Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Crestview Health and Rehabilitation,
(CCN: 44-5409),

Petitioner,

v.

Centers for Medicare & Medicaid Services

Docket No. C-13-433

Decision No. CR3886

Date: May 21, 2015

DECISION

Petitioner, Crestview Health and Rehabilitation, is a long-term care facility located in Nashville, Tennessee, that participates in the Medicare program. Based on a Life Safety Code (LSC) survey, completed December 4, 2012, the Centers for Medicare & Medicaid Services (CMS) determined that the facility was not in substantial compliance with multiple LSC provisions, including those related to emergency egress and fire alarm procedures, and that its deficiencies posed immediate jeopardy to resident health and safety. CMS imposed an $8,000 per-instance civil money penalty (CMP). Petitioner appeals.

For the reasons set forth below, I find that the facility was not in substantial compliance with Life Safety Code requirements and that the penalty imposed is reasonable. I have no authority to review the immediate jeopardy determination.

I. Background

The Social Security Act (Act) sets forth requirements for nursing facility participation in the Medicare program and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act § 1819. The Secretary's regulations are found at 42 C.F.R. Part 483, and include the requirement that facilities comply with all applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association (NFPA). 42 C.F.R. § 483.70(a). To participate in the Medicare program, a nursing facility must maintain substantial compliance with these and all other program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. The regulations require that each facility be surveyed annually, with no more than fifteen months elapsing between surveys. 42 C.F.R. § 488.308(a). Facilities must be surveyed more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a), 488.308.

Here, surveyors from the Tennessee Department of Health (state agency) completed health and LSC surveys on December 6, 2012.[1] Based on the survey findings, CMS determined that the facility was not in substantial compliance with the following LSC provisions:

- K018 (LSC § 19.3.6.3) – which regulates corridor doors – at scope and severity level D (isolated instance of noncompliance that causes no actual harm, with the potential for more than minimal harm);

- K025 (LSC § 19.3.7) – which regulates smoke barriers – at scope and severity level D;

- K038 (LSC §§ 7.1 and 19.2.1) – which includes means of egress requirements – at scope and severity level L (widespread immediate jeopardy);

- K050 (LSC § 19.7.1.2) – which governs fire drills – at scope and severity level L;

- K064 (L.S.C. §§ 9.7.4.1 and 19.3.5.6) – which governs fire extinguishers – at scope and severity level D;

[1] The LSC survey was completed on December 4, and the health survey was completed on December 6. The findings from the health survey are not included in this appeal.

- K067 (L.S.C. §§ 9.2 and 19.5.2) – which governs heating, ventilating, and air conditioning – at scope and severity level E (pattern of noncompliance that causes no actual harm with the potential for more than minimal harm);

- K130 (L.S.C. §§ 8.2.3.2.4.2 and 8.3.4.1) – which include miscellaneous requirements for smoke/fire barriers and penetrations and openings in those barriers – at scope and severity level D;

- K147 (L.S.C. § 9.1.2) – which governs electrical wiring and equipment – at scope and severity level D; and

- K211 (L.S.C. §§ 8.4.3 and 19.3.2.7) – which addresses alcohol-based hand-rub solutions – at scope and severity level D.

CMS Exs. 1, 10. Based on these findings, CMS has imposed a per-instance CMP of $8,000. CMS Ex. 8-9.

Petitioner timely requested a hearing.

The parties have filed pre-hearing briefs (CMS Br.; P. Br.), closing briefs (CMS Cl. Br.; P. Cl. Br.); and CMS filed a reply brief (CMS Reply). I have admitted into evidence CMS exhibits (CMS Exs.) 1-12 and Petitioner's exhibits (P. Exs.) 1-4. The parties submitted the direct testimony of their witnesses in the form of affidavits. Because neither party elected to cross-examine any of the witnesses, we did not convene an in-person hearing. Order Following Prehearing Conference (Nov. 7, 2013); Order (Dec. 13, 2013).

II. Issues

The issues before me are:

1. Was the facility in substantial compliance with Medicare LSC requirements; and

2. If the facility was not in substantial compliance, is the penalty imposed – $8,000 per-instance – reasonable.

Initially, Petitioner also challenged the immediate jeopardy findings. An administrative law judge may review CMS's scope and severity findings (which include a finding of immediate jeopardy) only if a successful challenge would affect the range of the CMP or if CMS has made a finding of substandard quality of care that results in the loss of approval of a facility's nurse aide training program. 42 C.F.R. § 498.3(b)(14), (d)(10);

Cedar Lake Nursing Home, DAB No. 2344 at 9 (2010); *Evergreen Commons*, DAB No. 2175 (2008); *Aase Haugen Homes*, DAB No. 2013 (2006). For a per-instance penalty, the regulations provide only one range ($1,000 to $10,000), so the level of noncompliance here does not affect the range of the CMP. 42 C.F.R. § 488.438(a)(2).

The facility does not claim that it risks losing approval of a nurse aide training program. Even if it did, CMS's scope and severity finding would not affect approval of such a program. By statute and regulation, if, as here, CMS imposes a penalty of $5,000 or more, the state agency cannot approve the program, so the facility would lose its approval without regard to the immediate jeopardy finding. Act § 1819(f)(2)(B); 42 C.F.R. § 483.151(b)(2)(iv).

Thus, because the immediate jeopardy finding does not affect the range of the CMP or cause the facility to lose approval of its nurse aide training program (if it has one), the finding is not reviewable, which Petitioner conceded in its closing brief. P. Cl. Br. at 4.

III. Discussion

A. The uncontested evidence establishes that the facility was not in substantial compliance with the requirements of the LSC cited at Tags K018, K025, K064, K067, K130, K147, and K211.[2]

In addition to the two immediate jeopardy deficiencies, the surveyors cited the following:

K018 (LSC § 19.3.6.3) – Among other requirements, corridor doors must "be provided with a means suitable for keeping the door closed. . . ." L.S.C. § 19.3.6.3.2; CMS Ex. 10 at 14. The surveyors observed that a corridor door to one of the clean utility rooms did not fully close and latch in its frame. CMS Ex. 1 at 2; CMS Ex. 2 at 12; CMS Ex. 11 at 2, 6 (Byrd Decl. ¶¶ 3, 11); CMS Ex. 12 at 2, 6-7 (Hart Decl. ¶¶ 2, 11). The surveyors, Richard Byrd and Caleb Hart, are fire safety specialists. They explain that, because the door could not be closed (creating a barrier), smoke and fire would not be contained in the utility room if a fire broke out there. Smoke and fire could spread through the facility corridors. CMS Ex. 11 at 6 (Byrd Decl. ¶ 11); CMS Ex. 12 at 6-7 (Hart Decl. ¶ 11).

K025 (LSC § 19.3.7) – Smoke barriers must have a fire resistance rating of at least a half hour. L.S.C. § 19.3.7.3; CMS Ex. 10 at 14. The surveyors observed a missing ceiling tile in the facility's mechanical room. CMS Ex. 1 at 3; CMS Ex. 2 at 15; CMS Ex. 11 at 2, 6 (Byrd Decl. ¶¶ 3, 11); CMS Ex. 12 at 7 (Hart Decl. ¶¶ 2, 11). As Fire Safety Specialists

[2] My findings of fact/conclusions of law are set forth, in bold and italics, as captions in the discussion section of this decision.

Byrd and Hart point out, an electrical fire can begin in the facility's mechanical room, and, with the ceiling tile missing, the fire would not be contained in that room. CMS Ex. 11 at 6-7 (Byrd Decl. ¶ 11); CMS Ex. 12 at 6-7 (Hart Decl. ¶ 11).

K064 (LSC §§ 9.7.4.1 and 19.3.5.6) – Portable fire extinguishers must be provided in all health care occupancies, and they must be inspected at least monthly. LSC §§ 9.7.4.1, 19.3.5.6; NFPA 10; CMS Ex. 10 at 11, 13. The surveyors noted that the fire extinguisher in the basement mechanical room had not been inspected since June 2012, six months earlier. CMS Ex. 1 at 12; CMS Ex. 2 at 25; CMS Ex. 11 at 2, 7 (Byrd Decl. ¶¶ 3, 11); CMS Ex. 12 at 2, 7 (Hart Decl. ¶¶ 2, 11). Because the extinguisher had not been inspected in such a long time, the facility risked its being inoperable if needed. CMS Ex. 11 at 7 (Byrd Decl. ¶ 11); CMS Ex. 12 at 7 (Hart Decl. ¶ 11).

K067 (LSC §§ 9.2 and 19.5.2) – Heating, ventilation, and air conditioning systems must be installed properly and must comply with NFPA standards. LSC §§ 9.2, 19.5.2; NFPA 90 A and B; CMS Ex. 10 at 10, 15. The surveyors noted that the vents in six of the resident bathrooms were not functioning. CMS Ex. 1 at 13; CMS Ex. 11 at 2, 7 (Byrd Decl. ¶¶ 3, 11); CMS Ex. 12 at 2, 7 (Hart Decl. ¶¶ 11). An inoperable bathroom vent can cause moisture to build up, leading to mold or water damage; it may expose residents to noxious fumes and unpleasant odors. CMS Ex. 11 at 7 (Byrd Decl. ¶ 11); CMS Ex. 12 at 7 (Hart Decl. ¶ 11).

K130 (LSC §§ 8.2.3.2.4.2 and 8.3.4.1) – Doors in smoke barriers must close with minimal clearance (the amount necessary for proper operation) and must not have undercuts, louvers, or grills. LSC § 8.3.4.1; CMS Ex. 10 at 8. Similarly, pipes, conduits, cables, wires, air ducts, pneumatic tubes and ducts, and similar equipment that passes through fire barriers must be protected. LSC § 8.2.3.2.4.2; CMS Ex. 10 at 7. The surveyors observed a door leading to the kitchen that did not close within its frame; they also observed a hole near a light fixture in a janitor's closet. That closet contained chemicals, which could ignite. CMS Ex. 1 at 14-15; CMS Ex. 2 at 30; CMS Ex. 11 at 2, 7 (Byrd Decl. ¶¶ 3, 11); CMS Ex. 12 at 2, 7 (Hart Decl. ¶¶ 2, 11). The fire specialists explained that these breaches in the smoke barriers meant that any smoke or fire originating in the kitchen or janitor's closet could not be contained, but would spread. CMS Ex. 11 at 7 (Byrd Decl. ¶ 11); CMS Ex. 12 at 7 (Hart Decl. ¶ 11).

K147 (LSC § 9.1.2) – Electrical wiring and equipment must comply with NFPA 70. LSC § 9.1.2; CMS Ex. 10 at 10. The surveyors observed unsecured and overloaded power strips, which created the risks of the strips overheating, sparking, and/or igniting a fire. Several outlets were in disrepair, creating risks of accidental electrocution and outlet sparking, which could start an electrical fire. CMS Ex. 1 at 15-16; CMS Ex. 2 at 30; CMS Ex. 11 at 7 (Byrd Decl. ¶ 11); CMS Ex. 12 at 7 (Hart Decl. ¶ 11).

K211 (LSC §§ 8.4.3 and 19.3.2.7) – Alcohol-based hand rubs must be installed properly. They may not be installed over or adjacent to an ignition source. LSC §§ 8.4.3, 19.3.2.7; CMS Ex. 1 at 16; CMS Ex. 10 at 9. The surveyors observed alcohol-rub dispensers mounted above a night light and an electrical outlet in the first floor physical therapy room. CMS Ex. 1 at 17; CMS Ex. 11 at 7 (Byrd Decl. ¶ 11); CMS Ex. 12 at 7 (Hart Decl. ¶ 11). The highly flammable alcohol could spill or leak into the electrical source, igniting a fire. CMS Ex. 11 at 7 (Byrd Decl. ¶ 11); CMS Ex. 12 at 7 (Hart Decl. ¶ 11).

Petitioner does not directly challenge any of these survey findings. Rather, it complains that, because CMS's December 14, 2012 notice letter did not specify "that the facility was not in substantial compliance due to any certain tag," CMS did not provide proper notice that the non-immediate jeopardy tags contributed to the finding of substantial noncompliance. P. Cl. Br. at 7; *see* CMS Ex. 8.

Referring to the December surveys, CMS's notice letter advises Petitioner: that the facility was not in substantial compliance with federal requirements for nursing homes participating in the Medicare and Medicaid programs; that, on December 3 and 4, the facility's deficiencies posed immediate jeopardy to resident health and safety; and that the facility remained out of substantial compliance thereafter. The letter refers the facility to the statement of deficiencies (CMS form 2567) provided by the state agency (CMS Ex. 1). CMS Ex. 8 at 1. The letter is explicit: CMS based the $8,000 per-instance CMP on "your facility's noncompliance as evidenced by the findings of the December 4, 2012 LSC survey. . . ." CMS Ex. 8 at 2. Thus, the notice letter advised Petitioner that CMS imposed the CMP because of *all* the deficiencies cited at scope and severity level D or greater. *See* Act § 1819(h); 42 C.F.R. § 488.400 (authorizing the Secretary to impose remedies when a facility is not in substantial compliance with program requirements); 42 C.F.R. § 488.301 (defining substantial compliance as a level of compliance such that deficiencies pose no greater risk than the potential for causing minimal harm). Nothing in the letter suggests that the CMP was limited to the immediate jeopardy findings. Moreover, Petitioner well understood this, as evidenced by its hearing request, which appeals "all deficiencies and findings of noncompliance in this matter[,]" including "each tag cited in the survey." Hearing Request at 2.

Citing 42 C.F.R. § 488.301, Petitioner also maintains that the non-immediate jeopardy tags did not "serve as bases for the CMP because they posed no greater risk to resident health or safety than the potential for causing minimal harm." P. Cl. Br. at 7. The undisputed evidence establishes otherwise. The non-immediate jeopardy deficiencies were cited at scope and severity levels D and E – levels considered substantial noncompliance. As the fire specialists' testimony establishes, each of these deficiencies have the potential for more than minimal harm. CMS Ex. 11 at 6-7 (Byrd Decl. ¶ 11); CMS Ex. 12 at 6-7 (Hart Decl. ¶ 11). Petitioner offers no evidence challenging that testimony.

Indeed, except to dismiss the significance of a door that does not latch properly or a missing ceiling tile (P. Cl. Br. at 7), Petitioner does not discuss the particular findings. But doors must close properly and ceilings must be intact because they are smoke and fire barriers. If breached, smoke and fire would not be contained, but would spread, putting facility residents and staff at risk of very serious harm. CMS Ex. 11 at 6-7 (Byrd Decl. ¶ 11); CMS Ex. 12 at 6-7 (Hart Decl. ¶ 11). If smoke and fire breach the ceiling, the breach is especially serious because the fire can spread undetected until the ceiling collapses.

Thus, CMS has presented compelling and unchallenged evidence establishing that the facility was not in substantial compliance with the non-immediate jeopardy deficiencies cited. I therefore conclude that the facility was not in substantial compliance with Medicare requirements, and CMS may impose a penalty.

B. The facility was not in substantial compliance with requirements of K050 because staff were not able to activate the fire-alarm system.

Facility staff must conduct quarterly fire drills on each shift to familiarize facility personnel with the alarm signals and how they should respond to them. LSC § 19.7.1.2; CMS Ex. 10 at 16. Personnel must respond promptly and effectively in order to protect residents. Among other requirements, all staff must know how to: 1) transmit an appropriate fire alarm signal to warn other building occupants; 2) summon staff; 3) confine the fire by closing doors; and 4) relocate residents. LSC § 19.7.2.1. Staff must be instructed in the use of and response to fire alarms. LSC § 19.7.2.3.

At the time of the survey, the facility had eighty residents. Only thirteen were able to ambulate independently. Twelve required assistance or an assistive device to ambulate. Fifty-five spent all or most of their time in chairs. Two were bedfast. CMS Ex. 4 at 1.

On December 3, the surveyors, with the assistance of the facility's maintenance director, staged a fire drill. Surveyor Hart pulled a resident's call-bell. When a staff member responded, he told her that the surveyors were conducting a fire drill. That staff member told a nurse aide to activate the nearest fire alarm. But the nurse aide did not activate the alarm; she lifted the cover but did not pull the handle to trigger the fire-alarm system. Seeing her error, another employee (either the maintenance director or the director of nursing) pulled the handle. CMS Ex. 12 at 2 (Hart Decl. ¶ 3); *but see* P. Ex. 3 at 1 (McKinnon Decl. ¶ 3).

Petitioner excuses the nurse aide's inability to activate the alarm, arguing that the facility is not required to execute every fire drill without incident. P. Cl. Br. at 2. Petitioner claims that the nurse aide had been properly trained and knew how to activate a fire alarm, but thought, "momentarily" and mistakenly, that she had activated the alarm.

Under an earlier system, someone could set off the alarm by simply lifting the plastic casing. P. Cl. Br. at 2-3. The nurse aide justifies her error by explaining that she was "really nervous" because the surveyor was watching her. P. Ex. 3 at 1 (McKinnon Decl. ¶ 3).

Notwithstanding its employee's inability to activate the fire alarm, Petitioner argues that it complied with the LSC requirements because it trained its staff and conducted fire drills. P. Cl. Br. at 3. But all the training sessions in the world will not satisfy the LSC requirements unless staff learn how to respond in an emergency. I have no doubt that the presence of a surveyor could be nerve-wracking, but that pales when compared to the stress induced by a rapidly expanding fire. Staff must be so well-trained that they can set off an alarm no matter how nervous they are. Lives may depend on it. Because the facility's employee was not able to activate the fire alarm as required, the facility was not in substantial compliance with the requirements of K050.

C. The facility was not in substantial compliance with the requirements of K038 because residents and staff could not immediately leave the facility in an emergency.

Residents and staff must be able to leave the facility in case of an emergency. To ensure this, the means of egress (i.e., way to get out) must be "free of all obstructions or impediments to *full instant use* in the case of fire or other emergency." LSC § 7.1.10.1; CMS Ex. 10 at 4. (emphasis added). Any device or alarm that restricts the "improper use of a means of egress" must be designed and installed so that it cannot impede or prevent the emergency use of the means of egress. LSC § 7.1.9; CMS Ex. 10 at 4. Exit doors may be equipped with an approved access control system, but that system must meet certain criteria. Among those criteria, if the part of the access control system that locks the doors loses power, the doors *must unlock automatically* in the direction of egress. LSC § 7.2.1.6.2(b); CMS Ex. 10 at 6. That way, residents and staff have a "safe and accessible escape route." CMS Ex. 11 at 4 (Byrd Decl. ¶ 7); CMS Ex. 12 at 3 (Hart Decl. ¶ 6).

Petitioner concedes that, during the December 3 fire drill, the system malfunctioned, and the exit doors did not unlock. P. Br. at 2. When the fire alarm went off, staff were not able to leave the building because the doors remained locked. CMS Ex. 11 at 2-3 (Byrd Decl. ¶ 4).

The facility's eight exit doors were equipped with magnetic locks, which the state agency approved, with the caveats that (among other requirements): 1) all staff have the exit code for the locking devices; and 2) the doors unlock if the power controlling the lock is

lost or the fire detection/sprinkler system is activated. CMS Ex. 6 at 2; *see* LSC § 7.2.1.6.2(b). These conditions comport with LSC requirements and are designed to make sure that facility residents and staff are not trapped in a burning building. CMS Ex. 11 at 3 (Byrd Decl. ¶ 7); CMS Ex. 12 at 3 (Hart Decl. ¶ 6).

Each of the exit doors had a card-reading device in place. To override or disable the magnetic locks, staff could manually swipe a card through the reader, that is, if staff had such a card. It seems that the facility initially complied with this condition and gave functional key cards to everyone, but staff misused the cards by propping the doors open at night. Without the state agency's knowledge or approval, the facility disabled most of the cards. P. Ex. 1 at 1-2 (Blaylock Decl. ¶ 6). At the time of the survey, only two key cards were equipped to disable the locks, one for the maintenance director and one for the facility's director of nursing. Understandably, during the fire drill, the surveyors did not observe any staff member using a card-reader to unlock the exit doors. CMS Ex. 11 at 4 (Byrd Decl. ¶ 8); CMS Ex. 12 at 4 (Hart Decl. ¶ 7). Thus, as the surveyors opined, the card-reader system was virtually worthless. To unlock any doors, the maintenance director or director of nursing had to be physically present in the facility and in possession of his/her key card. He or she would have to go to each of the eight exit doors to swipe the card and disable the locks. Considering that the smoke and fire would likely impede their ability to move through the facility, they would not be able to do it (assuming they were even present in the facility). CMS Ex. 11 at 5 (Byrd Decl. ¶ 9); CMS Ex. 12 at 4 (Hart Decl. ¶ 8). In the meantime, residents and staff would be trapped.

I reject Petitioner's claim that it was not required to provide exit codes to all staff because the state had approved, as failsafe, its alternative to the key card system – kill-switches. *See* P. Br. at 9; P. Ex. 1 at 3 (Blaylock Decl. ¶ 9). First, the state agency's approval letter unambiguously required that all staff be able to unlock the doors. CMS Ex. 6 at 2. Second, the kill-switches proved inadequate during the December 3 fire drill. The facility had only two such kill-switches. They were located far from the exit doors – at the nursing stations, which are in the centers of the facility's first and second floors. If smoke or fire blocked access to the nursing stations, the switches would be inaccessible. CMS Ex. 5; CMS Ex. 11 at 4 (Byrd Decl. ¶ 7); CMS Ex. 12 at 3 (Hart Decl. ¶ 6).

During the fire drill, a kill-switch did not immediately unlock the doors because it took time for someone to realize that the facility had an exit problem, then get to one of the kill-switches, and to activate it. When he realized that the facility's unlocking system had malfunctioned, the maintenance director – who had been on the second floor with Surveyor Hart – joined Surveyor Byrd on the first floor and, together, they went to the closest nurses' station and pushed the kill-switch. According to Surveyor Byrd, the doors began to unlock slowly and sequentially. Surveyor Byrd estimated that two to three minutes elapsed between the time the maintenance director pushed the button and the time the final door unlocked. CMS Ex. 11 at 3 (Byrd Decl. ¶ 5); CMS Ex. 12 at 2-3 (Hart Decl. ¶ 4). Petitioner concedes that the doors "are set at different time intervals," but

then says that they "immediately unlocked as soon as the kill switch button was pushed." P. Br. at 3; P. Ex. 2 at 2 (Santana Decl. ¶ 6). If set at different intervals, I do not understand how all could have opened "immediately," but, even assuming that the final door opened within a short time of the kill-switch activation, the system fell short. Surveyor Hart began the drill at 1:05 p.m. CMS Ex. 12 at 2 (Hart Decl. ¶ 3). The doors were finally unlocked at about 1:15 p.m. CMS Ex. 1 at 4. This can be a very long time when smoke and fire are bearing down on the aged and infirm.

Petitioner claims that the system is nevertheless failsafe because any staff member can push the kill-switch, and staff are almost always at or near the nurses' stations. P. Ex. 1 at 2-3 (Blaylock Decl. ¶ 9). The problem with this argument is that it did not happen during the December 3 fire drill. For whatever reason, no staff person activated a kill-switch button until the maintenance director went from the second to the first floor and did so.[3] I agree with the fire safety specialists. Having only two kill-switches in place to disable the locks was wholly inadequate.

The surveyors also tested the facility's smoke alarm system. The smoke detector activated facility-wide alarms, but the exit doors remained locked. CMS Ex. 11 at 3 (Byrd Decl. ¶ 6); CMS Ex. 12 at 3 (Hart Decl. ¶ 5).

Citing LSC § 19.2.2.2.5, Petitioner argues that the facility needed just one means of rapidly removing locks. P. Cl. Br. at 2. That provision says that each door may have only one locking device (i.e., doors may not have multiple locks), and lists potentially acceptable means for allowing building occupants to leave a locked building – remote control of locks, staff carrying exit keys "at all times," or other reliable means of unlocking the doors. But those means must be *adequate* and *reliable*. Here, the facility's means of unlocking exit doors was neither adequate nor reliable. The automatic unlocking system failed; the card-readers were virtually nonexistent; and the kill-switch was inadequate. It took too long for someone to realize that it had to be activated and then to get to one of the switches.

Thus, the facility did not meet LSC requirement that the means of egress be free of obstructions and that doors automatically unlock in case of an emergency. Nor did the facility comply with the state agency's conditions that all staff have the exit code for the locking devices and that doors automatically unlock in case of an emergency. The facility was therefore not in substantial compliance with Tag K038, LSC §§ 7.1 and 19.2.1.

[3] No one has explained why the maintenance director activated the first floor kill switch, given that he was on the second floor when the alarm went off.

D. The penalty imposed is reasonable.

To determine whether a CMP is reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f): (1) the facility's history of noncompliance; (2) the facility's financial condition; (3) factors specified in 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 in 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.

I consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found, and in light of the section 488.438(f) factors. I am neither bound to defer to CMS's factual assertions nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Ctr.*, DAB No. 1848 at 21 (2002); *Cmty. Nursing Home*, DAB No. 1807 at 22 *et seq*. (2002); *Emerald Oaks*, DAB No. 1800 at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1638 at 8 (1999).

Here, CMS imposed a penalty of $8,000 per-instance, which is in the higher range for a per-instance CMP ($1,000-$10,000), but is modest considering what CMS might have imposed. 42 C.F.R. § 488.408(e)(1)(iv); *see Plum City Care Ctr.*, DAB No. 2272 at 18-19 (2009) (observing that even a $10,000 per-instance CMP can be "a modest penalty when compared to what CMS might have imposed").

Except to argue that it was in substantial compliance so no penalty should have been imposed, Petitioner does not challenge the amount of the CMP, so it has arguably waived the issue. In any event, the December survey was a "Special Focus Certification Survey," which shows that the facility had a significant history of substantial noncompliance. A facility becomes subject to special focus surveys if it "has consistently demonstrated failure to maintain compliance," and its practices have caused harm to residents. A special focus facility must be surveyed at least once every six months. Act § 1819(f)(8).

Petitioner has not suggested that its financial condition affects its ability to pay this relatively small CMP.

Applying the remaining factors, I find that the facility's LSC deficiencies were significant, putting the entire facility – residents and staff – at risk. The facility was at heightened risk of fire spreading because not all staff knew how to activate the fire alarms, and the smoke/fire barriers were compromised. Even more frightening, residents and staff attempting to evacuate the building were likely to find themselves locked in. In

approving magnetic locks for the exit doors, the state agency had insisted that all staff be capable of unlocking the doors. Yet, without the state agency's knowledge or approval, the facility cancelled staff's means for disabling the locks, for which I find the facility culpable.

For these reasons, I find this relatively small CMP reasonable.

IV. Conclusion

The facility was not in substantial compliance with multiple Life Safety Code requirements, and the $8,000 per-instance penalty is reasonable.

/s/
Carolyn Cozad Hughes
Administrative Law Judge