Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
NHC Healthcare Glasgow,	)	
(CCN: 18-5093),	)	Date: June 20, 2007
	)	
Petitioner,	)	
	)	Docket No. C-06-276
- v. -	)	Decision No. CR1613
	)	
Centers for Medicare & Medicaid	)	
Services.	)	
	)	

DECISION

Petitioner, NHC Healthcare Glasgow (Petitioner or facility), is a long-term care facility located in Glasgow, Kentucky, that is certified to participate in the Medicare program as a provider of services. Fires broke out in two of its heating/air conditioning units on November 23 and December 5, 2005, respectively. Following the second fire, the Centers for Medicare & Medicaid Services (CMS) determined that the facility was not in substantial compliance with Medicare participation requirements, 42 C.F.R. § 483.70 (Physical Environment) and the Life Safety Code of the National Fire Protection Association (incorporated into the regulations at section 483.70(a)(1)), and that the facility's deficiencies posed immediate jeopardy to resident health and safety. CMS imposed a $10,000 per instance civil money penalty (CMP). Petitioner here challenges CMS's determinations.

For the reasons set forth below, I find that the facility was not in substantial compliance with program requirements, and I find reasonable the $10,000 per instance CMP. I have no authority to review the immediate jeopardy finding.

I. Background

Responding to a report of a November 23, 2005 fire in one of the facility's HVAC (heating, ventilation and air conditioning) units, surveyors from the Kentucky Office of the Inspector General (State Agency) completed a complaint investigation survey of the facility on November 29, 2005. At that time, the facility assured the surveyors that it would take steps to inspect each individual unit, and the State Agency took no further action. On December 5, 2005, however, a second fire broke out in another HVAC unit, and the State Agency completed a second complaint investigation on December 15, 2005. CMS Exhibits (Exs.) 2, 3. Based on those survey findings, CMS determined that the facility was not in substantial compliance with federal requirements for nursing homes participating in the Medicare program; specifically, the facility did not meet federal requirements under 42 C.F.R. § 483.70(f) (Tag F-463 – Physical Environment) and the Life Safety Code. CMS Ex. 4. CMS imposed a $10,000 per instance CMP.

The facility timely requested a hearing.

The hearing convened on December 7, 2006, in Louisville, Kentucky. Marian J. Hayden, Esq. appeared on behalf of Petitioner and Michelle A. Gilliam, Esq. appeared on behalf of CMS. I have admitted CMS Exs. 1 through 29, and Petitioner's (P.'s) Exs. 1 through 17. Order (November 28, 2006); Tr. at 1-2.

II. Issues

The case presents the following questions:

- Whether, from November 23 through December 4, 2005, the facility was in substantial compliance with requirements for facilities participating in the Medicare program, specifically 42 C.F.R. § 483.70, and the Life Safety Code (LSC) of the National Fire Protection Association (NFPA).

- If the facility was not in substantial compliance, is the amount of the CMP imposed, $10,000 per instance, reasonable?

Except insofar as the "scope and severity" of the deficiencies cited are factors considered in determining the reasonableness of the penalty, I have no authority to consider whether CMS's immediate jeopardy finding is clearly erroneous.

III. Discussion

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 (Secretary) to promulgate regulations implementing the statutory provisions. Act, section 1819. The Secretary's regulations governing nursing facility participation in the Medicare program are found at 42 C.F.R. Part 483. Facilities must maintain substantial compliance with program requirements, and, 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.

A. Knowing that its aging HVAC units presented significant risk of fire, the facility failed to inspect and maintain them adequately, and was therefore not in substantial compliance with the program participation requirements set forth at 42 C.F.R. § 483.70 and the Life Safety Code.[1]

Section 483.70 requires that the facility be equipped and maintained "to protect the health and safety of residents, personnel, and the public." Among other specific requirements, the facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. 42 C.F.R. § 483.70(c)(2).

The facility must also meet the applicable provisions of the 2000 edition of the Life Safety Code of the NFPA. 42 C.F.R. § 483.70(a)(1)(i). The Life Safety Code is a set of fire protection requirements designed to provide a reasonable degree of safety from fires. It requires that the facility maintain and operate in a manner that avoids undue danger to the lives and safety of its residents from fire, smoke, fumes, or resulting panic. NFPA 101 § 1.2.1.[2]

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[1] I make Findings of Fact and Conclusions of Law (Findings) to support my decision in this case. I set forth each Finding, in italics and bold, as a separate heading.

[2] In the Statement of Deficiencies, the surveyors cited to NFPA 101 and cross-referenced to NFPA 70 National Electrical Code § 110-3 (1999 ed.), and to NFPA 99 Standards for Health Care Facilities (1999 ed.). NFPA 70 National Electrical Code (1999 ed.) provides, at § 110-3, for the examination and use of equipment. It requires that the facility evaluate "heating effects under normal conditions of use and also under abnormal conditions likely to arise in service," and to consider "arcing effects." Section 110-3(a)(5) and (6); CMS Ex. 3, at 4. NFPA Standards for Health Care Facilities (1999 ed.) notes that equipment or wiring faults can cause abnormal temperatures, which can cause fires and explosions. Chapter 7-2.1; CMS Ex. 3, at 5. CMS has not explained the relationship between these provisions and the 2000 edition of the LSC. On the other hand, Petitioner has not challenged their applicability here. At a minimum, these

In this facility, the resident rooms were heated and air-conditioned by individual wall HVAC units. CMS Exs. 17, 18, 19. On November 23, 2005, a fire broke out in the HVAC unit of Room 108; it was caused by a loose internal wire that broke and ignited the unit's air filter. The unit was apparently turned off at the time. CMS Ex. 9, at 13; CMS Ex. 20, at 2 (Gunn Declaration (Decl.) ¶ 7); P. Ex. 3; P. Ex. 17, at 5. It seems that the unit was "bought new" in 1977. P. Ex. 17, at 7; CMS Ex. 12, at 1.

State surveyors, including Life Safety Code Inspector Michael Gunn, visited the facility on November 29, 2005, to investigate the fire. CMS Ex. 20, at 2. Responding to the surveyors' concerns, facility staff outlined steps they would take to prevent similar fires. Inspector Gunn has not been consistent as to what they actually promised. At a state administrative proceeding, he testified that staff "said they were going to have their maintenance supervisor to check all the units, all the other units in the facility." P. Ex. 17, at 5. In the declaration filed here, however, he said that "the facility was to have a certified electrician check all of [the facility's] 121 AC/heaters, and have its maintenance staff replace any faulty units." CMS Ex. 20, at 3 (Gunn Decl. ¶ 7). I find it highly unlikely that staff promised that a certified electrician would perform the inspections. By the time the surveyors arrived, the certified electrician had come and gone. On November 28, 2005, he checked the unit in Room 108 (which was the one that caught fire) and he checked the breaker, *i.e.*, made sure it went on and off. Tr. at 28-29. He did not look at the remaining units or perform any other service. Tr. at 29. Nevertheless, no one disputes that, at a minimum, the facility promised to "check" all 121 of the wall units, and to replace or repair any that were found faulty. The surveyors accepted this as adequate and cited no deficiencies. CMS Ex. 20, at 2-3 (Gunn Decl. ¶ 7); Tr. at 7-8.[3]

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provisions guide facilities in taking measures to avoid fire, and thus comply with NFPA 101. The discussion of their relationship to the LSC is somewhat academic in this case, however, since substantial noncompliance can be found based on the Physical Environment regulation alone (42 C.F.R. § 483.70).

[3] Pointing to the State Fire Marshall's Investigative Report, Petitioner argues that "neither routine maintenance nor replacing any internal components would have prevented the fire on November 23, 2005." P. Brief (Br.) at 2. Nothing in that report supports this claim. The report says that the fire was "caused by a loose wire." P. Ex. 3, at 3. I see no reason why an internal inspection might not have revealed a loose wire, and Petitioner offered no expert testimony to suggest otherwise. But the argument is irrelevant since CMS did not impose any penalty for the facility's failure to anticipate the November fire.

It seems, however, that the surveyors and the facility staff had different understandings of what it meant to "check" the operating units. The facility, using its own limited staff, neither of whom had received any specific HVAC training,[4] continued to provide only routine maintenance – which primarily involved changing air filters – and visually inspected the exteriors of the units. They did not remove covers to examine the wiring or any of the other interior components. CMS Ex. 20, at 3 (Gunn Decl. ¶ 7); Tr. at 8, 9; CMS Ex. 17; P. Ex. 17, at 7. Inspector Gunn explained, credibly, that since the first fire had been caused by electrical problems, the facility could not adequately examine the units without removing the covers and examining the switches, thermostats, and obvious electrical connections. Tr. at 9.

About a week later, on December 5, 2005, a fire broke out in the wall HVAC unit of Room 21. CMS Ex. 7, at 12. Fortunately, the occupant of Room 21 was elsewhere at the time. However, fire fighters reported that when they arrived at the facility on December 5, black smoke filled the hall of Room 21's wing. *Id.* One of the facility residents, whose respiratory system was already compromised, had to be taken to the emergency room for treatment of smoke inhalation, and subsequently required respiratory therapy. CMS Ex. 16, at 1, 2, 5, 11, 21; Tr. at 17.

Following the December 5 fire, the facility engaged its electrical contractor, HVAC Services, Inc. (HVAC Services), to inspect each unit. CMS Ex. 7, at 13. The HVAC inspectors completed their task that same evening, and, finding 41 units in resident-occupied rooms that required immediate attention due to potential fire hazards, removed them from service. CMS Ex. 2, at 4; CMS Ex. 3, at 4; CMS Ex. 12, at 16, 18; CMS Ex. 20, at 3 (Gunn Decl. ¶ 7). According to Inspector Gunn, the Service Manager for HVAC Services, Mark Brooks, specifically told him that the units were removed from service "due to conditions which were considered possible fire hazards." CMS Ex. 20, at 3 (Gunn Decl. ¶ 7).[5] According to Inspector Gunn:

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[4] The facility employed a maintenance supervisor and one maintenance staff member. CMS Ex. 12, at 2; CMS Ex. 20, at 3-4 (Gunn Decl. ¶ 9).

[5] I note a typographical error in the Gunn declaration. Referring to his interview with Service Manager Brooks, he indicates that the units were removed 12/04/05. CMS Ex. 20, at 3 (Gunn Decl. ¶ 7). Inasmuch as they were not even inspected until after the fire, and the other evidence identifies 12/5/05 as the appropriate date, the "04" was plainly a typo. *See* CMS Ex. 2, at 3; CMS Ex. 3, at 4; Tr. at 2.

> And this is a quote from Mr. Brooks: They found several units with cords and plugs that were discolored, possibly due to heat . . . He said that he found several units that needed immediate attention. He felt like all units needed to be gone through because of possible fire hazards . . . He gave me a list of 41 rooms, resident rooms, plus four other units in general purpose areas . . . He told me that they were unplugged and shut down until the repairs were made.
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> * * * *
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> I had to take the word of the people who were certified HVAC technicians that indicated to me that there were conditions in 41 units in resident rooms that had conditions that could be potential fire hazards.

P. Ex. 17, at 8.

Petitioner admits that units were removed from service, but denies that they posed any safety hazards, citing a January 9, 2006 letter from Service Manager Brooks. P. Br. at 3; P. Ex. 11. First, I would generally afford virtually no weight to Manager Brooks' letter, which was not made under oath or signed under penalty of perjury for false testimony. Petitioner did not include him as one of its witnesses, so he was not subject to cross-examination. Moreover, even accepting its contents, I note that the letter does not contradict Inspector Gunn's testimony. Manager Brooks does not deny the statements that Inspector Gunn attributes to him; he does not deny that multiple units were removed from service, nor that they presented potential hazards. The letter says that "no units were in a state of disrepair or in need of major care." But a unit that requires only minor repair can still present a serious fire hazard, as demonstrated by the November fire. That unit required only minor repair – one loose wire – which went undetected and resulted in a fire.

The letter goes on:

> Other changes were made to some units; however, our review did not uncover anything that was not in compliance with the manufacturer's recommendations or anything that had not been upgraded or addressed in compliance with the manufacturer's recommendations. It seemed apparent that the facility's maintenance department was servicing the units regularly.

P. Ex. 11. CMS has not alleged that the maintenance department failed to "service" the units in accordance with the manufacture's recommendations, *i.e.*, it changed filters regularly. For this reason, the surveyors gave the facility a pass following the November 23 fire. But mere adherence to the manufacturer's recommendations had not been sufficient to prevent that fire, and the facility was on notice that it needed to do more. If a facility has reason to believe that any of its mechanical systems are vulnerable, it has a duty to take all reasonable steps to ensure that those systems are in safe operating condition. I can think of no more effective notice of the fire dangers posed by these aging units – and the need to do more than what the facility had been doing – than the occurrence of an actual fire.

Petitioner thinks that, in order to establish substantial noncompliance, CMS must show a connection between the two fires, and must prove that the December fire was preventable. In truth, we will probably never be able to answer these questions, since the damage to the unit in Room 21 was so extensive that no one was able to determine the fire's cause. However, once the facility was on notice that its HVAC units were vulnerable, it was required to take all reasonable steps to inspect and maintain them. Had it taken those steps, and the December fire happened anyway, I could find no deficiency. But the evidence shows that it did not act until after the December fire. Only then did "the facility responsibly [contract] with an outside contractor to investigate and fully inspect all heating units in the facility." P. Br. at 3. I agree that the fire-prevention steps taken after the December fire were responsible and reasonable, but find that the facility should not have waited until after the *second* fire to act so responsibly.[6]

HVAC inspections, when finally performed, were not onerous; trained technicians (not a certified electrician) removed the covers and examined the interiors, a process that took hours, not days.

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[6] I note also that, on December 5, the sprinkler system did not activate, and the fire department discovered that it was not working. CMS Ex. 7, at 12. According to the fire department's report, as late as December 8, 2005, the facility did not have a reliable sprinkler system in place, and the facility employed a "fire watch system." CMS Ex. 7, at 14; CMS Ex. 23; P. Ex. 17, at 7. The fire marshal expressed concern that the documentation indicated that the sprinkler system's last inspection occurred in 2000. CMS Ex. 7, at 15; *see also*, CMS Ex. 28, at 2 (sprinkler system "in need of internal cleaning . . . pipes found to be partially full of foreign materials."). Inasmuch as Inspector Gunn gave the facility another pass, and CMS has barely mentioned, much less cited, this as a problem, the adequacy of sprinkler system maintenance is not before me.

The facility also contracted with a certified HVAC electrical technician to inspect all heating units in the facility, including all electrical components, and to service those units as needed. CMS Ex. 3, at 4. According to HVAC Services' documents, those inspections would occur quarterly. Among other tasks, HVAC Services agreed to inspect electrical connections at the compressor, heating elements, power cords, and receptacles. It would inspect and lubricate motors. It would remove the units at least semi-annually, chemically cleaning the evaporator and condenser coils. CMS Ex. 21, at 2-3. For these services, HVAC Services charged more than $40,000. CMS Ex. 21, at 3. The facility also determined that its maintenance staff required additional training in maintaining the units, and HVAC Services agreed to provide that. CMS Ex. 20, at 4 (Gunn Decl. ¶ 9).

Finally, Petitioner points out that the fire marshal's report following the November 23 fire did not include the kinds of recommendations contained in his report following the December 5 fire. P. Ex. 9. The contents of the fire marshal's report simply do not relieve the facility of its independent responsibility to maintain its equipment and to take reasonable steps to prevent fires.

B. I have no authority to review the finding of immediate jeopardy.

Because the facility was not in substantial compliance with program requirements, CMS has the authority to impose a remedy, and I have no authority to review CMS's choice of remedies, in this case, a per instance CMP. 42 C.F.R. § 488.438(e)(2); 42 C.F.R. § 498.3(b)(13); *see also*, 42 C.F.R. § 488.408(g)(2). 42 C.F.R. § 498.3(b) sets out those determinations (called "initial determinations") that are reviewable. The level of noncompliance – here, the immediate jeopardy finding – is reviewable only if a successful challenge would affect either: 1) the range of CMP amounts; or 2) a finding of substandard quality of care that results in the loss of approval of the facility's nurse aide training program. The penalty imposed here is a per instance CMP, for which the regulations provide only one range ($1,000 to $10,000), so the level of noncompliance does not affect the range of the civil money penalty. 42 C.F.R. § 488.438(a)(2); *see Aase Haugen Homes, Inc.*, DAB CR1273, at 4 (2005), *aff'd*, DAB No. 2013, at 3 (2006). *But see*, Discussion, section C, *infra* (scope and severity are relevant to determining the reasonableness of the CMP).

C. I find reasonable the $10,000 per instance CMP.

Having found a basis for imposing a CMP, I now consider whether the amount imposed is reasonable, applying 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. 42 C.F.R. § 488.438(f). 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.

It is well-settled that, in reaching a decision on the reasonableness of the CMP, I may not look into CMS's internal decision-making processes. Instead, I consider whether the evidence presented on the record concerning the relevant regulatory factors 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 other factors involved (financial condition, facility history, culpability). 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 Center*, DAB No. 1848, at 21 (2002); *Community Nursing Home*, DAB No. 1807, at 22 *et seq.* (2002); *Emerald Oaks*, DAB No. 1800, at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1683, at 8 (1999).

CMS has imposed a penalty of $10,000, which is the maximum per instance penalty ($1,000 – $10,000). 42 C.F.R. § 488.438(a)(2).

CMS acknowledges that Petitioner's compliance history is not a factor; and Petitioner has not claimed that its financial condition affects its ability to pay the penalty.

With respect to the other factors, however, I find that the scope of the deficiency was widespread, placing at risk virtually every resident of the facility. The potential for harm was severe. Fortunately, only one resident suffered injury in the December fire, but no one can dispute that the dangers inherent to fires in nursing homes present the likelihood of serious injury or death. Further, the facility here was especially culpable. Following the November fire, it knew or should have recognized that, unless it expanded its inspection and maintenance, the HVAC units would continue to present a serious risk of fire. Yet the facility took virtually no action.

I do not review CMS's decision to impose a per instance CMP rather than a per day CMP, where the range *starts* at $3,050 per day and would have run from the time the facility recognized its risk (November 23), until the day it was finally corrected (December 3). However, in considering whether a $10,000 penalty is reasonably related to an effort to produce corrective action, I note that "corrective action" ultimately cost the facility more than $40,000 per year. CMS Ex. 21, at 3. Relative to that cost, it is hard to see how anything less than $10,000 would be sufficient to produce correction.

Thus, while I recognize that the imposition of the maximum per instance penalty should be reserved for particularly egregious situations, after carefully reviewing the circumstances of this case in light of the section 488.438 factors, I am not able to find $10,000 an unreasonable amount.

IV. Conclusion

For all of the reasons discussed above, I uphold CMS's determination that Petitioner was not in substantial compliance with program participation requirements from November 23 through December 4, 2005.

I sustain as reasonable the $10,000 per instance CMP.

/s/

Carolyn Cozad Hughes
Administrative Law Judge