Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	)	
Sunset Manor,	)	DATE: March 3, 2008
Petitioner,	)	Civil Remedies CR1606
	)	App. Div. Docket No. A-07-133
- v. -	)	Decision No. 2155
Centers for Medicare & Medicaid Services.	)	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Sunset Manor, a Kansas skilled nursing facility, appeals the June 15, 2007 decision of Administrative Law Judge Keith W. Sickendick, Sunset Manor, DAB CR1606 (2007) (ALJ Decision). The ALJ concluded that Sunset Manor was not in substantial compliance with 42 C.F.R. § 483.70 because its fire alarm system failed to deliver notice of an alarm to the municipal fire department without unreasonable delay during an April 4, 2005 test, and because Sunset Manor had no alternative or back-up plan to notify the fire department in the event that the alarm system failed to work properly. The ALJ further concluded that a determination by the Centers for Medicare & Medicaid Services (CMS) that Sunset Manor's noncompliance with section 483.70 had created a situation of immediate jeopardy was not clearly erroneous. Finally, the ALJ concluded that a $2,000 per instance civil money penalty (CMP) imposed by CMS for the noncompliance was reasonable in amount.

For the reasons discussed below, we affirm the ALJ's conclusions and uphold the CMP imposed on Sunset Manor.

Legal Background

To participate in the Medicare program, a long-term care facility must comply with the requirements of participation found in 42 C.F.R. Part 483, subpart B. 42 C.F.R. §§ 483.1, 488.3(a). Compliance with these participation requirements is verified by surveys conducted by state health agencies. 42 C.F.R. §§ 483.1(b), 488.11-.12.

CMS may impose enforcement remedies, including a CMP, against a facility that is found not to be in "substantial compliance" with Medicare participation requirements. 42 C.F.R. §§ 488.402(c), 488.406. A facility is not in "substantial compliance" when it has a "deficiency" (violation of a participation requirement) that creates the potential for more than "minimal harm" to one or more residents. See 42 C.F.R. § 488.301. CMS's regulations (and we) use the term "noncompliance" to refer to any deficiency that causes a facility to be out of substantial compliance. Id. (definition of "noncompliance").

The participation requirement at issue here, section 483.70, entitled "Physical environment," states that a facility "must be constructed, equipped and maintained to protect the health and safety of residents, personnel and the public." In succeeding paragraphs, section 483.70 specifies various elements of a facility's obligation to provide a safe and healthful physical environment. One of these paragraphs, section 483.70(a), states in relevant part:

> (a) *Life safety from fire.* (1) Except as otherwise provided in this section --
>
> (i) The facility must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51 . . .

(Emphasis added).[1] "The [Life Safety Code] is a set of fire

[1] Section 483.70(a) implements section 1819(d)(2)(B) of the Social Security Act, which states:

> Life safety code. — A skilled nursing facility must

(continued...)

protection requirements designed to provide a reasonable degree of safety from fire. It covers construction, protection, and operational features designed to provide safety from fire, smoke, and panic." State Operations Manual (CMS Pub. 100-07), Chapter 2 — *The Certification Process* (Rev. 1, 05-21-04), § 2470.[2]

The survey reports cited two provisions of the 2000 edition of the Life Safety Code (LSC) as the legal basis for the deficiency findings: section 9.6, and section 19.3.4. LSC § 9.6, entitled *Fire Detection, Alarm, and Communications Systems*, "cover[s] the basic functions of a complete fire alarm system," one of those functions being the "summoning of appropriate aid[.]" CMS Ex. 11, at 3. The requirement for "summoning aid" is found chiefly in LSC § 9.6.4, which states in relevant part:

> **Emergency Forces Notification.** Where required by another section of this *Code*, emergency forces notification shall be provided to alert the municipal fire department and fire brigade (if provided) of fire or other emergency.
>
> Where fire department notification is required by another section of this *Code*, the fire alarm system

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[1](...continued)
meet such provisions of such edition (as specified by the Secretary in regulation) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes; except that—

(i) the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a facility, but only if such waiver would not adversely affect the health and safety of residents or personnel, and

(ii) the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects residents of and personnel in skilled nursing facilities.

42 U.S.C. § 1395i-3(d)(2)(B).

[2] The State Operations Manual is available on CMS's public website at http:// www.cms.hhs.gov/Manuals/IOM/list.asp.

> shall be arranged to transmit the alarm automatically via any of the following means acceptable to the authority having jurisdiction and shall be in accordance with NFPA 72, *National Fire Alarm Code*:
>
> (1) Auxiliary alarm system
> (2) Central station connection
> (3) Proprietary system
> (4) Remote station connection.
>
> *Exception: For existing installations where none of the means of notification specified in 9.6.4(1) through (4) is available, a plan for notification of the municipal fire department, acceptable to the authority having jurisdiction, shall be permitted.*

Id. at 4 (italics in original).[3] Sunset Manor used a central station connection, which is further described as a system or group of systems –

> in which the operations of circuits and devices are signaled automatically to, recorded in, maintained by, and supervised from a listed central station staffed by competent and experienced servers and operators. Upon receipt of a signal, the staff take such action as is required. Such service is controlled and operated by a person whose business is the furnishing, maintaining, and monitoring of supervised fire alarm systems.

CMS Ex. 12, at 13-14 (LSC *Handbook* § 9.6.4).

The National Fire Alarm Code (NFAC), NFPA 72 (1999 ed.) referenced in the preceding LSC provision requires at section 5-2.6.1.1 that the central station "[i]mmediately retransmit the alarm to the public fire service communications center." CMS Ex. 14, at 4. The NFAC Appendix, as well as the NFAC *Handbook*, explain that "the term *immediately* in this context is intended to

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[3] LSC section 9.6.1 states that the "provisions of Section 9.6 shall apply only where specifically required by another section of this *Code*." CMS Ex. 11, at 3. The LSC expressly makes section 9.6 applicable to long-term care facilities: LSC section 19.3.4.1 states that "[h]ealth care occupancies shall be provided with a fire alarm system in accordance with Section 9.6," and section 19.3.4.3.2 states that "[f]ire department notification shall be accomplished in accordance with 9.6.4." Id. at 7.

mean 'without unreasonable delay,'" and that "[r]outine handling should take a maximum of 90 seconds from receipt of an alarm signal by the central station until the initiation of retransmission to the public fire service communications center." CMS Ex. 14, at 3 (NFAC Appendix § A-5-2.6.1.1(1)) (italics in original); CMS Ex. 14, at 4 (NFAC *Handbook* § A-5-2.6.1.1(1)). The same provision points out the importance of quick action to retransmit given that untoward circumstances could have delayed the receipt of the alarm by the central station, even, "under the most adverse condition," by as much as 15 minutes. Id.

CMS determines the amount of a CMP based in part on the "seriousness" of the facility's noncompliance. See 42 C.F.R. §§ 488.438(f)(3), 488.404. The most serious type of deficiency is one that creates "immediate jeopardy," which is defined as "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301.

Case Background[4]

Sunset Manor is located in Frontenac, Kansas. CMS Ex. 1, at 1. On April 4, 2005, when the events at issue here occurred, Sunset Manor had a fire alarm system that automatically transmitted an alarm signal triggered on its premises to an off-site fire alarm monitoring company known as a "central station." Tr. at 28-30, 39, 73-74, 155. When a central station receives an alarm signal, it is supposed to take steps necessary to notify emergency forces of the alarm. Id. In this case, Sunset Manor had instructed the fire alarm monitoring company to have the central monitoring station phone the Frontenac emergency dispatch center, which served the municipal police and fire departments. Tr. at 39.

On April 4, 2005, the Office of the Kansas State Fire Marshal, acting on behalf of the Kansas Department of Aging (the state survey agency), performed an annual LSC inspection of Sunset Manor. CMS Ex. 7. An employee of the State Fire Marshal named Brian Love performed the inspection and reported his findings on form CMS-2567 ("Statement of Deficiencies and Plan of Correction") and form CMS-2786R ("Fire Safety Survey Report 2000

[4] The information in this section is drawn from the ALJ Decision and the record before the ALJ, and is presented to provide a context for the discussion of the issues raised on appeal. Nothing in this section is intended to replace, modify, or supplement the ALJ's findings of fact or conclusions of law.

Code"). CMS Exs. 1-2; Tr. at 24-26.

As a result of his inspection, Inspector Love reported three problems with Sunset Manor's fire alarm system: (1) "end of the line resistors" were installed on some of the fire alarm control panel's terminals; (2) Sunset Manor had failed to sound its fire alarm during "silent drills" in four of the preceding 12 months; and (3) during an April 4, 2005 fire alarm test (witnessed by Inspector Love), Sunset Manor's fire alarm monitoring company was unable to notify the Frontenac emergency dispatch center of the alarm for more than five minutes because of busy signals on the dispatch center's phone lines. CMS Ex. 1, at 15; CMS Ex. 2, at 10. These three problems were reported by Inspector Love as deficiencies in the Statement of Deficiencies and Fire Safety Survey Report under survey "tag" (identification) number K051. CMS Ex. 1, at 15; CMS Ex. 2, at 9-11.

Based on these survey findings, the state survey agency concluded that Sunset Manner was not in substantial compliance with LSC standards. CMS Ex. 7, at 1. The state survey agency also concluded that residents were in immediate jeopardy on April 4, 2005 because of the delay in reaching the Frontenac emergency dispatch center during the fire drill that day.[5] Id.; CMS Ex. 2, at 11 (indicating that the facility abated the immediate jeopardy situation with measures to ensure prompt fire department notification of an alarm). CMS concurred with these conclusions and imposed a $2,000 "per instance" CMP for the noncompliance cited under tag K051.[6] P. Ex. 2.

The ALJ Proceedings

Sunset Manor requested and received an in-person evidentiary hearing before the ALJ to challenge CMS's enforcement action. The record before the ALJ included documentary evidence, a joint stipulation of facts, and in-person testimony by Inspector Love and Kevin Knaup, Sunset Manor's administrator at the time of the April 4, 2005 LSC survey. The record also included excerpts from the following:

- 2000 edition of the LSC (CMS Exhibit 11);

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[5] Sunset Manor was found to have abated the immediate jeopardy condition on April 4, 2005. CMS Ex. 1, at 15.

[6] CMS initially set the CMP at $5,000 but reduced it to $2,000 based on the state survey agency's recommendation. P. Ex. 2, at 1.

- *Life Safety Code Handbook*, a publication containing commentary on or explanation of LSC provisions (CMS Ex. 12);

- 1999 edition of the *National Fire Alarm Code* (NFAC) (CMS Ex. 13);

- Appendix A to the *NFAC* (CMS Ex. 14, at 1-3); and

- *National Fire Alarm Code Handbook* (CMS Ex. 14, at 4).

Based on this record, the ALJ concluded that CMS had failed to make a prima facie showing that the presence of end-of-line resistors on the fire alarm control panel violated section 483.70(a). ALJ Decision at 4 (¶ 8), 13-14. The ALJ further concluded that CMS had also failed to make a prima facie showing of noncompliance based on Sunset Manor's failure to sound its fire alarm during four months of the 12-month period preceding the LSC survey. Id. at 5 (¶ 10), 14-16. The ALJ concluded, however, that CMS had "made a prima facie showing that on April 4, 2005, [Sunset Manor] was in violation of 42 C.F.R. § 483.70, because the fire alarm caused by the drill the surveyor triggered was not delivered to the fire department without unreasonable delay," and that Sunset Manor did not effectively rebut that showing. Id. (¶ 11). The ALJ found that the situation exposed Sunset Manor's failure to have and maintain an effective plan "to protect the health and safety of its residents, its personnel, and the public during periods when its system was not functioning." Id. at 17. The ALJ noted that Sunset Manor had presented no evidence that it had a "back-up notification process such as calling 911" in the event that its alarm system could not make fire department notification without unreasonable delay. Id. at 16-18. Finally, the ALJ concluded that CMS's finding of immediate jeopardy was not clearly erroneous, and that the amount of the CMP imposed by CMS for the alleged noncompliance was reasonable. Id. at 19-20.

Standard of Review

We review a disputed finding of fact to determine whether the finding is supported by substantial evidence, and a disputed conclusion of law to determine whether it is erroneous. Departmental Appeals Board, *Guidelines for Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs* (DAB *Guidelines*), http://www.hhs.gov/dab/guidelines/prov.html; Golden Age Nursing & Rehabilitation Center, DAB No. 2026 (2006).

Discussion

1. *Sunset Manor was not in substantial compliance with 42 C.F.R. § 483.70 on April 4, 2005.*

Sunset Manor does not dispute the essential factual findings on which the ALJ relies but objects to the inferences and legal conclusions that the ALJ drew from these facts to conclude that the facility was not in substantial compliance with section 483.70 on April 4, 2005.[7] In our view, substantial evidence in the record as a whole supports the ALJ's factual findings and those findings together with inferences reasonably drawn from them are legally sufficient to support the ALJ's conclusion that Sunset Manor was not in substantial compliance with its obligation under section 483.70.

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[7] Sunset Manor does not separately dispute the determination that the noncompliance, if any existed, presented immediate jeopardy. The immediate jeopardy determination here is in any case not subject to appeal since a per instance CMP was imposed and reversal of the immediate jeopardy determination, therefore, would not affect the "range" of amounts of the CMP that could be applied, unlike in the case where a per-day CMP is imposed. The ALJ commented that facilities could appeal immediate jeopardy determinations where a successful challenge "would affect the amount of the CMP that could be collected by CMS or impact upon the facility's nurse aide training program." ALJ Decision at 6, citing 42 C.F.R. §§ 498.3(b)(14) and (d)(10)(i). To the extent this comment might be read as expanding the scope of our review of immediate jeopardy determinations to situations where, as here, the amount but not the applicable range of amounts is at issue, we note that that reading would misstate the law. Further, although Sunset Manor disagrees with the finding that the amount of the per-instance CMP was reasonable, it offers no argument as to why the amount would be excessive under the circumstances found. See P. Br. at 3. Rather, its position is simply that all remedies should be vacated because the ALJ could not properly have found it out of substantial compliance on these facts. We reject that position for the reasons explained herein. In any case, the per-instance amount imposed, $2,000, is on the low end of the applicable range despite the finding of immediate jeopardy, which was based on evidence that even brief delays in fire emergency response can dramatically increase the threat from a fire. See Tr. at 56 (Inspector Love states that uncontrolled fires "will double in size every minute."). We would therefore, in any case, sustain the amount as reasonable under these circumstances.

As noted earlier, Sunset Manor arranged to make fire department notification via a "central station" connection. Its alarm system automatically transmitted a fire alarm signal triggered at the facility to a fire alarm monitoring company, called Guard Tronic, located in Ft. Smith, Arkansas. Tr. at 29-31, 39, 152-53; CMS Ex. 6. Sunset Manor provided a call list to Guard Tronic instructing its operators of the numbers to be called in the event of a fire alarm signal arriving from the facility. Tr. at 40. When it received the signal, Guard Tronic was first supposed to phone the Frontenac emergency dispatch center. Tr. at 40-41. The second number on the call list was that of a former administrator of the facility (the father of the present administrator) who had died well before the date of the survey. Id. The third number on the list was the office of the present administrator. Id.

At the time of the survey, the Frontenac dispatch center received emergency calls on three telephone lines, all of which were accessible using a single seven-digit number and all of which were also shared with the Frontenac City Hall. Tr. at 42, 76. If one of the lines was in use when a second call to the number was made, the second call would roll over to one of the other available lines. Tr. at 76. If all three lines were in use, the caller would get a busy signal. The problem with this configuration, according to the record, was that none of the three lines was a "prioritized" or "dedicated" emergency line. Tr. at 41-42. Thus, not only would an emergency caller receive a busy signal, no one at the dispatch center would even be aware of the attempted call. Tr. at 45, 51-52. The result here, as discussed below, was that Guard Tronic called repeatedly and got repeated busy signals without the dispatch center ever knowing that the monitoring company was trying to reach them. According to Inspector Love, that would not have occurred had one of the dispatch center's phone lines been a dedicated or prioritized emergency line, which cannot be used for outgoing calls and which rolls over all incoming calls so that each call rings at the emergency communications center until answered. Tr. at 76, 79; P. Ex. 1, at 20.

During the April 4, 2005 fire drill, Sunset Manor's fire alarm system activated visual and audible alarm signals throughout the facility and automatically transmitted an alarm signal to Guard Tronic, which, within a matter of a few seconds, began dialing the phone number for the Frontenac emergency dispatch center in accordance with the established protocol. Tr. at 38-39, 82-83. Guard Tronic was unable to establish a connection with the Frontenac emergency dispatch center for more than five minutes as a result of busy signals on the dispatch center's phone lines.

Joint Stipulation of Facts and Joint Statement of Issues (Oct. 21, 2005). Guard Tronic also attempted to call the other two numbers on the call list. Tr. at 47-48. It got through to the second number only to learn that the identified contact was deceased. The number in the facility administrator's office was not answered (presumably because he was in the process of overseeing the facility's response to the fire drill).

Sunset Manor's main contention is that the circumstances which caused the delay in signal transmission here were entirely outside its control, as the facility had no prior awareness of the problem with the telephone lines, and hence the facility should not be held responsible.[8] P. Br. at 7-8. Sunset Manor also argues that its alarm system was properly designed and installed. Id. at 8-9. Further, Sunset Manor contends that standards in the NFAC requiring that a fire signal must be immediately passed on to emergency dispatch personnel without

[8] In this regard, we considered the arguments made in the brief filed by the American Health Care Association (AHCA). On October 17, 2006, one day after Sunset Manor filed its reply brief, the AHCA, an organization representing long-term care providers, filed a motion seeking permission to file a brief as amicus curiae in support of Sunset Manor's appeal. On November 6, 2007, CMS filed a brief objecting to AHCA's motion, contending that the amicus brief was untimely and "does not bring any relevant matters to the attention of this tribunal that have not already been brought to the tribunal's attention by the parties in interest." As CMS correctly pointed out in its objection, the regulations and Board guidelines governing Sunset Manor's appeal do not indicate whether the filing of briefs by non-parties will or may be permitted. See 42 C.F.R. § 498.85; *Guidelines - Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs*, available on the DAB internet website at http://www.hhs.gov/dab/guidelines/prov.html. However, neither do the regulations or guidelines prohibit the Board from accepting or considering amicus briefs. Accordingly, in the interest of ensuring that the issues raised by Sunset Manor are fully explored, we grant AHCA's motion to file its amicus brief. AHCA's main concern was that nursing homes should not be held responsible for unforeseeable matters outside their control, such as the inadequate phone lines at a local emergency dispatch center, because doing so amounts to strict liability. AHCA Br. passim. As we discuss in the text, we focus here on what the facility could have indeed foreseen and could have managed more effectively by taking action within its control.

unreasonable delay (generally within 90 seconds) should not be applied to the facility for two reasons. Id. at 10-15. First, Sunset Manor points out that this standard is not in the LSC itself (which has been incorporated by reference into the nursing home regulations) but rather in the NFAC, to which the LSC in turn refers. Hence, according the Sunset Manor, the NFAC should not be used in any way adverse to it because the NFAC does not have the force or effect of a regulation. P. Br. at 12-15. Second, Sunset Manor notes, this standard references the responsibilities of the monitoring center, not the facility itself. Thus, Sunset Manor insists that it met all applicable regulatory requirements because its fire alarm system was compliant with the LSC. Id. at 9-12. Sunset Manor claims that its fire alarm system was compliant with the LSC because the April 4, 2005 test alarm was quickly transmitted to an approved central station. Id. at 10-11. In addition, Sunset Manor contends that, by requiring it to have a back-up plan to notify emergency responders in the event that the central station encounters a delay retransmitting the alarm signal, the ALJ effectively imposed upon it a requirement not contained in either section 483.70 or the LSC. Id. at 15.

We reject Sunset Manor's narrow conception of its obligations under the regulations.

Sunset Manor's responsibility was not merely to have an alarm system installed and operational. That requirement is just one element of a facility's overarching obligation under section 483.70 to equip and maintain its facility in a manner that *actually* does "protect the health and safety of residents," as well as the staff and the public. Hence, the facility must do more than merely hook up its fire alarm system to a central station and hope for the best. It must take reasonable steps to ensure that its alarm system and associated protocols operate to achieve their intended protective purpose in the circumstances for which they were designed.

In our view, critical failures in that regard lay either partly or entirely in the hands of the facility itself – that is, the call list protocol which it selected for its alarm monitoring company to follow. Sunset Manor supplied the central station with an inadequate call list. That call list contained, in order of priority, phone numbers for the following: (1) the Frontenac emergency dispatch center; (2) Ray Knaup, Sunset Manor's former administrator; and (3) Kevin Knaup, Sunset Manor's administrator at the time of the April 4, 2005 fire alarm test. Tr. at 43, 47-48; CMS Ex. 10-5.

The first problem with the call list was, as Inspector Love testified, that it did not contain a number for a dedicated emergency phone line. Tr. at 43. Thus, on April 4, 2005, when Guard Tronic called the Frontenac emergency dispatch center to give notice of the test alarm and received a busy signal, the center was unaware of Guard Tronic's call, which was the primary element in delaying notification to the fire department. As an element of its immediate corrective actions, Sunset Manor was able to have its monitoring company call the dedicated emergency line at a nearby sheriff's office (while later the Frontenac dispatch center upgraded its system to provide that service).

The second problem with the call list was that it was out-of-date. After encountering busy signals at the emergency dispatch center, Guard Tronic phoned Ray Knaup, the second contact on the list, but learned from his wife that he was deceased. Tr. at 47-48. The pointless call to Ray Knaup caused delay in notifying the facility of the difficulties experienced by the central station in notifying the fire department. We note that when the central station attempted to call the third number on the call list, for Kevin Knaup, it had to leave a message, Tr. at 48, and thus no one at the facility became aware of the delay in contacting the fire department until after the test. Had a viable contact number been available, facility administration or staff could have been quickly informed of the problems experienced at the central monitoring station in trying to retransmit and could have immediately called 911 themselves to obtain emergency response.[9]

In addition to the inadequate call list, Sunset Manor failed to have an adequate backup plan. The ALJ found, and Sunset Manor does not dispute, that it had not trained its staff in any plan of action in the event that fire department notification was unreasonably delayed. Even if it were arguably unforeseeable that the Frontenac emergency dispatch center's phone line

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[9] The central monitoring station could not itself call 911 because it was located in a different jurisdiction and would have been connected to its local emergency dispatch services. As immediate corrective measures, Inspector Love accepted the facility's decision to train staff to call 911 themselves whenever an alarm sounded. Ultimately, the problem of access to a dedicated emergency dispatch line was solved when Frontenac added a dedicated line, which the central monitoring station used thereafter, and the back-up call list problem was solved by the facility providing the alarm company with a current list of viable numbers. Tr. at 55, 171.

configuration would cause a delay in retransmission of the alarm signal, it was not unforeseeable that the chain of transmission of an alarm from the facility to the alarm company to the emergency responders might break down in any number of ways. It was not outside the control of the facility to design and plan for a backup response to such an event.

Sunset Manor objects that the regulations nowhere require it to call 911 when it has a fire alarm system that provides automatic notification to a central station or to specify any other contingency plan measures. P. Reply Br. at 16. But neither CMS nor the ALJ suggested that facilities are always required to call 911 when they have a functioning fire alarm system. The nursing home regulations give facilities considerable discretion to select appropriate means of meeting the specific requirements in a manner suitable for their circumstances, so long as the regulatory standards are met. Here, the policy of having staff call 911 whenever an alarm sounds was elected by the facility as its plan for correcting the problem exposed by the April 4, 2005 fire alarm test. CMS Ex. 2, at 10. Alternative backup plans might have been developed. What is clear is that the possibility of system failures should have been considered and planned for to ensure that fire department notification was accomplished without unreasonable delay.

Sunset Manor claims that it had "no reason to anticipate the need for 'back-up' or contingency plans to supplement" its automated alarm system because it did not know about "any technical limitations or logistical difficulties" affecting Guard Tronic's ability to expeditiously contact the Frontenac emergency dispatch. P. Reply Br. at 16. This claim lacks plausibility, however, given that Sunset Manor did provide contact numbers (albeit outdated) for Guard Tronic to call to give notice of alarms and presumably of any problems. Sunset Manor need not have known in advance what the source of those potential problems might be in order to have recognized and acted on the need to protect its residents from the severe potential consequences of any communications breakdown.

In addition to the flawed call list and the lack of back-up planning, Sunset Manor did not implement an alarm testing program designed to maximize the potential to expose any breakdown in its communication and response chain. It was not disputed that Sunset Manor was required to and did test its alarm system during each shift (of the three daily shifts) on a quarterly basis. ALJ Decision at 14. On the months when the overnight shift was drilled, Sunset Manor ran through a silent review rather than trigger its alarm. Id. In the corrective action plan,

Administrator Knaup stated that the night drills consisted of all the staff assembling to discuss "about using our code word for annunciation of fire, use and location of fire extinguishers, fire alarm panel controls, and resident evacuation procedures." CMS Ex. 2, at 8. He stated that he "was unaware this did not constitute a fire drill." Id. The LSC permitted drills conducted between 9 PM and 6 AM to use "a coded announcement" instead of sounding the alarms. Tr. at 135-36. Administrator Knaup planned to change the facility procedures for night drills "to announce our code word over the intercom and let them respond as if there was a fire." CMS Ex. 2, at 8. The ALJ rejected CMS's allegation that Sunset Manor's failure to sound its alarm at least once a month constituted an independent basis for finding the facility out of substantial compliance.[10] We do not disturb the ALJ's conclusion that CMS failed to establish a specific requirement to perform monthly audible alarms.[11] Nevertheless, testing the full system under real life conditions is one obvious way that the facility could uncover any problems in the full alarm transmission process. It is reasonable to think that more frequent testing of the system would have made it more likely that the potential for busy signals on the phone number used for retransmission would have been uncovered earlier.

Kevin Knaup, Sunset Manor's administrator, testified that, prior to April 4, 2005, the facility did conduct at least some drills in which the alarm notification process was tested and evaluated. Tr. at 165, 174. But it is unclear how often that process was tested and evaluated. And although Administrator Knaup testified that he never considered the fire department response times to be excessive or unreasonably long (Tr. at 173),[12] Sunset Manor

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[10] Inspector Love opined that the industry standard was to test the audible alarm system during the day at some point during months in which an overnight shift performed only a silent drill. Tr. at 37. The ALJ noted that Inspector Love "provided no basis for that opinion, and that, even if he was correct about the industry standard, that would not "amount to a legal requirement" to perform such tests. ALJ Decision at 15.

[11] CMS did not appeal the adverse rulings in the ALJ Decision but nevertheless sought to challenge certain of his legal conclusions. We discuss these challenges in the next section.

[12] Administrator Knaup responded "no" when asked if he was aware of any pre-April 4, 2005 fire alarm test in which there was

(continued...)

produced no records of what those times were.[13] Hence, we do not find persuasive Sunset Manor's reliance on the absence of prior records of delays during pre-April 4, 2005 testing as providing reasonable assurance that its fire alarm signals were always re-transmitted from the central station to the fire department without unreasonable delay.

Sunset Manor also suggests it was "rare" that all three phone lines at the Frontenac emergency dispatch center were busy so that more frequent testing would not have uncovered the potential problem.[14] See P. Br. at 7, n.4. But Inspector Love testified that when he met with Frontenac's city manager and police chief

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[12](...continued)
a delay of two to six minutes in the transmission of an alarm signal from Sunset Manor to the Frontenac emergency dispatch center. Tr. at 168-69. Sunset Manor also notes that prior inspections did not note any unreasonable delays. P. Br. at 7-8. Inspector Love testified, however, that the State Fire Marshall inspections did not include witnessed fire drills prior to 2005, so that this visit was the first in which the problem could have been detected. Tr. at 92; see also Tr. at 168 (Mr. Knaup agreed that no prior witnessed drill had been done by inspectors).

[13] The LSC requires that electronic or written records of alarm system tests should be available. CMS Ex. 1, at 15. We do not imply that Sunset Manor failed to keep required records. Nevertheless, the ALJ could reasonably find Mr. Knaup's rather vague testimony, based on memory alone, of whether any of the drills and tests involved an "unreasonable" or "excessive" delay to be unreliable, in the absence of any documentation of the response time found in prior events.

[14] Sunset Manor cites to a memorandum from the Frontenac police chief to the State Fire Marshall's office expressing concern that the interim plan to remove the immediate jeopardy by routing calls to the Crawford County Sheriff might create different delay problems because that office cannot directly dispatch the Frontenac Fire Department. CMS Ex. 5, at 1. He suggests making the Frontenac emergency center again the first call to be placed and, if that is busy, routing a second call to the sheriff's office. In that context, he says that "it rarely occurs for all three of the lines to be busy at the same time." Id. In addition, Sunset Manor cites to its administrator's testimony that he attended a meeting of Inspector Love with the city manager who reportedly said all three lines were seldom busy. Tr. at 170.

the day after the alarm test, he observed or was told that all three of the dispatch center's phone lines were once again simultaneously busy. Tr. at 51-52; CMS Ex. 10, at 3; CMS Ex. 2, at 10-11. This evidence undercuts Sunset Manor's evidence that the occurrence was rare, as does evidence that the city soon after this episode acted to add another phone line with dedicated service for emergencies. Tr. at 170. Further, Sunset Manor provided no evidence that, before it instructed Guard Tronic to call the Frontenac dispatch center, Sunset Manor inquired about the telephone services available at the city dispatch center or received any assurances that emergency calls there would be answered quickly.

Of course, section 483.70 does not require a facility to envision the unforeseeable or do the impossible. But it clearly requires the facility to ensure that safety measures within its control are likely to be effective in protecting residents from foreseeable threats to their safety. This is consistent with the outcome-based approach embodied in the participation requirements for long-term care facilities. Under this approach, facilities are required to achieve certain outcomes relating to patient health and safety but are given flexibility to select methods effective for achieving the outcomes specified in the statute and implementing regulations. See Lake Mary Health Care, DAB No. 2081, at 17 (2007), and sources cited therein.

We also disagree with Sunset Manor's position that the NFAC provisions for retransmission of a signal by a monitoring center without unreasonable delay to emergency responders has no relevance to evaluating the facility's compliance here. Regardless of whether the provisions are viewed as directly applicable to Sunset Manor, we find them relevant for the purpose for which the ALJ considered them – as a measure of the industry-standard time frame for signal transmission. As the ALJ noted, the 90-second guideline refers to the time between the receipt of the alarm by the monitoring company and its "immediate" initiation of retransmission to the fire department. ALJ Decision at 16. LSC section 9.6.4 expressly required the alarm system to be operated in accordance with NFAC. NFAC § 5-2.6.1.1, in turn, required the central station to "[i]mmediately retransmit" the test alarm to the "public fire service communications center." CMS Ex. 13. Inspector Love testified that "initiation of retransmission" by the central stations means the point at which the central station delivers notice to the fire department or other dispatching authority. Tr. at 60, 87. On April 4, 2005, initiation of retransmission did not occur for about five minutes after Guard Tronic received the test alarm signal, and Inspector Love testified, without contradiction by

anyone, that this delay was unreasonable under the circumstances. Tr. at 60, 82-84, 102, 152.

The parties disputed before the ALJ whether the NFAC was properly incorporated by reference where it was referenced in the LSC but not in the regulations themselves, based on the requirements of 1 C.F.R. Part 51. See discussion in ALJ Decision at 9-11. The ALJ accepted Sunset Manor's position that NFAC requirements regarding retransmission of an alarm signal do not have the force and effect of regulations because they have never been directly incorporated by reference in the Secretary's regulations pursuant to the Administrative Procedure Act (APA). ALJ Decision at 10, citing 5 U.S.C. § 552(a). In support of this conclusion, Sunset Manor contends that because CMS failed to incorporate the NFAC by reference in its regulations, and because it also failed to publish NFAC standards in the *Federal Register*, the NFAC may not be applied "in any manner to support any findings, conclusions or determinations that adversely affect the interests of Sunset Manor[.]" Reply Br. at 3 n.2, 14 (citing 5 U.S.C. § 552(a)).

We vacate the ALJ's conclusion that the NFAC was not incorporated by reference in 42 C.F.R. § 483.70(a) because deciding whether or not the NFAC had the force and effect of a regulation is unnecessary to our decision in this case. Even if the NFAC does not independently have the force and effect of a regulation, the ALJ recognized that it can be relevant for other purposes such as evidencing industry standards. ALJ Decision at 12-14, 16-17. Furthermore, the ALJ recognized that under the APA a party may be adversely affected even by an unpublished rule where the party has actual and timely notice.

Here, Sunset Manor is not being held to substantial provisions of the NFAC on how long a delay may be countenanced for retransmission of an alarm. Rather, the NFAC provisions provide relevant context for assessing the reasonableness of measures Sunset Manor adopted to protect residents from fire hazards. The ALJ did not (and we need not) hold that Sunset Manor could meet its regulatory responsibilities only by ensuring that its alarm signal retransmission met the specific standards in the NFAC. Even Sunset Manor does not suggest, however, that it could properly provide for the safety of residents, as required by section 483.70, if it did not take steps needed to avoid lengthy and patently unreasonable delays in emergency response that might occur if there was a disruption in communication between the central monitoring station and the emergency responders. We find that the NFAC discussion of immediate retransmission provides a useful and widely accepted point of reference to understand whether the delay here was unreasonable.

At a minimum, the LSC was indisputably adopted by reference into the regulations by the Secretary (as specifically provided for in section 1819(d)(2)(B) of the Act quoted above), and the LSC provisions at issue referred in turn to the NFAC to explain their meaning. Thus, the NFAC must reflect CMS's understanding of what those LSC requirements mean and how they will be applied to determine whether a facility's fire alarm system is functionally adequate. It is hardly reasonable for those bound by the LSC to fail to inquire about the significance of the NFAC provisions referenced in the LSC. When a regulator has expressed policies or interpretative judgments about the meaning or application of a regulation, we generally defer to those policies or judgments so long as they are reasonable and consistent with the underlying regulation. Thomas M. Horras and Christine Richards, DAB No. 2015 (2006). If the regulated entity had no prior actual or constructive notice of such policies or judgments, we do not apply them if the entity can demonstrate that it had an alternative reasonable interpretation of the regulation upon which it actually relied. Id.

The ALJ here found that CMS did not prove that Sunset Manor had actual knowledge of the contents of the NFAC provision on unreasonable delay in retransmission. ALJ Decision at 4. The ALJ made no finding about actual or constructive notice apart from actual knowledge. LSC section 9.6.4's references to the NFAC provided at least constructive notice to Sunset Manor that the regulation must be understood in light of the referenced NFAC provisions. Certainly, Sunset Manor cannot avoid complying with LSC requirements that are delineated by reference to NFAC provisions simply by failing to obtain a copy of the NFAC or request guidance from CMS as to the contents of the relevant NFAC provisions. The LSC inspection forms provided to Sunset Manor at the end of each LSC inspection explicitly point to the applicable NFAC provisions. CMS Ex. 1, at 15-16. Furthermore, Sunset Manor has not identified any alternative reasonable interpretation of the LSC under which the five-minute delay in retransmission could be considered reasonable.

We conclude, for reasons discussed above, that Sunset Manor was not in substantial compliance with section 483.70 on April 4, 2005, and that CMS was authorized to impose a CMP for that noncompliance.

2. *CMS did not timely appeal the legal conclusions made by the ALJ in Sunset Manor's favor.*

In its brief opposing Sunset Manor's appeal, CMS objects to the ALJ's conclusions regarding the presence of the end-of-line

resistors and Sunset Manor's failure to sound its fire alarm every month. Response Br. at 13-14. CMS failed to make a timely request for Board review of those conclusions, however.

Title 42 C.F.R. § 498.82 provides that any party dissatisfied with an ALJ decision may file a request for review of the decision and must file that request within 60 days from receipt of the notice of decision or dismissal, unless the party shows good cause to extend the filing period. Under section 498.82(a)(2), which incorporates the presumption-of-receipt rule in section 498.22(b)(3), CMS is presumed to have received the ALJ Decision on June 20, 2007. Accordingly, CMS should have filed a request for review by August 19, 2007. The brief containing CMS's objections to the ALJ Decision — CMS's initial filing in this appeal — was filed on September 27, 2007.

Furthermore, the brief does not purport to serve as an appeal. CMS does not ask that we take any action on its challenges and simply concludes that the ALJ Decision "should be affirmed as it is not erroneous as a matter of law and is supported by substantial evidence based on the record as a whole." CMS Br. at 15.

We therefore do not further address CMS's challenges to the ALJ's resolution of the allegations relating to citations regarding end-of-line resistors and audible alarm testing.

Conclusion

Based on the foregoing analysis, we affirm the ALJ Decision, except that we vacate as unnecessary the ALJ's conclusion that the NFAC did not have the force and effect of a regulation. We therefore conclude Sunset Manor was not in substantial compliance

with section 483.70 on April 4, 2005. Thus, CMS was legally authorized to impose a $2,000 per instance CMP for that noncompliance.

/s/
Judith A. Ballard

/s/
Sheila Ann Hegy

/s/
Leslie A. Sussan
Presiding Board Member