Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Covington Manor Nursing Home
(CCN: 11-5588),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-933

Decision No. CR4706

Date: September 16, 2016

DECISION

Following a survey that ended April 5, 2013, the Georgia Department of Community Health (survey agency) determined that Covington Manor Nursing Home (Covington or Petitioner) was not in substantial compliance with the Medicare program participation requirement that a skilled nursing facility (SNF) ensure an environment for residents that is as free of accident hazards as is possible and ensure adequate supervision of residents. 42 C.F.R. § 483.25(h). Specifically, the survey agency determined that Covington's noncompliance began on September 20, 2012, and that from September 20, 2012, through April 4, 2013, a total of 197 days, Covington's noncompliance posed immediate jeopardy to the health and safety of its residents because Petitioner did not provide its residents with a safe smoking environment. The survey agency also found that Covington's noncompliance continued from April 5, 2013, but this noncompliance did not pose immediate jeopardy. Based on a subsequent survey, the survey agency determined that Petitioner returned to substantial compliance on April 26, 2013. The Centers for Medicare & Medicaid Services (CMS) accepted the survey agency's findings, and imposed a $3,550 per-day civil money penalty (CMP) against Petitioner for the period of immediate jeopardy level noncompliance, and a $100 per-day CMP for the remaining period of noncompliance, for a total CMP of $701,450. Petitioner requested a hearing before an administrative law judge (ALJ) challenging the immediate jeopardy

level noncompliance finding and the enforcement remedy based on that finding, but did not challenge the CMP imposed from April 5, 2013, through April 26, 2013.

Based on the record, I conclude that Petitioner was not in substantial compliance with Medicare participation requirements for the period the survey agency cited based on its failures to properly assess the smoking ability of a resident and supervise that resident, who accidently lit her clothes on fire while trying to light a cigarette, and to have a fire extinguisher located within 75 feet of the facility's designated smoking area. I also conclude that Petitioner's noncompliance posed immediate jeopardy to resident health and safety on September 20, 2012, the date that the resident lit her clothes on fire, through October 10, 2012, the date by which Covington implemented substantial improvements to its resident smoking procedures and Covington's Quality Assurance Committee assessed the effectiveness of those procedures. I further conclude that the $3,550 per-day CMP that CMS imposed is reasonable for September 20, 2012, through October 10, 2012. Finally, I conclude that Petitioner has come forward with evidence to establish that CMS's determination that Petitioner's noncompliance posed immediate jeopardy to resident health and safety from October 11, 2012, through April 4, 2013, was clearly erroneous, and I reduce the CMP against Petitioner to $100 per day from October 11, 2012, through April 4, 2013. Therefore, including the $100 per-day CMP from April 5, 2013, through April 26, 2013, Petitioner is liable for a total CMP of $94,350.

I. Background

The Social Security Act (Act) sets forth requirements for a SNF's participation in the Medicare program and authorizes the Secretary of Health and Human Services (the Secretary) to promulgate regulations implementing those statutory provisions. 42 U.S.C. § 1395i-3. The Secretary's regulations are found at 42 C.F.R. Parts 483 and 488. To participate in the Medicare program, an SNF must maintain substantial compliance with program participation requirements. To be in substantial compliance, an SNF's deficiencies may "pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. "Noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." *Id.*

The Secretary contracts with state agencies to conduct periodic surveys to determine whether SNFs are in substantial compliance. 42 U.S.C. § 1395aa(a); 42 C.F.R. § 488.10. The Act also authorizes the Secretary to impose enforcement remedies against SNFs that are not in substantial compliance with the program participation requirements. 42 U.S.C. § 1395i-3(h)(2). The regulations specify the enforcement remedies that CMS may impose. 42 C.F.R. § 488.406. Among other enforcement remedies, CMS may impose a per-day CMP for the number of days an SNF is not in substantial compliance or a per-instance CMP for each instance of the SNF's noncompliance. 42 C.F.R. § 488.430(a). A per-day CMP may range from either $50 to $3,000 per day for less serious noncompliance, or $3,050 to $10,000 per day for more serious noncompliance that poses

immediate jeopardy to the health and safety of residents. 42 C.F.R. § 488.438(a). If CMS imposes a CMP based on a noncompliance determination, then the facility may request a hearing before an ALJ to challenge the noncompliance finding and enforcement remedy. 42 U.S.C. §§ 1320a-7a(c)(2), 1395i(h)(2)(B)(ii)); 42 C.F.R. §§ 488.408(g), 488.434(a)(2)(viii), 498.3(b)(13).

Immediate jeopardy exists when a facility's noncompliance "has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. An ALJ must affirm an "immediate jeopardy" determination unless Petitioner shows that it is clearly erroneous. 42 C.F.R. § 498.60(c)(2). The "clearly erroneous" standard imposes a heavy burden on SNFs and CMS may prevail where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *See Barbourville Nursing Home*, DAB No. 1962, at 11 (2005) (citing *Florence Park Care Ctr.*, DAB No. 1931, at 27-28 (2004). The regulation does not require that a resident actually be harmed. *See Lakeport Skilled Nursing Ctr.*, DAB No. 2435, at 8 (2012).

Covington is an SNF located in Covington, Georgia, that participates in the Medicare program. Between April 1 and April 5, 2013, the state agency conducted a standard survey of Petitioner's facility. Petitioner Exhibit (P. Ex.) 5 at 4. While that survey was ongoing, on April 3, 2013, surveyors notified Petitioner that it was not in substantial compliance with federal regulations for long-term care facilities beginning September 20, 2012, and that the noncompliance posed ongoing immediate jeopardy to resident health and safety since that time. The surveyor's determination of immediate jeopardy focused on a September 20, 2012 incident where a resident ignited her blouse while she tried to light a cigarette, as well as certain resident smoking practices that had been ongoing since September 20, 2012. *See* P. Ex. 5 at 15-22. Specifically, surveyors noted "the use of unsafe ashtrays; lack of a fire extinguisher in close proximity of the smoke area; and unsecured storage of smoking materials." P. Ex. 5 at 15. These factors, according to surveyors, "resulted in the likelihood of an immediate and serious threat to resident health and safety for those six (6) residents" at the facility who smoked. P. Ex. 5 at 15.

From these findings, surveyors documented a violation of 42 C.F.R. § 483.25(h), which requires that a facility ensure the resident environment remain as free from accident hazards as possible and that each resident receives adequate supervision and assistive devices to prevent accidents. The surveyors also determined that Covington abated immediate jeopardy on April 5, 2013, by providing an acceptable corrective plan to remove immediate jeopardy, although Covington continued to be noncompliant at a lower level of noncompliance when surveyors ended the survey on April 5, 2013, because "the effectiveness of these corrective plans could not be fully assessed to ensure ongoing application and completion . . . ." P. Ex. 5 at 4. The surveyors also found that Covington was not in compliance with seven other health and safety regulations (i.e., 42 C.F.R. §§ 483.13(a), 483.15(a), 483.15(h)(2), 483.20(k)(3)(i), 483.25(k), 483.35(i), 483.65), all of which were below the immediate jeopardy level. P. Ex. 5 at 5-15, 22-34.

In an April 23, 2013 initial determination, CMS stated that it was imposing enforcement remedies on Covington based on the findings from the survey completed on April 5, 2013. CMS imposed a $3,550 per-day CMP from September 20, 2012, through April 4, 2013, and a $100 per-day CMP effective April 5, 2013, until Covington achieved substantial compliance. P. Ex. 6.

The survey agency conducted a revisit of Covington's facility and, CMS determined that Covington achieved substantial compliance with Medicare program requirements as of April 26, 2013. P. Ex. 8; CMS Ex. 24. In a July 24, 2013 letter, CMS informed Covington that the total CMP owed was $701,450, which was based on 197 days of immediate jeopardy and 21 days of noncompliance at a level below immediate jeopardy. P. Ex. 9.

Petitioner timely requested a hearing to dispute CMS's finding that it was not in substantial compliance with 42 C.F.R. § 483.25(h) and that its lack of compliance resulted in immediate jeopardy. Petitioner did not appeal the other seven deficiencies below the immediate jeopardy level. Following receipt of Petitioner's hearing request, I issued an Acknowledgment and Initial Prehearing Order. In that order, I directed the parties to file briefs, proposed exhibits, and written direct testimony for all witnesses they wanted to present in this case.

In compliance with my prehearing order, CMS filed a prehearing brief (CMS Br.) and 30 proposed exhibits (CMS Exs. 1-30). Petitioner then filed its prehearing brief (P. Br.) along with 55 proposed exhibits (P. Exs. 1-55). Subsequently, Petitioner filed the written direct testimony for a substitute witness, which I marked as P. Ex. 56. Hearing Transcript (Tr.) at 7

CMS and Petitioner both requested to cross-examine witnesses. I held a video-hearing at which Petitioner's counsel cross-examined two of CMS's witnesses (Cynthia Lane and Anne Thomas) and CMS's counsel cross-examined three of Petitioner's witnesses (John Kampmeyer, Thomas Peters, and Trisha Arroyo). *See* Tr. at 3. At the hearing, I admitted CMS Exs. 1-27, 29-30 and P. Exs. 1-30, 37, 39, 40-53, 55-56. Tr. at 21-22, 25. However, because one of Petitioner's witnesses, Chris Wells, was not present to be cross-examined, I later excluded P. Ex. 48, which was his written direct testimony. Tr. 14-15, 21, 25.

After the hearing CMS and Petitioner filed post hearing briefs (CMS Post Hearing Br. and P. Post Hearing Br.), reply briefs (CMS Reply and P. Reply) and Sur-reply briefs (CMS Sur-reply and P. Sur-reply).

II. Issues

The issues presented are:

1. Whether Petitioner was in substantial compliance with Medicare participation requirements at 42 C.F.R. § 483.25(h) from September 20, 2012, through April 4, 2013;

2. If Petitioner was not in substantial compliance with Medicare program requirements, whether CMS's determination that immediate jeopardy existed at the facility from September 20, 2012 through April 4, 2013, is clearly erroneous; and

3. If Petitioner was not in substantial compliance with Medicare participation requirements, is the CMP amount imposed on Petitioner reasonable.

III. Jurisdiction

I have jurisdiction to hear and decide this case. 42 U.S.C. §§ 1320a-7a(c)(2), 1395i(h)(2)(B)(ii); 42 C.F.R. §§ 488.408(g), 488.434(a)(2)(viii), 498.3(b)(13).

IV. Findings of Fact

1. Prior to September 20, 2012, Covington had smoking policies and procedures that called for assessing each resident who smoked to determine whether the resident could "keep smoking supplies on their person" and smoke "out of doors"; however, for "[r]esidents deemed incapable of smoking safely," Covington indicated it might counsel the residents, remove the residents' smoking supplies to be kept in the nursing medication room, supervise the residents while smoking, and require the residents to use a smokers' apron. P. Ex. 10 at 2; CMS Ex. 12 at 2.

2. Resident B, also referred to as Resident 41, is a female born on May 16, 1957, who had previously had brain surgery and was diagnosed with Alzheimer's disease. CMS Ex. 14 at 1; CMS Ex. 18 at 4, 5.

3. On July 18, 2012, a social worker at Covington assessed Resident B for smoking, noting that Resident B had a Brief Interview for Mental Status (BIMS) score of 9, but otherwise appeared able to independently smoke cigarettes. P. Ex. 17 at 10; P. Ex. 45 at 2; CMS Ex. 18 at 4.

4. Although Resident B had previously quit smoking, on August 8, 2012, she started to smoke again and, by August 15, 2012, was found to comply with the requirement that she smoke on the front porch of the facility. CMS Ex. 18 at 5.

5. On September 20, 2012, Resident B went to the facility's front porch and, while attempting to light a cigarette, put the lighter too close to her body, resulting in her blouse catching fire. P. Ex. 17 at 9; P. Ex. 55 at 2; CMS Ex. 18 at 1, 6, 7.

6. Resident B unsuccessfully attempted to extinguish the fire out by "slapping at it," and ultimately had to remove the blouse. CMS Ex. 18 at 6.

7. Although other residents were present when Resident B lit her blouse on fire, no Covington staff members were present. Tr. 130; CMS Ex. 18 at 6.

8. Resident B stated that "I set myself on fire" and described her injures as being burned from her "waist all the way up," with burn scars resulting on "her left chin/neck and left breast." CMS Ex. 18 at 1, 6; CMS Ex. 26 at 1; *see also* P. Ex. 55 at 2, 3.

9. Resident B was sent to a hospital and then a burn center. P. Ex. 55 at 2-4; CMS. Ex. 18 at 6.

10. Resident B received second degree burns. P. Ex. 17 at 9.

11. Following the incident with Resident B, on September 20-21, 2016, Covington instituted several changes regarding smoking safety (Tr. at 44; P. Ex. 41 at 3). Covington:

    a. Issued a new smoking policy with the following provision (P. Ex. 10 at 1; CMS Ex. 12 at 1; *see also* P. Ex. 41 at 4; P. Ex. 42 at 3-5; P. Ex. 43 at 2; P. Ex. 45 at 3; P. Ex. 46 at 2-3; P. Ex. 49 at 2; *see also* Tr. at 51):
        i. Residents may only smoke at seven set times during the day;
        ii. A facility staff member will be present to monitor and assist residents;
        iii. Residents may only smoke on the facility's front porch;
        iv. Residents' smoking materials are kept at the nurse station; and
        v. Residents must wear a smoking apron when smoking;

    b. Reassessed each of the residents who were smokers at the facility (Tr. at 50-51; P. Ex. 14; P. Ex. 45 at 4; P. Ex. 46 at 2); and

    c. Posted signs informing guests that they could not give residents smoking materials (Tr. 65; P. Ex. 43 at 4; P. Ex. 45 at 3; P. Ex. 46 at 3; P. Ex. 49 at 2).

12. On September 21, 2012, Covington initiated in-service training for staff on the new smoking policy, and completed the training of all personnel on September 24, 2012. P. Ex. 20 at 1-3; P. Ex. 43 at 3; P. Ex. 45 at 2.

13. Resident B returned to Covington on September 25, 2016, but ceased smoking. P. Ex. 55 at 4; *see also* P. Ex. 17 at 9.

14. On September 25, 2012, Covington conducted a new assessment for Resident B and determined that she was not a safe smoker and that "[i]f she smokes she will be observed by staff, cigarettes will be lit by staff and a smoking apron will be provided." P. Ex. 17 at 9.

15. On October 10, 2012, Covington's Quality Assurance Committee considered all of the steps Covington had taken with regard to smoking safety following Resident B's incident on September 20, 2012, and determined that it was in agreement with the new policy and that it did not have any additional recommendations to make. P. Ex. 23 at 1; P. Ex. 41 at 5; P. Ex. 45 at 5; P. Ex. 46 at 5-6; P. Ex. 50 at 2; *see also* P. Ex. 49 at 3.

16. During the survey in April 2013, the front porch designated as Covington's smoking area had sprinklers (P. Ex. 43 at 3; P. Ex. 44 at 2; P. Ex. 46 at 2, 6; P. Ex. 47 at 5).

17. During the survey conducted in April 2013, the front porch was more than 75 feet away from a fire extinguisher in the facility. Tr. 164-65, 232; P. Ex. 43 at 4; CMS Ex. 29 at 3; CMS Ex. 30 at 3.

18. During the survey conducted in April 2013, Covington's smoking area had a large metal ash receptacle with a plastic liner. *See* Tr. 72-74.

19. The plastic liner used in the ash receptacle melted rather than ignited when in contact with flames. Tr. 76-77, 186-87; P. Ex. 1; P. Ex. 40 at 4; P. Ex. 41 at 6; P. Ex. 43 at 3; P. Ex. 45 at 6.

20. During the survey conducted in April 2013, Covington personnel would extinguish cigarettes by placing the cigarettes into a cup of water. Tr. 66; P. Ex. 42 at 8; CMS Ex. 26 at 1.

21. During the survey conducted in April 2013, the residents' smoking materials were stored in an unlocked tackle box at the nurse's station. Tr. 58-59, 158; P. Ex. 45 at 6; CMS Ex. 26 at 4; CMS Ex. 27 at 1.

22. Covington has not had any other incidents where residents have been burned while smoking. P. Ex. 41 at 5; *see also* Tr. 128.

V. Conclusions of Law and Analysis

My conclusions of law are in italics and bold.

An SNF "must ensure that . . . the resident environment remains as free of accident hazards as is possible" and "[e]ach resident receives adequate supervision . . . ." 42 C.F.R. § 483.25(h). In order for an SNF to be in substantial compliance with this requirement, the SNF's deficiencies may "pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301.

1. Covington was not in substantial compliance with 42 C.F.R. § 483.25(h) at the immediate jeopardy level because Covington failed to provide an environment as free as possible from accident hazards, and failed to provide an adequate smoking assessment and supervision to Resident B while she was lighting a cigarette, resulting in accidental burns.

The immediate jeopardy determination related to 42 C.F.R. § 483.25(h) rests initially with the September 20, 2012 incident where Resident B lit her blouse on fire causing injuries to her body. P. Ex. 5 at 16-17. As CMS made clear in its prehearing brief:

> In this case, immediate jeopardy was determined to exist from September 20, 2013 through April 4, 2013. On September 20, 2012, Resident B caught either a lit cigarette or a lighter too close to her blouse, catching it afire. She required hospitalization and has burn scars on the left side of her chin and neck and on her left breast. There were several other residents present, and they could have been injured. Moreover, had the fire spread, residents who did not even smoke (and staff and visitors) could have been injured. It is unclear how the fire was contained, but when staff arrived, the fire was no longer burning. That situation, along with deviations from the [National Fire Protection Association's] requirements, constituted immediate jeopardy. . . . Even if residents are assessed as safe smokers and they have moderate or higher cognitive functioning, they still may not

> be able to think or move fast enough to extinguish a fire before they or others are severely injured. Indeed, Resident B may have initially fanned the flames higher unintentionally before she removed her burning blouse.

CMS Br. at 6-7 (citations omitted).

Section 483.25(h) does not provide instructions on how an SNF may ensure an environment free from accident hazards, except to include a requirement that SNF's provide adequate supervision of residents. However, CMS issued an interpretive guideline for section 483.25(h) in the State Operations Manual on the subject of smoking. SNFs may permit residents to smoke, however; a facility's assessment of a "resident's capabilities and deficits determines whether or not supervision is required." State Operations Manual, Appendix PP; CMS Ex. 6 at 7. Further, "[t]he facility must ensure precautions are taken for resident's individual safety . . . such precautions may include . . . supervising residents whose assessment and plans of care indicate a need for supervised smoking . . . ." State Operations Manual, Appendix PP; CMS Ex. 6 at 8.

Covington assessed Resident B in July 2012 as a safe smoker who could smoke independently. However, even though the social worker making the assessment noted that Resident B had an Alzheimer's disease diagnosis and a BIMS score of 9, she did not believe this impeded her ability to smoke independently. P. Ex. 45 at 2; CMS Ex. 18 at 4. It is significant that the BIMS score relates to an "individual's attention, orientation and ability to register and recall information" and that a score of 9 means that Resident B was at the low end of being "moderately impaired" (i.e., a score of 7 is "severe impairment"). CMS Ex. 22 at 2, 5. As indicated above, Resident B lit her blouse on fire, injuring herself, while attempting to light a cigarette without supervision from staff.

Most of Covington's witnesses registered disbelief that Resident B accidently lit her blouse on fire while trying to light a cigarette since Covington had assessed her as a safe smoker. P. Ex. 41 at 2 ("Still, somehow, her blouse ignited and she suffered a burn requiring treatment."); P. Ex. 42 at 2; P. Ex. 43 at 2 ("The fact she suffered this incident was unfortunate."); P. Ex. 45 at 2 ("The incident that occurred on September 20, 2012 was very unfortunate and truly an aberration."); P. Ex. 46 at 2; P. Ex. 49 at 1 ("In my opinion, she was a safe smoker that had [an] unfortunate accident."). However, when Resident B returned to Covington after being away for five days at a burn center, Covington immediately assessed her as follows: "She is unsafe [at] smoking and will not be allowed to keep lighter, matches, or cigarettes in room or on self." P. Ex. 17 at 9. Had Covington truly believed that it had correctly assessed Resident B initially as a smoker who could independently smoke and that the September 20, 2012 incident was purely an accident, Covington would not have radically reassessed Resident B's smoking abilities.

In fact, Resident B was not the only one who Covington reassessed as no longer being able to smoke independently. Resident 7 had been assessed as a safe smoker who could independently smoke for years, including as late as September 6, 2012; however, on September 20, 2012, he was reassessed and determined not to be an independent smoker. P. Ex. 14 at 14-19; P. Ex. 17 at 7-8. Further, Resident B.T. was assessed as a safe smoker on June 6, 2012, but determined not to be one on September 20, 2012. P. Ex. 17 at 2-3. These new assessments call into question the efficacy of Covington's previous assessments.

On November 10, 2011, CMS issued an alert to state survey agencies concerning smoking safety. In that document, CMS stated that it had learned of a resident of a long term care facility who had been assessed to smoke unsupervised, but who accidently ignited her clothes and died of those injuries. CMS Ex. 5 at 1. When discussing assessments for smoking ability, CMS counseled that "[f]acilities should err on the side of caution and provide staff, family or volunteer supervision when unsure of whether or not the resident is safe to smoke unsupervised." CMS Ex. 5 at 2.

In the present case, Covington failed to properly assess Resident B and, consequently, failed to supervise her while smoking. This lead to an environment that was far from free of accident hazards. In fact, Resident B was injured. Therefore, based on the September 20, 2012 incident involving Resident B, I conclude that Covington was not in substantial compliance with section 483.25(h) as of September 20, 2012. Further, I conclude that CMS's determination that Covington's noncompliance was at the immediate jeopardy level is not clearly erroneous. *See* 42 C.F.R. § 498.60(c)(2).

2. Covington was not in substantial compliance with 42 C.F.R. § 483.25(h) because it failed to have a fire extinguisher located no more than 75 feet from Covington's designated smoking area; however, it was clearly erroneous for CMS to conclude that this deficiency was at the immediate jeopardy level.

The deficiency related to section 483.25(h) rests in part on the survey agency's findings related to fire extinguishers. During the survey, a surveyor, questioning a certified nursing assistant who was supervising residents who were smoking, was unable to locate a fire extinguisher near the designated smoking area. P. Ex. 5 at 18. Later in the survey, a surveyor and a Covington employee measured the distances from the designated smoking area to the fire extinguishers at the facility and determined that they were all more than 75 feet away. P. Ex. 5 at 19.

Petitioner asserts in response that CMS's determination is in error because: the certified nursing assistant told the surveyor that if a resident were on fire, she would smother the fire and would not use a fire extinguisher; fire extinguishers are not supposed to be used on people; and Covington's designated smoking area is free of flammable or hazardous

materials. P. Post Hearing Brief at 1-4. From this, Petitioner concludes that the distance between the designated smoking area and the closest fire extinguished is irrelevant. P. Post Hearing Br. at 4-6.

CMS contests that Petitioner's designated smoking area does not have flammable materials present, and asserts in particular that Petitioner's designated smoking area does not have a concrete floor. CMS Sur-reply at 5-6. CMS avers that one of Petitioner's employees was unable to locate a fire extinguisher when asked by a surveyor and that Petitioner did not identify what staff would use to smother a fire. Finally, CMS argues that "most importantly, it remains undisputed that Petitioner did not meet an explicit requirement to have fire extinguishers within 75 feet of the smoking area." CMS Sur-reply at 6.

Section 5.1.4 of the National Fire Protection Association's (NFPA) Life Safety Code requires the maximum travel distance to a fire extinguisher be 75 feet. CMS Ex. 7 at 4. SNFs must comply with NFPA's Life Safety Code. 42 C.F.R. § 483.70(a). Further, meeting the NFPA's fire extinguisher requirement is part of ensuring that a smoking area is safe. *See* CMS Ex. 5 at 2.

There is no dispute in this case that during the survey conducted in April 2013, the front porch (i.e., the designated smoking area) was more than 75 feet away from a fire extinguisher in the facility. Tr. 164-65, 232; P. Ex. 43 at 4; CMS Ex. 29 at 3; CMS Ex. 30 at 3. As discussed below, while a fire extinguisher is not preferred as a method of extinguishing a person who is on fire, it nevertheless is extremely important to stop the spread of fire on other combustible materials. As Petitioner's fire safety expert testified:

> Q -- please just bear with me there. Okay. So then, if -- so would you say, then, what is the purpose of the NFPA regulation requiring fire extinguishers to be every 75 feet? Is it -- what would you say that? Let me leave it open-ended like that.
> A Typically, it's there so that someone seeing a fire in material laying on a floor, in a can, whatever, can run to get that fire extinguisher and train it on the fire, within a reasonable length of time before it would become deep seated.

Tr. 184. As can be seen by the incident involving Resident B, smoking or attempting to smoke can result in fire. Resident B's blouse went on fire and Resident B, unable to extinguish it with her hands, removed the blouse still aflame. Assuming that the front patio of Petitioner's facility has concrete flooring (a matter CMS disputes because Petitioner's pictures of the front porch appear to show wood planks and not concrete), the pictures of the smoking area show other combustibles, such as wooden rocking chairs and

a bench. P. Ex. 25 at 7; *see also* Tr. 122. Therefore, I conclude that Petitioner's failure to comply with the NFPA's standard for fire extinguishers, especially in connection with an area designated for lighting and smoking cigarettes, could result in more than minimal harm to residents and thus placed Petitioner out of substantial compliance with 42 C.F.R. § 483.25(h).

Although I conclude that Petitioner failed to have a fire extinguisher within 75 feet of the designated smoking area, I also conclude that CMS's determination that this deficiency resulted in immediate jeopardy is clearly erroneous. "Immediate jeopardy" exists when "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. In the present case, Petitioner's conduct is not likely to cause serious injury, harm, impairment, or death.

As Petitioner's fire safety expert witnesses make clear, a fire extinguisher is not used on people if they are on fire because it may injure them. Tr. 180, 209-210. Individuals on fire should stop, drop, and roll, if able, or if another individual is assisting, that individual could smother the fire with a lab coat, smoker's apron, or jacket. Tr. 181-83, 211; P. Ex. 40 at 5. Therefore, Petitioner's failure to have a fire extinguisher within 75 feet of the designated smoking area would not have affected the possible harm or death that could result if a resident were on fire, as Resident B had been on fire. To the extent that Petitioner's deficient conduct resulted in reduced firefighting capability concerning fires of combustible objects, the record shows that the designated smoking area had a sprinkler system that could suppress fire. (P. Ex. 43 at 3; P. Ex. 44 at 4; P. Ex. 46 at 2, 6; P. Ex. 47 at 5). This sprinkler does not absolve Petitioner from meeting NFPA standards for fire extinguishers, but it does significantly reduce the potential for harm regarding combustible objects in the designated smoking area.

Therefore, I conclude that Petitioner was out of substantial compliance with 42 C.F.R. § 483.25(h) based on its failure to properly locate a fire extinguisher within 75 feet of the designated smoking area, but that it is clearly erroneous to determine that this deficiency placed residents in immediate jeopardy.

3. Covington's ashtrays do not support a determination that Covington was not in substantial compliance with 42 C.F.R. § 483.25(h).

CMS contends that Covington had an unsafe resident environment because it extinguished cigarettes in cups of water and placed a plastic liner in its ash trays located in the designated smoking area. Section 19.7.4 of NFPA's Life Safety Code requires that ashtrays be made of noncombustible materials. CMS Ex. 7 at 3; *see also* CMS Ex. 5 at 2.

As a preliminary matter, although the Statement of Deficiencies prepared by the survey team may have indicated that Petitioner was unsafe for extinguishing cigarettes in cups of

water, the survey team members did not indicate so during testimony. Tr. 71, 157. Following the September 20, 2012 incident with Resident B, Covington heavily regulated resident smoking, which included staff supervision of all smoking by residents. The use of a cup of water to extinguish cigarettes was supervised by staff and meant to ensure safety. *See* P. Ex. 42 at 8; P. Ex. 45 at 6. I conclude that such a practice does not constitute a failure to be in substantial compliance with 42 C.F.R. § 483.25(h).

Further, the survey team thought that Petitioner's ash trays were safe, except for the fact that Petitioner added plastic liners to the ash receptacle. Tr. 74. However, the survey team appears to have assumed that the liners in the ash receptacles were flammable, rather than determining the liners were flammable. Tr. 72 ("I don't know that [the plastic liners] were flammable."); Tr. 158-160. In fact, the survey team did not know what type of plastic liner was being used in the ash receptacles during the survey. Tr. 77, 113-114.

I conclude that Petitioner has presented sufficient evidence that the liners in the ash receptacle would not burn, but rather would melt. Petitioner submitted a video demonstration of a liner melting on contact with a flame. P. Ex. 1; *see also* Tr. 76 (surveyor acknowledging that the video showed a liner that "did not appear to be flammable."). Although this video and associated documentation (P. Ex. 2) about the type of liner Petitioner used appeared to lack authentication during the hearing, based on my review of the testimony in this case, there is sufficient reason to conclude that the video and associated documentation is reliable evidence.

One of Petitioner's witnesses expressly identified Covington's now former operator, Ronny Crump, and its now former Administrator, C.L. Johnson, as the individuals who made the video. P. Ex. 43 at 3. Mr. Crump testified that Petitioner had "video evidence that the ashtrays are not a fire hazard. The video evidence demonstrates that the ashtrays do not support combustion at all." P. Ex. 41 at 6. Further, he testified that "the video demonstrates that, contrary to the surveyor's conclusion, the plastic liner they cite as a basis for immediate jeopardy is not combustible. It cannot support a flame, let along cause a fire." P. Ex. 41 at 8. CMS had the opportunity to cross-examine Mr. Crump regarding the video or the type of plastic liner used by Covington, but decided not to do so. Tr. 251. While Petitioner ought to have submitted testimony that clearly authenticated the video and other evidence regarding the plastic liners used by Covington, I have no reason to conclude that Petitioner's video is not what Petitioner purports it to be.

Based on the information provided from Petitioner, Petitioner's fire safety expert, John Kampmeyer, testified that the plastic liners, being made of high density polyethylene, represented only a slight or minimal risk of being a fire hazard. P. Ex. 40 at 4. Mr. Kampmeyer concluded that "[t]he portion of the plastic liner tha[t] extended several inches from the bottom of the top metal portion of the ashtray did not represent a risk of a hazard and was not likely to cause or contribute to a fire." P. Ex. 40 at 4. I give weight

to the opinion of Mr. Kampmeyer because he has had 52 years of experience in the field of fire protection and mechanical engineering, has been affiliated with/served on NFPA committees for 38 years, and testified without evasion. Tr. 195; P. Ex. 40 at 1, 8-11.

One of the surveyors also took the position that even if the liner was not combustible, the melting plastic liner could still burn a resident. Tr. 155. However, Mr. Kampmeyer gave testimony refuting this potential:

> Q -- Okay. And do you know how that would affect the surrounding areas of that bag? Specifically, okay, the flame, touched to that particular area of the bag, the bag would be hot to the touch, wouldn't it?
> A Yes, but it was very -- in other words, what will happen with high-density polyethylene is it will begin to contract as you do -- it melts at a temperature of something in the order of 450 degrees. It in and of itself has no ignition temperature, according to the MSDS sheet. So therefore, it will simply melt when you heat -- put a flame to it, as was done in the video. So the video is very typical of the way high-density polyethylene reacts.
> Q -- Okay. And would the area -- the metal area around that bag, while it's melting, would that get any hotter?
> A There would be a rise in temperature, but nothing significant, mainly because there's no -- very little mass to that polyethylene. You know, I mean, any time you have some -- a source of heat near it, probably there would be more heat transmitted from the torch that the gentleman was using than there would be from the burning plastic, simply because it was essentially no mass to the plastic.

Tr. 186-187.

I accept Mr. Kampmeyer's expert opinion that there was minimal risk using the plastic liners and that there would be no significant rise in temperature of the metal touching a melting plastic liner. Therefore, I conclude that Covington's ash receptacle liners do not serve to support that it was not in substantial compliance with 42 C.F.R. § 483.25(h).

4. Covington's placement of smoking materials in an unlocked box at the nurse's station does not support a determination that Covington was not in substantial compliance with 42 C.F.R. § 483.25(h).

The surveyors observed that Covington collected all of the smoking materials from the residents and kept them in a container at the nurse's station. P. Ex. 5 at 17. During their time at the Covington, surveyors noted that the unlocked container holding the smoking materials was often on the floor just inside the nurse's station and that the nurse's station did not have any secured entrances to it. P. Ex. 5 at 19, 20; CMS Ex. 26 at 4-5. One of the members of the survey team thought that Covington's previous policy of locking residents' smoking materials in the facility's medication room was "stronger" than the new policy of keeping the smoking materials at the nurse's station. Tr. at 48; *see also* Tr. 49 ("Other than where the smoking materials were stored, I didn't have any other concerns.")

Covington collected the smoking materials of all of the residents and placed them in a tackle box, and placed the tackle box at the nurses' station. P. Ex. 41 at 4; P. Ex. 42 at 5; P. Ex. 43 at 2. The survey team did not observe any residents try to take smoking materials from the box at the nurse's station, and did not ask Covington staff if that had happened in the past. Tr. 100. The survey team indicated that no rule required that the box be locked, but that it must be inaccessible. Tr. at 108. Indeed, CMS indicates that a precaution that a facility may take regarding smoking is "limiting accessibility of matches and lighters by residents who need supervision when smoking." State Operations Manual, Appendix PP; CMS Ex. 6 at 8.

As Petitioner pointed out during cross-examination, and the state surveyor agreed, after September 20, 2012, Covington took smoking materials away from all residents, even assessed safe smokers, and that this exceeded the standard of care. Tr. at 108-09. Petitioner's witnesses all testified that the box with the smoking materials was safe.

Mr. Crump testified to the following:

> The surveyors stated a resident could sneak behind the nurses' station and retrieve these materials. I disagree. All residents voluntarily complied with new restrictions. In 30 years, I have never seen or heard of [a] time when a resident sneaked behind the nurses' station at Covington Manor. Based on those 30 years of experience at Covington Manor, my personal knowledge of the residents and their demonstrated compliance with the stringent safe smoking guidelines, it was not likely any resident would sneak behind the nurses' station to get cigarettes. The latched box kept behind the nurse's station that contained the smoking materials was "secure."

P. Ex. 41 at 4. Mr. Johnson testified:

> We required the tackle box with a latch to be kept behind the nurses' station. We had no reason to believe that was not a safe area or that any of the residents who were smokers would attempt to go to the tackle box. I am personally aware of the residents who were assessed as safe smokers. I knew them all very well. And, I also know that they were compliant and obeyed our enhanced smoking policies and requirements.

P. Ex. 42 at 5. Linda Portfield, Covington's former Director of Nursing, testified: "I have never in the 18 years I worked at Covington Manor seen a resident go behind the nurses' station, unless brought there by a nurse. Based on almost two decades of experience at Covington Manor, I disagree with the surveyor's statement that the smoking materials were not secure." P. Ex. 43 at 2; see also P. Ex. 44 at 5; P. Ex. 45 at 6.

A surveyor agreed during cross-examination that she had no reason to disbelieve Covington personnel who said that none of the residents had tried to remove the box with smoking materials from the nurse's station. Tr. 147-148. Mr. Kampmeyer, one of Petitioner's fire safety experts, opined that Petitioner's method of storing the smoking supplies was secure, and pointed to the fact that Covington did not experience any attempts by residents to improperly take smoking supplies from the tackle box. P. Ex. 40 at 6-7.

I conclude, based on the record, that Petitioner's placement of smoking supplies in a tackle box and storing that box at the nurse's station was sufficient to render the smoking materials inaccessible to residents, and, therefore, not a basis to conclude that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h).

5. Covington was not in substantial compliance with Medicare program requirements from September 20, 2012, through April 26, 2013; however, Covington's noncompliance was at the immediate jeopardy level only from September 20, 2012, through October 10, 2012, the date on which Covington had implemented all of its changes to its smoking safety policy and Covington's Quality Assessment Committee had time to assess their effectiveness.

The survey agency and CMS determined that Petitioner's deficient conduct commenced on September 20, 2012, due to the accident in which Resident B lit her clothes on fire while trying to light a cigarette and continued until April 2013, when Petitioner corrected three practices that were determined to be unsafe: lack of a fire extinguisher in close proximity to the smoking area; unsafe ashtrays; and the unsecured storage of smoking materials. P. Ex. 5 at 15-22; P. Ex. 8. Based on the record in this case, I concluded that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h) because it failed to provide an adequate smoking assessment and supervision to Resident B to ensure that

she did not accidently injure herself while lighting a cigarette and failed to meet maximum safe distance requirement to obtain a fire extinguisher in the Life Safety Code of the National Fire Protection Association (NFPA). Further, Petitioner did not appeal various other deficiencies for which CMS determined Petitioner returned to compliance on April 26, 2013.

As indicated above, CMS's determination that Petitioner's actions related to Resident B caused immediate jeopardy, starting on September 20, 2012, was not clearly erroneous. However, I concluded that CMS's determination that Petitioner placed residents in immediate jeopardy until April 4, 2013, was clearly erroneous. Therefore, I modify CMS's determination and conclude that Petitioner placed residents in immediate jeopardy from September 20, 2012, until October 10, 2012, the date by which Petitioner had implemented all of its changes to its smoking procedures and Petitioner's Quality Assurance Committee reviewed and approved the effectiveness of those changes. However, because I concluded that Petitioner was not in substantial compliance concerning the position of its fire extinguishers, and that that deficiency was not remedied until April 4, 2013, I conclude that Petitioner was not in substantial compliance with Medicare program requirements below the immediate jeopardy level from October 10, 2012, through April 4, 2013.

My choice of October 10, 2012, as the final day of immediate jeopardy is based on the significant actions Petitioner took in response to Resident B's incident (see Findings of Fact 11 through 15 above). Further, Mr. Kampmeyer, the fire safety expert, assessed the changes Petitioner made after September 20, 2012, and he called them "significant steps . . . to tighten up procedures to prevent further accidents." He also concluded:

> Because of the appropriate measures instituted by the facility as of September 20, 2012, I do not believe that there was a risk of any resident suffering serious harm in the very near future as a result of the smoking environment. To the contrary, it is my expert opinion that when considering all of the measures and interventions undertaken by the staff, it was unlikely any resident would be harmed . . . .

P. Ex. 40 at 7. Petitioner's other fire safety expert also stated that the changes Petitioner instituted would make another incident like the one Resident B suffered very unlikely. Tr. 224-25.

Therefore, Petitioner is subject to civil money penalties for 21 days of immediate jeopardy and 188 days of substantial noncompliance below the immediate jeopardy level.

6. CMS's determination of the amount of CMP per day is reasonable.

In determining whether the per day CMP amounts imposed against Petitioner are reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f). 42 C.F.R. § 488.438(e)(3). These factors include: (1) the facility's history of compliance; (2) the facility's financial condition; (3) the factors specified at 42 C.F.R. § 488.404; and (4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort, or safety. The absence of culpability is not a mitigating factor. The factors at 42 C.F.R. § 488.404 include: (1) the scope and severity of the deficiency; (2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and (3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies. Unless a facility contends that a particular regulatory factor does not support the CMP amount, the ALJ must sustain it. *Coquina Ctr.*, DAB No. 1860, at 32 (2002).

In the present case, CMS imposed a CMP of $3,550 per day for Petitioner's noncompliance at the immediate jeopardy level and $100 per day for its noncompliance at below the immediate jeopardy level. P. Ex. 6. The total CMP imposed was $701,450.

CMS urges me to accept the per day amount imposed for the immediate jeopardy level deficiencies because that amount is only $500 more than minimum required under regulations. CMS Br. at 8; CMS Post Hearing Br. at 12; CMS Reply 9-10. CMS also points out that the $100 per-day CMP for the deficiencies below the immediate jeopardy level is only $50 above the minimum permissible amount, although CMS indicates that it might want to have the opportunity to raise this amount should I not conclude that immediate jeopardy existed from September 20, 2012, through April 4, 2013. CMS Br. at 8 n.6; CMS Reply Br. at 10 n.7. Petitioner only urges me not to impose any CMP, but otherwise did not set forth any argument as to what amount I should set if I upheld any of the deficiencies. P. Post Hearing Br. at 19; P. Reply Br. at 16-17; P. Sur-reply at 11.

To the extent that CMS seeks remand of this case to reevaluate the CMP amount in this case, I deny that request. Remand is not necessary because I have authority to review the penalty amount as long as I apply criteria from the regulations, do not review CMS's discretionary decision to impose a CMP, and do not reduce the penalty to zero. 42 C.F.R. § 488.438 (e).

After considering the factors in the regulations, I conclude that the per day CMP amounts imposed by CMS are reasonable.

Petitioner has a history of noncompliance related to smoking and fire safety issues; however, they comprise only four "D" level deficiencies (i.e., the lowest level of noncompliance) from 2009. CMS Ex. 23 at 1-2.

In regard to consideration of Petitioner's financial condition, I cannot conclude that this is a reason to reduce the penalty amount in this case because the record does not contain any information showing Petitioner's financial condition.

I consider Petitioner to be culpable regarding the incident of Resident B. As indicated above, Petitioner permitted a resident with Alzheimer's disease and a BIMS score showing a moderate degree of impairment to independently smoke, resulting in physical harm to the resident.

In regard to the scope and severity of the deficiency, as indicated above, I agree that CMS properly determined that Petitioner's deficiency was at the immediate jeopardy level; however, I determined that not all of the deficiencies cited concerning the immediate jeopardy existed or were at the immediate jeopardy level. As a result, I concluded that Petitioner was able to abate the immediate jeopardy earlier than CMS determined. However, I upheld the total amount of time Petitioner was noncompliant with Medicare program requirements, just at a level below the immediate jeopardy level.

Based on the factors above, I conclude that a $3,550 per-day CMP during the immediate jeopardy period is reasonable and a $100 per-day CMP is reasonable for the period below the immediate jeopardy level. The $3,550 amount is in the lower range for immediate jeopardy matters (i.e., per-day CMPs for immediate jeopardy can be from $3,050 to $10,000). 42 C.F.R. § 488.438(a)(1)(i). The $100 per-day amount is only $50 more than minimum amount that the regulation requires to be imposed. 42 C.F.R. § 488.438(a)(1)(ii).

VI. Conclusion

I conclude that Petitioner was not in substantial compliance with Medicare program requirements from September 20, 2012, through April 26, 2013, and that Petitioner's noncompliance was at the immediate jeopardy level from September 20, 2012, through October 10, 2012, and owes a CMP of $3,550 per day for each day of noncompliance at the immediate jeopardy level and a CMP of $100 per day for each day of noncompliance at a level below the immediate jeopardy level. Therefore, Petitioner is liable for a total CMP of $94,350.

/s/
Scott Anderson
Administrative Law Judge