompson, 363 F.3d 583 (6th Cir. 2003).

Meridian Nursing Center, DAB No. 2265, at 3.

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[5] The Board references the SOM in defining an accident as:

> "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 Appendix PP, Guidance to Surveyors, Part 2, SOP 483.25 Quality of Care (Rev. 274, June 1995) (SOM Guidance).

Woodstock Care Center, DAB No. 1726, at 4. As discussed below, the incident involving Resident A falls within this definition of "accident."

Following a complaint survey conducted on July 9, 2009, based on a June 30, 2009 incident at the facility, the state agency determined that Petitioner:

> . . . did not provide a safe environment by failing to prevent 1 of 170 residents, (Resident A), who resided on the second and third floors, from exiting through a second floor window. Resident A fell approximately 15 feet and because of the fall sustained multiple fractures (broken bones).

CMS Ex. 1, at 1. The parties submitted a stipulation of undisputed facts regarding this incident, which I summarize here.

Petitioner is a 305-bed facility. Resident A was readmitted to the facility on June 6, 2009 with diagnoses of post left hip fracture, dementia, and Korsakoff's psychosis.[6] Resident A's June 19, 2009 minimum data set (MDS) assessed Resident A as having severely impaired cognitive skills and long- and short-term memory problems.

Resident A resided in Room 312. Room 312 has a north-facing floor-to-ceiling window that measures 7'10" high by 4'10" wide. The window has two separate sliding sections that slide from right to left. The bottom sliding section measures 2'5" high by 4'10" wide. The top sliding section measures 5'5" high by 4'10" wide. The bottom and top sliding sections are separated by a window frame. On the date of the incident, there were previously installed horizontal wooden barrier barrister-railing bars across the windows at 1'4" and 3'2" high from the floor.[7]

On the morning of June 30, 2009, the charge nurse, RN Ramos,[8] saw Resident A remove his lap-tray and attempt to stand up from his geri-chair several times. To address the resident's fall risk as he attempted to stand on his own, Ramos immediately implemented the use of a wheelchair with a backwards-facing seatbelt,[9] between 10:30 and 11:00 a.m. Very soon after her intervention, Ramos observed Resident A in the hallway at

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[6] Surveyor Gattis testified that Korsakoff's could be explained as Petitioner's brain "literally being pickled by excessive alcohol use. He's delusional, hallucinations, has no short or long-term memory ability." Tr. at 24.

[7] Since the upper and lower windows could slide open and shut overlapping side to side, the width of the actual window opening would be effectively reduced to approximately half its overall dimension. P. Br. at 5.

[8] The charge nurse was identified at hearing as RN Ramos. Tr. at 168; P. Ex. 15.

[9] Nurse's notes reflect that Petitioner used the intervention of the wheelchair and back-facing seatbelt until Resident A could be re-assessed by Petitioner's rehabilitation department. CMS Ex. 7, at 6; *see* Tr. at 170; CMS Ex. 6, at 1; P. Ex. 15.

approximately 11:10 a.m. At that time, Resident A was able to propel himself in the hallway. Ramos noted that Resident A did not attempt to stand on his own and did not appear restless or agitated.

At approximately 11:10 to 11:15 a.m., CNA Palado[10] observed Resident A in his room, seated in his wheelchair near the "A" bed, the bed closest to the doorway of his room. Palado told Resident A that he was taking residents to the dining room for lunch and that Resident A would be next.

Sometime between 11:20 and 11:30 a.m., CNA Palado returned to Resident A's room to take him to the dining room for lunch. At that time, Palado did not find Resident A in his room.[11] Palado and RN Ramos began a search for Resident A, checking the rooms and restrooms near Room 312. During the search, Palado looked outside the window of another room and saw Resident A lying on the ground one story below the window of his room.

A "Code Green" was called at the facility, and a 911 call to emergency services was placed. CNA Palado, accompanied by another CNA who spoke Spanish, spoke with Resident A (whose primary language is Spanish but who speaks and understands English (CMS Ex. 9, at 26; P. Ex. 2, at 42, 209, 240)) while waiting for paramedics to arrive. When asked what happened, Resident A told the Spanish-speaking CNA that he was looking out the window and fell.[12]

At the time the incident was discovered, the bottom and top windows of Room 312 were observed to be open. The screen for the bottom window was noted to be on the ground with Resident A. The screen from the top window was torn from the window frame.

Somewhere between 11:40 and 11:50 a.m., Resident A was transferred to Sharp Memorial Hospital for treatment. At approximately 12:30 p.m., the incident was reported as an unusual occurrence to the state agency. At approximately 1:30 p.m., state agency surveyors arrived at Petitioner's facility. A situation of immediate jeopardy at the facility was declared at 3:30 p.m. Petitioner immediately began implementing a plan of correction.

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[10] The CNA was identified at hearing as CNA Palado. Tr. at 121-22; P. Ex. 12.

[11] Petitioner asserts, and CMS does not dispute, that the curtains in Resident A's room were drawn shut at the relevant time. CMS Ex. 6, at 1; P. Br. at 5.

[12] Surveyor Gattis' surveyor notes worksheet reflects that upon interview Resident A did not recall falling out a window. However, a Spanish translator who had been working with Resident A since his hospital admission told Surveyor Gattis that Resident A told her that he was "going to go outside to help the workmen." CMS Ex. 9, at 26-27.

At approximately 6:30 p.m. on June 30, 2009, the state agency completed its inspection and conducted an exit conference. The state agency advised Petitioner that the situation of immediate jeopardy was considered abated; no life and safety code violations were found; no deficiencies would be issued by life and safety; and a notice of intent would be issued for the deficiency found at Tag F 323.

The July 9, 2009 survey followed, and by notice letter dated July 21, 2009, CMS informed Petitioner that it had approved a finding of noncompliance based on the July 9, 2009 survey. CMS imposed a $10,000 per instance CMP. The sole regulatory violation cited, based on the July 9, 2009 survey, is 42 C.F.R. § 483.25, at a scope and severity level J.

Although the parties did not stipulate to this point, I find that there is no real dispute that the Office of Statewide Health Planning and Development (OSHPD), the California state agency that approves the design of skilled nursing facilities, had approved the building and the window design. Tr. at 49-52. Nor is there any dispute that state agency surveys of the facility, beginning in 1990, never previously cited Petitioner's windows as an identifiable hazard or as otherwise out of substantial compliance with participation requirements. Tr. at 64. There is also no dispute Petitioner had a locked or secured unit on its bottom floor for residents who pose an elopement risk or display wandering behavior, behavior risks Resident A did not pose or display. Tr. at 59-61.

With regard to the windows themselves, CMS does not dispute that each window section had a window latch that would be difficult for most residents to open. In addition, each window had a heavy screen. The bottom section of the windows had a screw or bolt[13] that prevented the windows from opening. Tr. 135, 142. Petitioner had considered putting screws or bolts at the top window; however, prior to the survey, an individual from the state agency, Mr. Yalung, had informed Petitioner that doing so would violate the life safety code. On August 3, 2009, Mr. Yalung changed his position and informed Petitioner that it could bolt the windows, because the local fire department would approve it. P. Ex. 26; Tr. at 142-46. The bolts or screws in the lower windows were put in before the survey and did not completely stop the window from opening. After the survey, the bottom window screws did not allow the window to open at all, and bolts or screws were installed which limited the opening of the upper windows to about six inches. They were screwed into the track itself. Tr. at 149-52. I do not consider any of these subsequent actions that Petitioner took, as part of its plan of correction, as proof that Petitioner was out of compliance with participation requirements at the time of the incident.

CMS notes that the Board has repeatedly held that "a facility must determine whether any condition exists in the environment that could endanger a resident's safety. If so, the facility must remove the condition if possible, and, when not possible, it must take action

[13] The parties use the words "screw" or "bolt" interchangeably. It is irrelevant to my decision whether a device placed in a window to prevent it from opening is termed a "screw" or a "bolt."

to protect residents from the danger posed by that condition." *Woodland Vill. Nursing Center*, DAB No. 2172, at 19 (2008) (*citing Alden Town Manor Rehab. and HHC*, DAB No. 2054, at 7 (2006)). CMS argues that Petitioner should have assessed Resident A and his environment to determine whether a potential hazard existed that could have endangered his safety. In addition, CMS asserts that, upon this assessment, Petitioner should then have taken action to remove the hazards, or implement interventions to protect Resident A from the hazard. CMS argues that Petitioner failed to do so.[14]

Specifically, CMS asserts that Petitioner knew that Resident A could not protect himself from accident hazards in his environment, or from accident hazards of his own making, prior to June 30, 2009. CMS argues that Petitioner had a duty to act on this knowledge and design a care plan and a room environment that protected him from all safety hazards. CMS asserts that Petitioner had assessed Resident A's cognitive status, physical limitations, and safety judgment and knew Resident A suffered from dementia and delirium and had such severe cognitive impairments that it was "highly unlikely" that he would appreciate the danger inherent in an attempt to open a window. Further, CMS asserts Petitioner knew that Resident A was a fall risk, that he required extensive assists to transfer from his wheelchair; and that his attempts at standing or walking from his wheelchair were dangerous. CMS notes that Resident A was able to take only about two steps safely when he was using a forward wheel walker. CMS Br. at 2-3. In support, CMS referred to the testimony of LVN Terry that Resident A had an altered mental status and to RN Ramos' testimony that Resident A had a history of failure to follow directions. Tr. at 118; Tr. at 180-81. CMS referred also to the MDS found in Resident A's clinical record, noting his poor safety judgment and cognitive impairments. CMS Ex. 7, at 10. CMS also referred to a resident assessment protocol (RAP) summary dated June 19, 2009, which noted that "all [of Resident A's] needs must be anticipated." CMS Ex. 7, at 12.

CMS points out that anticipating Resident A's assessed needs was critical to protecting him from hazards in his environment. Surveyor Gattis testified:

> I'd have to liken it to child-proofing your home. You look in the environment to see what hazards are there, and what the potential is for the child to harm themselves. In the case of the elderly, cognitively impaired resident, you would look in the environment to observe areas in the facility that could pose a danger to the resident.

Tr. at 26-27. Gattis also testified that he would expect a facility to determine a potential accident hazard:

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[14] CMS does not contend that the incident was a result of the physical failure of the window.

> [b]ased on the residents diagnoses, based on evaluation – assessments that have been done by nursing, physical therapy, occupational therapy, based on facility's own observations of the resident's behaviors. That would be all used in developing an approach to how they would safely handle this resident . . . .

Tr. at 35-36.

CMS notes that Surveyor Gattis measured Resident A's window on June 30, 2009. He found a vertical space of approximately 13" between the bottom safety railing and the window partition. CMS Ex. 8, at 4. The bottom window section had a sliding section of 2'5" high. CMS Ex. 1, at 3; CMS Br. at 8. The open space on the bottom of the window was 13" high by 29" wide. The two safety rails were installed prior to when the current assistant maintenance supervisor, Mr. Pérez, began working at the facility (approximately 14 years ago). Tr. at 134, 151.

CMS asserts that there was nothing blocking this "large" or "huge" 13" by 29" opening on the bottom window, and there was nothing to prevent a resident from exiting through the window. CMS Br. at 8, 12. According to CMS's view of the evidence, the only thing Petitioner had in place to stop resident access to the space was a "belief and hope" that it was too difficult to fall through accidentally, or that no resident would intentionally crawl over the horizontally-placed safety bar. CMS Br. at 12. CMS notes that DON Fontecha and Ms. Morales testified that, in their opinions, someone would have to spend time on the floor to use the window as an exit. Tr. at 160, 193-94. As Ms. Morales agreed during cross-examination, there was nothing to prevent a resident from inserting himself or herself between the safety railings and the window partition, which CMS asserts must have been the method that Resident A used. CMS Br. at 11; Tr. at 164. CMS thus asserts that Petitioner's method of ensuring that no resident went out a window was to expect a "resident to see how much work it would take to get down on the floor so they could climb over the bottom rail and decide against it." CMS Br. at 10. CMS argues that, given all that Petitioner knew about Resident A's status, it is unclear why Petitioner believed he would never spend time on the floor, crawl over a safety bar, or simply fall to the floor and decide to go out a window.

Now, although CMS does not dispute that Petitioner had a locked or secure unit on the first floor of its facility for residents with wandering behavior (*see* CMS Ex. 9, at 17), CMS suggests that Petitioner was aware that residents with certain diagnoses might attempt to use windows as a means of egress. It notes that skilled nursing facilities such as Petitioner's have used various methods to limit how far a window can open, including mechanical means such as securing all resident room windows and windows in common areas so that they can open no more than six to eight inches. CMS Br. at 6-7. CMS argues that it was foreseeable that a fall, or attempted exit, from a window is an accident hazard, if the windows are unobstructed and can open far enough to allow a resident to climb out or fall out. CMS asserts that Petitioner was aware that the bottom section of the sliding windows in its residents' rooms was able to be opened "all the way." CMS

Br. at 7. CMS refers to Ms. Morales' testimony that Petitioner had placed screws in the bottom sliding section to prevent the windows from opening but that family members might take the screws out to abate smells in the room by enhancing ventilation. *Id.*; Tr. at 155. Surveyor Gattis testified he was never provided documentation that the screws were being maintained, although he was told facility staff were going around quarterly looking at the screws. Tr. at 30. Administrator Chancler was not aware of whether screw placement was documented. Tr. at 109.

CMS asserts that Petitioner never considered other options for securing the windows, such as a window alarm system. And, no evidence or testimony establishes that Petitioner even considered whether lesser measures than complete window closure were available to it under state fire codes. CMS argues that on June 30, 2009, Petitioner knew nothing was blocking the bottom sliding section of the window from opening wide enough for someone to slide through and knew residents could not be relied on to take responsibility for their own safety and make safe, logical, and well-thought-out choices. CMS argues that Petitioner did "nothing to effectively ameliorate the danger of those bottom sliding window sections and left it up to Resident A to stop himself from exiting through the window." [15]

CMS also asserts that Resident A was not adequately supervised, or provided assistance devices, to address the open window space. Resident A was alone at the time of the incident. CMS acknowledges that after being switched from a geri-chair to a wheelchair it appeared Resident A had calmed down. However, no staff members were instructed to watch him regularly or remain in close enough proximity to stabilize him if he attempted to stand unassisted. CMS refers to the testimony of RN Ramos that "at first I asked the CNA to keep an eye on him, how he would do with that – where we placed him on that wheelchair with backwards seatbelt. But since he remained calm, and no further episodes

[15] At hearing, Surveyor Gattis testified that he thought Resident A may have gone out the upper window. Gattis testified specifically ". . . if you have one resident who can literally pull himself up using - - and I believe this is how it happened, how he grabbed a hold of that bar, and was able to somehow either go over the top of the bar or between the bars and out the window. . . ." Tr. at 33; *see* Tr. at 47. Petitioner observes that if Resident A had tried to exit through the upper window, he would have to unlatch it, open it, remove the screen or make a hole large enough for a man to go through, and climb out of his wheelchair. He would then have had no reason to knock the lower screen completely out. Petitioner notes that the fact the lower screen was found on the ground next to Resident A indicates he may have gone through the lower windows, because it was easier to exit that way. In its post-hearing briefing, CMS appears to have abandoned the argument espoused by Gattis that Resident A went out the upper window, although it left in an argument raised in its pre-hearing brief that measures were not taken to address the accident hazard created by a "4 feet 10 inch wide window that can open wide enough for anyone, visitor, staff member or Resident to climb out of. . . ." CMS Br. at 12. Given that the window opening was only half that width, I do not consider the actual window opening to be 4'10".

of getting up, he's just wheeling himself, so no further intervention or no further things done as far as putting him on one-on-one supervision or so." Tr. at 182. CMS notes that when Resident A fell out the window he was not being observed.

CMS also asserts that missing from the facility's assessment of Resident A's new behavior of trying to get up and ambulate from his geri-chair was any consideration of a wheelchair alarm. CMS acknowledges that prior to June 30, 2009, Resident A had not tried to get up unassisted or ambulate and admits that his most recent MDS, from June 19, 2009, assessed Resident A as not walking on the unit or in his room in the seven days prior to the assessment. And, Resident A was assessed as totally dependent on staff for movement between locations in his room and to different locations in the facility. CMS Ex. 7, at 11, 12. However, given what it characterizes as the unexpected change in his ambulation habits, CMS would expect documentation or testimony regarding consideration of the pros and cons of other assistance devices, such as the use of an alarm, which might have given Petitioner's staff warning that the resident was attempting to rise from the chair, especially given that the resident was a known fall risk. In CMS's view, this would have been particularly helpful, as only RN Ramos and CNA Palado knew that morning that Resident A was attempting to rise unassisted and ambulate.[16]

Petitioner argues that there was no reason to believe any resident on Resident A's floor might attempt to climb out a window that was latched, covered by a barrier bar, had a heavy duty screen in place, and, in the case of the lower window, was bolted shut — in essence, that Resident A's accident was not reasonably foreseeable. Petitioner argues that Resident A's elopement out the window was totally unexpected and unforeseeable, and that the need to intervene relating to Resident A's attempt to get out of his geri-chair is unrelated to his determining, and then attempting, to climb out a window. Petitioner points out that Surveyor Gattis admitted that Resident A did not exhibit elopement-risk or wandering behaviors. Tr. at 27. Petitioner insists that Resident A had no previous history indicating that he might try to go out the window, and Petitioner's staff never saw Resident A trying to open the window in his bedroom. Petitioner notes that when Resident A attempted to get out of his geri-chair without assistance, Petitioner's staff

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[16] A June 6, 2009 care plan for restraints indicated that Resident A was a high fall risk. It suggested that: he could be up in a geri-chair for positioning; side rails should be up when he was in bed for safety; and he should use a bed alarm to alert staff to give him help when transferring. P. Ex. 2, at 197. A June 6, 2009 care plan for falls suggested: Petitioner monitor Resident A's environment for wet spots or items placed on the floor below his field of vision; assure that lighting is adequate; monitor him for side effects of medications that could contribute to a fall; place a call light within reach and respond promptly; put up both full side rails while he is in bed for safety and mobility; maintain his bed in the lowest position and lock it at all times; and place him up in a geri-chair for positioning. P. Ex. 2, at 217. On June 16, 2009, Resident A was evaluated for the use of physical restraints. Side rails were the only restraint recommended at the time, and a geri-chair was indicated for positioning. P. Ex. 2, at 230.

immediately intervened by temporarily placing him in a wheelchair with a back-facing seatbelt, which he could not easily release, pending a re-assessment. In addition, Petitioner monitored Resident A by placing him in the line of vision of the nursing station and having a CNA observe him until he was calm. Moreover, Petitioner notes that Gattis did not opine that use of and reliance on the backward seatbelt restraint until Resident A calmed down was unreasonable, improper, or an inappropriate use of restraints, although he asserted Petitioner could have used a cross-strap vest to tie Resident A to his wheelchair. Tr. at 31. Petitioner's policy, however, is to place residents with elopement tendencies in its secure unit, and not to restrain them, and then to monitor them for signs of agitation. CMS Ex. 9, at 17.

Moreover, Petitioner brought the window design to the attention of state agency personnel in 2007, when it wanted to bolt the windows for air conditioning purposes. At that time, the state agency found no fault with the window design, although it did not approve bolts for the upper windows. CMS Ex. 9, at 16; P. Ex. 26. Petitioner notes that when Surveyor Gattis observed all of the lower windows on June 30, 2009, all of the screw mechanisms or bolts in those lower windows were in place. Tr. at 30-31; 43-45; CMS Ex. 9, at 11-14.[17] Petitioner argues further that the state agency's life safety code survey on June 30, 2009, found no violations of participation requirements. P. Ex. 8. Petitioner argues also that the window was not wide enough for Resident A to "fall" or "jump through" accidentally. It asserts that Resident A had to make an intentional effort to open and climb through the window. P. Br. at 10.

The Board held in *Josephine Sunset Home*:

> 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, DAB No. 1908, at 14-15 (2004). The Board also held that the "mere fact that an accident occurred does not, in itself, prove that the supervision or devices provided must have been inadequate to prevent it." *Id.* at 13.

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[17] Petitioner argues that, because the bolts were all in place for the lower windows, there was no basis to declare immediate jeopardy for failure to bolt the upper windows. The need to limit the opening of the upper window was not the basis of any immediate jeopardy citation, as the state agency declared the immediate jeopardy was abated once the lower windows were secured. No physical modification was made to abate anything relative to the upper window on that date. As noted above, a finding of immediate jeopardy is not relevant to my decision in this case.

In this case, it is undisputed that an accident occurred. The question is whether the accident constituted noncompliance with both parts of the regulation at 42 C.F.R. § 483.25(h) — the part addressing potential accident hazards in Resident A's environment and the part addressing whether Petitioner's supervision of Resident A was adequate. I find that even though Resident A incurred an accidental injury, CMS has not shown that Petitioner was noncompliant with participation requirements. This specific accident was not foreseeable, and Petitioner took all reasonable steps to meet the assessed needs of this Resident.

In *Briarwood Nursing Center*, DAB CR1551 (2007), *aff'd, Briarwood Nursing Center*, DAB No. 2115 (2007), I heard a case in which it was suspected that a resident had eloped through an unalarmed and unsecured window. In that case I noted:

> It is puzzling that the Facility did not address an obvious escape route for a resident with such a hazardous tendency. There are several ways that the Facility could have implemented sufficient interventions to curb R1's wandering and exit – seeking behavior. Two courses of action that the Facility could have taken to address the unalarmed and unsecured windows in R1's bedroom are: 1) the Facility could have installed windows that could not open more than eight inches; or 2) the Facility could have installed alarms on their windows.
>
> The Facility could have followed the example of other nursing homes and installed windows in R1's bedroom that open no more than six to eight inches, thus making it more difficult for a resident to escape through a window. This could have easily been accomplished by installing some type of device above the window to effectively stop or limit the opening of the window. The use of mechanical means to limit how far a window could open in a resident's room is not a novel idea, as exemplified by the extended discussions of such mechanisms in *Sonogee Rehabilitation and Living Center*, DAB CR754 (2001); *Estes Nursing Facility Civic Center*, DAB CR1240 (2004); *Estes Nursing Facility Civic Center*, DAB No. 2000 (2005); and *Estes Nursing Facility Civic Center*, DAB CR1370 (2005). Nor is the use of such devices unknown in the nursing home industry: one of the ways that some nursing homes protect the safety of residents is to "secure all windows in resident rooms and common areas so that they open no more than 6 to 8 inches from sill." CMS Ex. 32. Any resident would have difficulty getting through a window that could open only eight inches. For a wanderer, limiting the means of escape is essential, and this option would have been both easy and quick to implement.

Briarwood, DAB CR1551, at 5.

There are obvious differences between these two cases and between these two residents that make my decision in *Briarwood* inapposite to my decision here. Those differences are instructive, and they illuminate the important facts on which this decision turns. The resident in *Briarwood* was a known elopement risk, and the facility failed to provide adequate supervision to the resident, not even following its own policy to monitor the resident every two hours. Here, Resident A was neither an assessed elopement risk nor wanderer. In addition, Petitioner places its residents with the potential to elope or wander in a separate and secured part of the building. Also, the type and structure of the window was different in this matter.

It may not be possible to guard against all elopements from a window. I note Judge Kessel's discussion in *Estes Nursing Facility Civic Center*, DAB CR1370 (2004):

> . . . [a]lthough I held that Petitioner undertook all reasonable steps to protect its residents, I did not hold that the action Petitioner undertook made its windows elopement-proof. I held there, and I reiterate, that such would have been impossible to accomplish short of putting bars on the windows or putting residents in windowless rooms. Windows are made from glass and glass easily can be shattered. Any resident who is sufficiently determined to elope via a window, including any of the windows of Petitioner's facility, can easily do so simply by breaking out the window's glass. What Petitioner did fulfilled its obligation that was reasonable to protect its residents given that *no* approach, short of barring or bricking up the windows would have protected residents completely.

Estes Nursing, DAB CR1370, at 4.

I further note Surveyor Gattis' testimony that a window that can be opened and climbed through is not in and of itself an identifiable hazard. Gattis recognizes a standard of reasonableness in testifying that a window five feet off the ground, not floor to ceiling, would not necessarily be an identifiable hazard, even if there were a small chair and table in the room, a resident with dementia were in the room, and that resident could climb up to open the window. The resident would have to be observed doing those behaviors to make it an identifiable hazard. Tr. at 61-63. Resident A was never observed trying to go out the window, or even to trying to leave the facility or wander about in it. In addition, no resident prior to Resident A had ever fallen through or jumped from a window at the facility. Finally, no one surveying the facility had alerted the facility that its windows were a potential hazard.

Although Resident A had cognitive deficits, he was not assessed as a wanderer or an elopement risk, and he had not previously been shown to exhibit exit-seeking behavior. He had never crawled on the floor. He was indisputably a fall risk, having fallen at the facility, been hospitalized for a fractured femur, and then been readmitted to the facility. P. Ex. 2, at 135, 239. But CMS has not shown that being a fall risk made him more likely to elope the building through a window. In fact, given his fracture and his placement in a

wheelchair with a back-facing seatbelt, it was not foreseeable that, in the 10 or 15 minute period between when CNA Palado saw him sitting calmly in his wheelchair in his room and when he found him missing from his room, Resident A would be able to exit his wheelchair, get to the window, push out a heavy screen, and go out the window.

Although CMS argues that Resident A's supervision was inadequate, the entire episode, from the first noting of Resident A's agitation, to the instituting of the intervention based on the wheelchair and the back-facing seatbelt, to the observation that Resident A had calmed down, and finally to the discovery that Resident A had eloped through the window, took place over a period of approximately one hour. RN Ramos had determined to refer Resident A for re-assessment based on his attempting to rise from his geri-chair, but, as a temporary safety measure, she had him placed in the wheelchair with the back-facing seatbelt and had him monitored until he calmed down. Tr. at 170. Given the situation and Resident A's assessed condition, that intervention was adequate and reasonable. There was no indication that he would intentionally exit the facility via a window. Nor was it reasonably foreseeable that a window, such as the one in Resident A's room, with barrier bars, heavy screens, and an opening that I do not consider large or huge, was a foreseeable means for Resident A to elope the facility.

2. As Petitioner was in substantial compliance with participation requirements, CMS is not authorized to impose a remedy against Petitioner.

For the reasons set out in detail above, I find that the preponderance of the evidence establishes that Petitioner was in compliance with Medicare participation requirements at the relevant time. Because Petitioner was in compliance with those Medicare participation requirements, CMS is not authorized to impose remedies against Petitioner.

V. Conclusion

Petitioner was in substantial compliance with participation requirements at the relevant time, and CMS is not authorized to impose a remedy against Petitioner.

/s/
Richard J. Smith
Administrative Law Judge