

**Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division**

Franklin Care Center
Docket No. A-18-8
Decision No. 2869
May 10, 2018

**REMAND OF
ADMINISTRATIVE LAW JUDGE DECISION**

Franklin Care Center (Franklin) appeals the August 15, 2017 decision of an Administrative Law Judge (ALJ) upholding the imposition by the Centers for Medicare & Medicaid Services (CMS) of civil money penalties (CMPs) of \$10,000 per day, effective October 30, 2014 through November 24, 2014, and \$350 per day, effective November 25, 2014 through December 22, 2014, for a total CMP of \$269,800. *Franklin Care Center*, DAB CR4922 (2017) (ALJ Decision). The ALJ granted summary judgment in favor of CMS, concluding that Franklin was not in substantial compliance with three regulatory participation requirements, that CMS's determination that the noncompliance constituted immediate jeopardy during the relevant period was not clearly erroneous (while noting that Franklin did not challenge the non-immediate jeopardy findings), and that the CMP amounts were reasonable.

The dispute centers on physical conditions at Franklin involving repeated leaks from the roof and the development of mold in areas which were not sealed off from the residents, some of whom had respiratory illnesses. Franklin contends that disputes of fact which should have precluded summary judgment existed relating to how extensive these problems were and how likely or serious were the risks to residents.

For the reasons explained below, we conclude that the undisputed facts in the record, even viewed in the light most favorable to Franklin, compel the conclusion that Franklin was not in substantial compliance with the cited requirements. It is undisputed that mold was present in areas of the facility from which residents were not securely excluded and such mold, even based on the facility's own expert testimony and other undisputed evidence, poses a risk of more than minimal harm to those residents with pre-existing respiratory conditions.

We conclude, however, that Franklin has raised genuine disputes of material fact relating to whether the conditions in the facility created a likelihood of serious harm, so the ALJ could not properly determine based on summary judgment that CMS's immediate jeopardy determination was not clearly erroneous. Moreover, Franklin challenged the

reasonableness of the amount of the CMP, which was set at the highest permissible daily amount, and the evaluation of the reasonableness of the amount requires consideration of factors that involve disputed facts. We therefore remand to the ALJ to develop the record as needed and then evaluate the immediate jeopardy determination under the clearly erroneous standard and the reasonableness of the CMP amount on the record as a whole.

Applicable legal authorities

To participate in the Medicare program, a skilled nursing facility (SNF) must be in “substantial compliance” with the participation requirements in 42 C.F.R. Part 483, subpart B (sections 483.1-.75).¹ 42 C.F.R. §§ 488.400, 483.1. A SNF is not in substantial compliance when it has a “deficiency” – that is, a failure to meet a participation requirement – that creates a risk of more than minimal harm to one or more residents. *Id.* § 488.301 (defining “substantial compliance”). “Noncompliance,” as used in the applicable regulations, is synonymous with lack of substantial compliance. *Id.* (defining “noncompliance”).

A SNF’s compliance with Medicare participation requirements is verified through onsite surveys performed by state health agencies. *Id.* §§ 488.10(a), 488.11. Such surveys may be triggered by the receipt of complaints. *Id.* § 488.301 (definition of “abbreviated standard survey”). A state survey agency reports any deficiency (failure to meet a participation requirement) it finds in a Statement of Deficiencies (SOD). *Id.* §§ 488.325(f)(1), 488.331(a).

CMS may impose enforcement “remedies,” including CMPs, on a SNF that is found to be not in substantial compliance. *Id.* §§ 488.400, 488.402(b), (c), 488.406. When CMS elects to impose a CMP, it sets the CMP amount based on, among other factors, the “seriousness” of the SNF’s noncompliance. *Id.* §§ 488.404(a), (b), 488.438(f). Seriousness is a function of the noncompliance’s scope (whether it is “isolated,” constitutes a “pattern,” or is “widespread”) and severity (whether it has created a “potential for” harm, resulted in “[a]ctual harm,” or placed residents in “immediate jeopardy”). *Id.* § 488.404(b). The most serious noncompliance is that which puts one or more residents in “immediate jeopardy.” *Id.* § 488.438(a) (authorizing the highest range of per-day CMPs for immediate-jeopardy-level noncompliance); *Woodland Oaks*

¹ On October 4, 2016, CMS issued a final rule that amended the Medicare participation requirements for long-term care facilities published in 42 C.F.R. Part 483. Final Rule, *Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities*, 81 Fed. Reg. 68,688 (Oct. 4, 2016). Our analysis and decision are based on the version of the participation requirements in effect in 2014 when the compliance survey at issue was performed. *Carmel Convalescent Hosp.*, DAB No. 1584, at 2 n.2 (1996) (applying the regulations in effect on the date of the survey and resurvey).

Healthcare Facility, DAB No. 2355, at 2 (2010) (citing authorities). “Immediate jeopardy” means “a situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.” 42 C.F.R. § 488.301.

A SNF may appeal a CMS determination of noncompliance that has resulted in the imposition of a CMP or other enforcement remedy. *Id.* §§ 488.408(g)(1), 498.3(b)(13).

Case background²

Franklin is a New Jersey SNF. Franklin’s facility has two floors but only the first floor housed residents during the relevant period.

The deficiency findings at issue arose from a complaint survey ending November 3, 2014. CMS Ex. 1, at 1. The surveyors cited noncompliance at the immediate jeopardy level under three regulatory provisions: **42 C.F.R. § 483.25(h)** (Tag F323) (at a scope and severity level of “L”);³ **42 C.F.R. § 483.75(d)(1)-(2)** (Tag F493) (at a scope and severity level of “J”); and **42 C.F.R. § 483.75(o)(1)** (Tag F520) (at a scope and severity level of “J”). ALJ Decision at 4; CMS Ex. 1, at 13-32, 36-40 (SOD). Franklin submitted a series of proposed plans of correction (POCs) to address the alleged noncompliance findings. After accepting the last POC and conducting a revisit, the state survey agency concluded that immediate jeopardy was abated by November 25, 2014, but that noncompliance continued at a lower level until December 23, 2014. Based on these findings, CMS imposed the total CMP of \$269,800.00.

Franklin timely sought an ALJ hearing. The parties filed exhibits and written direct testimony, and requested cross-examination of each other’s witnesses. CMS moved for summary judgment and to exclude certain of Franklin’s exhibits. The ALJ granted CMS’s motion for summary judgment as to all issues and excluded some but not all of the exhibits to which CMS objected.

This appeal ensued, and both parties provided briefing. At Franklin’s request, the Board heard oral argument in this matter on January 31, 2018. Transcript of Oral Argument at 3, 7 (Tr.).

² The factual information in this section is drawn from the ALJ Decision and the record and is presented to provide a context for the discussion of the issues raised on appeal. Unless otherwise noted, the facts stated here are undisputed. We discuss in our analysis below Franklin’s arguments that certain material facts remain in dispute.

³ Scope and severity are rated on a letter scale with “L” indicating widespread immediate jeopardy to resident health or safety and “J” indicating isolated immediate jeopardy to resident health or safety. The scale is currently located at CMS’s State Operations Manual, ch. 7, § 7400.5.1.

Standard of review

We review an ALJ's grant of summary judgment de novo. *Avalon Place Kirbyville*, DAB No. 2569, at 6 (2014). "Summary judgment is appropriate when the record shows there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law." *Id.*

Analysis

1. On appeal, Franklin continues to focus on arguments which the ALJ correctly found were not relevant to the issues on review.

Before addressing the core question of whether summary judgment was appropriately granted in this case, we first address several topics which Franklin raised before the ALJ and continues to focus on in its appeal to us but which have no relevance to the issues in the present posture of this case.

First, Franklin emphasizes that the survey was triggered as a result of complaints from a disgruntled former employee. Franklin request for review (RR) at 2-3; Franklin Reply Brief (Reply) at 8-9. One written complaint alleges that Franklin tried to cover up issues that might result in citations, specifically neglect of roof deterioration causing frequent leaks with repeated damage to ceiling tiles in the occupied areas of the facility and "large areas of mold" which were sometimes painted or wallpapered over without remediation. CMS Ex. 20, at 1-2. Attached to this complaint were photographs showing darkened areas on walls, stained or fallen ceiling tiles, and buckets and towels spread in hallways. *Id.* at 3-21. Franklin describes this complaint as the "vengeful act of an employee who had recently received disciplinary notices." RR at 3. For purposes of summary judgment, we accept Franklin's characterization of the complainant and do not rely on the descriptions in the complaint letter.⁴ The relevant issue, in any case, is not why or by whom the survey was triggered but what the evidence in the record establishes as to the conditions in the facility.

⁴ Franklin argues that the ALJ failed to evaluate the credibility of the complainant, citing the ALJ's exclusion of proffered evidence related to the individual's employment history. RR at 16 (citing ALJ Decision at 5). On summary judgment, an ALJ should not be evaluating credibility of competing witness accounts, but rather simply viewing all evidence in the light most favorable to the non-movant. Franklin goes on to contend that the ALJ extensively relied on the contested account in the complaint letters. *Id.* (citing ALJ Decision at 6-7). At the cited page, the ALJ describes the receipt and content of the complaint letters, as well as the attached photographs, but it is not evident that the ALJ is making any finding of fact about the facility's condition based on the content of the letters as opposed to merely recounting their receipt as part of the chronology of events. ALJ Decision at 6-7. Regardless, we decide summary judgment de novo, and we place no reliance on the content of the complaint letters themselves in our consideration.

We note, however, that Franklin has not denied in its appeal to us that the attached photographs were authentic and taken in the facility at the relevant time period. Instead, Franklin quarrels with the complainant's discussion of the causes and extent of the conditions shown. *See, e.g.*, RR at 2-4; Reply at 8-9. Franklin did state before the ALJ that the photographs of areas of apparent mold were taken in unoccupied rooms with signs indicating that they were closed for repairs. Franklin Opposition to Summary Judgment at 3. We accept these statements as accurate for purposes of evaluating summary judgment, and leave it to the ALJ on remand to determine the significance of and weight to attribute to particular photographs.

Second, Franklin denies that its staff engaged in any effort to actively cover up or hide evidence of mold infestations. RR at 2. Despite granting summary judgment in favor of CMS, the ALJ specifically found that no evidence in the record supported any allegation of an intentional cover-up. ALJ Decision at 15 (“[T]here does not appear to be evidence for CMS’s assertion that Petitioner was actively attempting to conceal the presence of mold by applying new wallpaper.”). CMS did not dispute this finding, and we therefore conclude that this question is not at issue before us.

Third, Franklin proffers evidence purporting to demonstrate that conditions did not require an emergent evacuation of residents from the facility, and that such an evacuation might cause harm to residents. *See, e.g.*, RR at 9, and record citations therein. The record contains conflicting assertions about whether resident evacuation was required by survey agency personnel or proposed by the facility itself in some iterations of its plans of correction which were not accepted. *Compare* P. Ex. 59, at 4 (Karine Peterside Decl.; “verbal order for evacuation” issued even before laboratory results) *with* CMS Ex. 91, at 10-11 (Surveyor Baker Decl.; POCs proposing resident transfers). In any case, the possible need for an evacuation, and the potential or relative harm of an evacuation (as opposed to remediation with residents remaining in the facility), are not relevant to this case in its present posture. No evacuation was ordered or implemented. ALJ Decision at 4, 14, and record citations therein. CMS is not now contending that Franklin should have evacuated the facility. CMS determined that Franklin returned to substantial compliance without having evacuated the facility. Evidence about whether an evacuation would have been appropriate or harmful is therefore of no relevance.

For these reasons, we decline to revisit the ALJ’s ruling excluding exhibits proffered by Franklin for the purposes described. *See* ALJ Decision at 5 (excluding P. Exs. 10 and 27). On remand, if the ALJ intends to rely on or weigh the content of the allegations in the complainants’ letters (as opposed to the attached photographs, the authenticity of which Franklin did not contest), the ALJ may then consider whether the excluded exhibits purporting to relate to the employment record of one of the anonymous complainants is relevant to evaluating credibility. To the extent that the ALJ’s review is based on the evidence collected during the survey(s) without regard to the accuracy of

any complaint allegations that triggered the initiation of the survey, those exhibits would remain irrelevant.

2. Summary judgement was not appropriate here to resolve whether CMS's immediate jeopardy determination was clearly erroneous.

While undisputed facts in the record, even viewed in the light most favorable to Franklin, establish that the facility was not in substantial compliance, disputes of material fact as to the extent of the noncompliance and the degree of potential harm preclude summary judgment as to the issues of immediate jeopardy and the reasonableness of the CMP amount based on that determination. In this section, we identify first what is undisputed on the record that establishes noncompliance and then what requires remand for the ALJ to resolve.

- a. Undisputed facts establish noncompliance.

Franklin relies most heavily on its expert witness, Dr. Robert J. Laumbach, who inspected the facility at the time of the survey and after remediation efforts, and submitted three reports. We therefore begin our evaluation of undisputed facts with his reports. Dr. Laumbach reported that "exposure to indoor mold has been associated with a limited range of health-related outcomes" and that the ones "recognized by impartial authoritative bodies" include "worsening of allergies and asthma, and associated upper respiratory symptoms." P. Ex. 3, at 2 (Oct. 12, 2015, report). The level of mold spores that may trigger response in sensitized patients is highly individual. *Id.* He also notes that respiratory symptoms such as cough and wheeze have been reported in persons without known allergies. *Id.* He asserts that other possible health effects are merely "speculation," and, in particular, that there is no "clear evidence" that "mycotoxins from indoor mold, if and when they are present, are a health concern." *Id.* at 2-3.

Dr. Laumbach advised that, in order to "reduce the possibility of mild as well as more serious allergy and asthma responses to indoor mold, isolation of the affected areas, and prompt remediation is prudent." *Id.* at 3. He recognizes that nursing home patients may be at higher "perceived risk," while stating that the "prevalence of pre-existing allergy and asthma" among such patients is "likely to be similar to other older adult populations." *Id.* Nevertheless, he agrees that "[f]rail elderly may be more vulnerable to serious allergy or asthma exacerbations," while also susceptible to transfer stress if relocated. *Id.* He discussed World Health Organization findings from 2009 to the effect that mold had not been proven to cause illness but had been shown to be associated with temporary worsening or onset of symptoms in people with allergies, asthma, or sensitivity. *Id.* at 4.

In his first report, Dr. Laumbach described his observations at the facility, stating that he did not see anything requiring immediate evacuation, but that he did see “conditions of varying degrees of concern relating to growth of indoor mold on interior surfaces.” P. Ex. 1, at 1 (Nov. 2, 2014, report). He attributed the highest “concern for possible occupant exposure and long-term health risk” to the Shower Room which was closed to use and had an area of presumed mold of about three feet by four feet which tested positive for a mold associated with indoor water damage and also tested positive for airborne spores. *Id.* at 1. He noted that a system venting air to the outdoors reduced the risk of spread but also that the area above the ceiling tiles was not ventilated and advised plastic sheeting to block this pathway for spread, to be followed by a “timely and thorough” remediation plan implemented by qualified persons. *Id.* at 1-2. He reported smaller areas of mold or water-related discoloration in eight other rooms also in the “Princeton” unit. *Id.* at 2. For these areas, he recommended remediation following applicable Environmental Protection Agency guidelines. *Id.* He advised that, out of “an abundance of precaution,” residents occupying rooms where “minor areas of mold growth were identified” should “be temporarily relocated during remediation activities.” *Id.* at 3.

He also observed roof leaks on the unoccupied second floor (above the occupied “Franklin” unit) which were being caught in “containers” after a “heavy rain.” *Id.* He asserted that the level of airborne spores on both floors was consistent with outdoor air which did not indicate indoor mold growth, but also opined that “water intrusion to the second floor has the potential to affect the first floor occupied areas and must be remediated by promptly fixing the roof leaks.” *Id.*

Dr. Laumbach’s admissions are consistent with the photographs submitted by CMS that were attached to the complaint and which, as we noted above, Franklin admits show facility rooms, albeit mostly unoccupied. CMS Ex. 20, at 3-19; Reply at 9. The admissions in his reports are also consistent with the reports of the two mold testing companies in the record in showing that mold was present at various locations in the facility, some of them including the Shower Room in the Princeton unit and some occupied rooms. *See* P. Exs. 13 and 14.⁵ Franklin’s project manager who oversaw

⁵ The Hayes report shows spores of one to three types of mold at concentrations slightly or significantly higher than outdoor air at three sampled locations (Room 122, the Shower Room, and a rear hallway), but no increased spore concentrations on the second floor. P. Ex. 14, at 3-4. The elevated types of spores are noted to be from molds associated with water damage but not those identified as common allergens. *Id.* The report from Pro-Lab to AdvantaClean identified elevated mold spore levels on tape samples from Room 122 and the Shower Room (but not in Room 138) and provided microscopic identification of mold types from the Shower Room and Rooms 115, 120, 122, and 138. P. Ex. 13, at 2-4. As discussed later, CMS views the laboratory reports as establishing conditions far more serious than Dr. Laumbach’s interpretations, but for the purposes of this section, we simply recognize that the statements of Dr. Laumbach recognizing the existence of mold in these areas and the potential for some significant health effects on residents are corroborated by the laboratory results.

remediation efforts reports working on the Shower Room (which contained an area of mold falling in the “medium” remediation requirements range of 10-100 sq. ft.) as well as on eleven other rooms. P. Ex. 61. He coordinated with staff to move residents out of those rooms that were occupied while the remediation took place over the course of two weeks. *Id.* Franklin does not deny the recurrent roof leaks, including those observed by Dr. Laumbach on the second floor, but contends that it took action to repair leaks as they occurred. RR at 3; P. Ex. 60, at ¶ 7 (Richard Pineles Decl.; owner/officer “familiar with the various problems” with facility roof, but “continuously worked to repair the leaks when they occur”); P. Ex. 28 (repair invoices/documentation).

Franklin does not dispute that it placed signage on the rooms which were unoccupied but did not lock or otherwise seal them to prevent resident access. ALJ Decision at 14-15, and record citations therein. Nor does Franklin deny that some of its residents who were cognitively impaired might therefore have been able to access those rooms. *Id.*

Franklin states that its facility housed only an “average percentage of residents who suffer from respiratory conditions given the patient population,” not a “significant percentage” as characterized by CMS. RR at 12 (citing P. Exs. 63, and 33). The first cited exhibit includes the testimony of Dr. Robert Platzman that he treats patients at Franklin who have “respiratory issues including asthma, COPD [chronic obstructive pulmonary disease], pleural effusion, etc.” and that pneumonia is a common cause of infection, as with other nursing homes. P. Ex. 63, at 1-2. The second exhibit merely provides guidelines for the treatment of COPD in long-term care patients. P. Ex. 33. Franklin itself provided the surveyors with a list of 18 residents on oxygen with respiratory diagnosis, including asthma and COPD. CMS Ex. 79, at 1. (CMS identified additional residents whom it concluded had respiratory vulnerabilities, but for purposes of this discussion we focus only on undisputed evidence. *See* CMS Response Brief on Appeal (CMS Br.) at 19-20, and record citations therein). In any case, the relevant and undisputed fact is that at least 18 residents were known to have the kind of preexisting conditions that Dr. Laumbach recognized could be worsened by mold exposure.

It is sufficient to establish noncompliance with 42 C.F.R. § 483.25(h) if conditions are present in the environment that place residents at risk of injuries with a potential for more than minimal harm. *See* 42 C.F.R. §§ 488.402(b), 488.301. The undisputed facts, even viewed in the light most favorable to Franklin, definitively establish that mold was present in areas occupied by or accessible to residents who included patients vulnerable

to possible exacerbations of respiratory conditions which certainly constitutes at least a risk of more than minimal harm.⁶

b. Issues remaining in dispute

Although the undisputed facts establish the presence of mold in areas of the facility that were not sealed off to prevent possible exposure to vulnerable residents, and thus a risk of more than minimal harm, a determination that immediate jeopardy was present at the time of the survey requires more. Immediate jeopardy involves noncompliance which “has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.” 42 C.F.R. § 488.301. In evaluating CMS’s determination of immediate jeopardy, the ALJ (and the Board) must defer to CMS’s assessment unless it is clearly erroneous, as mentioned earlier. In making this evaluation, however, the Board has held that, where expertise is applied to assess the likelihood of serious harm from noncompliance, “it is material to evaluating the immediate jeopardy determination to consider the factual underpinnings” to which that expertise was applied. *Innsbruck HealthCare Ctr.*, DAB No. 1948, at 6 (2004). If aspects of the “factual underpinnings” are in dispute which may bear on that assessment, the ALJ cannot properly evaluate whether the determination was clearly erroneous without first resolving material disputes of fact as to what the facts were and whether they were different than those to which the surveyors (or here, also CMS’s expert witness) applied their expert judgment. That is the situation in this case, as we explain below.

Moreover, in this case, the CMP was at the highest permissible per-day amount for noncompliance constituting immediate jeopardy (\$10,000). Franklin contests the reasonableness of the CMP amount. RR at 20; ALJ Decision at 1-2. To evaluate the reasonableness of the CMP amount, an ALJ is to consider: (1) the facility’s history of noncompliance; (2) the facility’s financial condition; (3) the 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 (but the absence of culpability is not a mitigating factor). 42 C.F.R. § 488.438(f). The factors in section

⁶ CMS alleged in the SOD that a closet with hazardous cleaning materials was unlocked. CMS Ex. 1, at 14. Franklin argues that CMS failed to include this allegation in its briefing below. RR at 19. Franklin also alleges, however, that no likelihood of serious harm flowed from the fact that the closet was unlocked because it was located across from a nursing station and under observation sufficient to prevent entry by vulnerable residents. *Id.* CMS argues that Franklin had ample opportunity to respond to the allegations since they were contained in the SOD. CMS Br. at 36. We agree with CMS that Franklin had notice of the allegation and that it is properly before the ALJ. The problem is that CMS’s motion for summary judgment had to identify the facts which it claimed were not in dispute but it is not clear from CMS’s combined prehearing brief and motion for summary judgment (filed August 6, 2015) which facts were alleged and which were assertedly undisputed. Specifically, CMS did not clearly assert that the facts relating to the closet were undisputed. Therefore, Franklin was not put on notice that the issue might form part of the basis for summary judgment in favor of CMS. The issue of what risk of harm was presented by the closet should be resolved on remand based on the record as a whole.

488.404, in turn, 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. Where the ALJ's assessment of one or more of these factors is based on factual determinations about which genuine issues of fact are disputed, and the full amount of the CMP is not supported by the undisputed facts alone (construed in favor of the facility), it is improper to resolve the reasonableness of the amount on summary judgment. That, too, precludes summary judgment here.

CMS proffered considerable evidence of both visible and hidden mold in more areas of the facility, as well as other potentially dangerous conditions, going well beyond the undisputed facts discussed above. This evidence included testimony and notes by surveyors about their observations and interviews with staff and residents. *See, e.g.*, CMS Ex. 88 (Maxine Charles Decl.; survey team leader, citing notes and write-ups at CMS Exs. 19 and 83); CMS Ex. 90 (Rita Njoku Decl.; survey team member and nurse, citing her notes and documents collected at CMS Exs. 77, and 78); CMS Ex. 91 (Julie Baker Decl.; survey team member and public health consultant, and her notes at CMS Ex. 17); CMS Ex. 92 (James Inman Decl.; survey team member and Physical Plant and Life Safety Code Surveyor, citing mold training materials he studied at CMS Exs. 69 and 70, and his notes at CMS Exs. 8, 9 and 11). In these and other exhibits, the surveyors recounted day-by-day and room-by-room the specific conditions on which they based their determination that the mold and other problems were so serious as to present immediate jeopardy for residents, as they concluded in the SOD. CMS Ex. 1.

Taken as true, this evidence collectively presents a picture of what CMS describes as years of water leaking into the facility over and over again without proper repairs creating a "fertile environment for mold to proliferate" resulting in extensive mold growth throughout the facility. CMS Br. at 3-4, 9. CMS also argues that its evidence showed that between 27 and 31 residents had respiratory illnesses and that some residents were hospitalized with conditions that might have resulted from mold exposure. *Id.* at 19-20, and record citations therein.

Franklin, however, requested the opportunity to cross-examine all of CMS's witnesses on their observations and the bases for their opinions.⁷ Franklin Opposition to Summary Judgment at 2; Franklin Request to Cross-examine Witnesses (Dec. 16, 2015). Franklin offered testimony suggesting that the surveyors reacted with unfounded "hysteria" to the black spots in the Shower Room and a "handful of patient rooms" which were "under

⁷ CMS also requested to cross-examine all of Franklin's witnesses, and that request too remains outstanding in light of our determination that summary judgment was improperly granted. CMS Cross-examination Request (Nov. 13, 2015).

repair.” P. Ex. 60, at ¶ 12 (Pineles Decl.). Franklin’s witness also alleged that the surveyors had no expertise relating to mold, instead “[a]t best . . . relied upon commonly held misconceptions about mold,” did not call in any mold experts of their own, and yet were so “absolutely committed to shutting down the facility” that they “would not let the opinion of the only expert on site . . . get in their way.” *Id.* at ¶¶ 34, 39. The facility’s administrator also asserted that the surveyors “coopted” the mold testing services (AdvantaClean) hired by Franklin and that they were “unrelenting in their mission to shut the facility down and would do whatever it took to accomplish this.” P. Ex. 59, at ¶¶ 26, 47 (Peterside Decl.). Overall, Franklin raised questions about the credibility of the surveyors’ assessment and reporting of the scope and impact of the problematic conditions sufficient to justify permitting Franklin to test those witnesses in cross-examination, whether or not the ALJ ultimately concludes that the questions have any merit at all.

Franklin also raised a genuine dispute of material fact as to the assessment of the likelihood of and seriousness of the harms created by the types and extent of mold that was present, particularly through the statements of its expert witness. Dr. Laumbach did not deny that mold could sometimes worsen respiratory conditions. He did, however, assert that his inspections of the facilities and review of the laboratory results did not indicate “an imminent health risk due to mold for the patients” or others. P. Ex. 1, at 3; *see also* P. Ex. 6 (e-mail from Dr. Laumbach after inspection reporting that he saw “no conditions presenting an urgent health hazard or imminent threat to the health of patients” or others). He described the areas of mold growth apart from the Shower Room as “minor,” and opined that remediation could take place using established protocols without an evacuation of the facility. P. Ex. 1, at 3; P. Ex. 2, at 1. While these statements do not precisely address the degree of likelihood of serious harm from the level of mold he described, a reasonable trier of fact could infer from them that he did not believe that serious harm was likely under the circumstances presented by the facts as he viewed them.⁸ Furthermore, Dr. Laumbach expressly characterized CMS’s expert’s opinion as having “exaggerated” in claiming a “likelihood of serious harm to the patients of Franklin Care Center, including but not limited to respiratory disease and failure.” P. Ex. 3, at 7 (citing CMS Ex. 97, at 10). Ultimately, he opined that CMS’s determination “that mold at FCC presented immediate jeopardy from October 30, 2014 to November 24, 2014 was in error, because there was no likelihood of serious injury, harm, impairment or death to an individual” and he held “these opinions to a reasonable degree of medical and scientific certainty.” P. Ex. 3, at 14.

⁸ The ALJ discounted Dr. Laumbach’s comments as addressed solely to rejecting any need for an evacuation, on the grounds that, as we have already said, no evacuation ultimately occurred. ALJ Decision at 14. While this context may indeed be important to consider when weighing the expert’s opinion, summary judgment requires a factfinder to view all evidence in the light most favorable to the non-movant and to draw all reasonable favorable inferences, rather than to weigh conflicting evidence and evaluate testimony. In that light, Dr. Laumbach’s opinions about the lack of seriousness or immediacy to any health impacts of the mold he saw are material to the immediate jeopardy finding, not only to the no-longer-relevant evacuation issue.

CMS's expert, Dr. Ernest Chiodo, did not visit the facility but provided his opinions based on reviewing the anonymous complaint and attached photographs, the surveyors' notes, the SOD, Dr. Laumbach's reports, the laboratory results discussed above, and some other documents also in the record, including medical records of a patient previously housed in Room 138 who had died of pneumonia. CMS Ex. 97, at 2-3. Dr. Chiodo's opinion stated that it was based on an understanding of the facts that included finding "[e]xtensive mold contamination" on both "the first and second floors" of the facility, including Room 138. *Id.* at 3. This factual premise directly conflicts with Dr. Laumbach's report of observing only "minor" mold areas in any area outside of the closed Shower Room. The two experts interpret the results of the air and swab sample laboratory reports dramatically differently as well. *Compare id.* (mold tests "showed mold contamination of the Franklin Care Center with mold species including *Aspergillus*, *Pencillium*, *Chaetomium*, *Memmoniella*, and *Stachybotrys*") with P. Ex. 3, at 4 (noting air samples from four of six tested indoor areas had mold spore levels "below the outdoor sample, as well as similar species in common with the outdoor sample," while those from Room 122 and the Shower Room were higher with some "species that do grow on indoor materials, including *Chaetomium* and *Memmoniella*") and *id.* at 6 ("An air sample on the second floor showed low levels of mold spores consistent with outdoor air, indicating lack of general concern about mold spores in the air on this unoccupied floor. A sample on the first floor Franklin hallway showed similar low-level results, consistent with outdoor mold spores and lack of a source of mold growth in the Franklin Unit."). Dr. Chiodo cites a variety of scientific articles and other sources to opine that patients in Franklin "must be assumed" to have been exposed to "an increased risk of cancer" due to mycotoxins "in levels encountered in agricultural settings," particularly the mold known to produce aflatoxin B1, a potent natural carcinogen; that they were "placed at increased risk of serious neurological disease" due to mold exposure; and that they were at "risk of serious adverse health effects or death due to exposure to endotoxin." CMS Ex. 97, at 5-8. Moreover, although he acknowledged he could not determine if the residents with asthma or other respiratory illnesses developed them due to mold while in the facility, he suggested that one patient's lack of response to Lasix treatment for respiratory disease "points to mold exposure as the cause of the patient's recurrent episodes of respiratory distress." *Id.* at 5.

CMS denies that this case involves a "battle of the experts" (CMS Br. at 1; *see also* Tr. at 14), but expends considerable argument directed at disputing and discrediting Dr. Laumbach's opinions. CMS Br. at 26-35. We disagree. Among other points, CMS (and its expert) assert that his opinions here are inconsistent with his conclusions in an unrelated case, that he misread or misused mold guidelines on which he relied, and that he failed to properly assess the individualized risks to residents from mold exposure. *Id.* Dr. Laumbach, for his part, describes Dr. Chiodo's opinions as "contrary to any rational science-based methodology for considering health risk from exposure to indoor mold."

P. Ex. 3, at 7. Dr. Laumbach argued that the field is “rapidly evolving” and that Dr. Chiodo’s discussion relies on outdated information from the 1990s which has been replaced in some cases by sources relied on in Dr. Laumbach’s reports. *Id.* at 7-8. Dr. Laumbach denies that airborne mycotoxins from indoor mold have been shown to present the hazards claimed by Dr. Chiodo, that there is any relation between indoor mold and Lasix-resistance or pneumonia, that the risks of cancer or neurological illness were elevated by any exposure at the facility, and that any evidence exists of endotoxins present at the facility or having any relation to indoor mold or dampness. *Id.* at 7-11; *see also* Tr. at 13-14 (arguing factual disputes about seriousness of mold hazards). It thus appears that the credibility and foundation of the competing expert opinions is indeed hotly disputed.

In granting summary judgment, the ALJ relied on Dr. Chiodo’s opinions in finding the mold to be “extensive” and accepting his characterization of the extent of risk (and possible actual impact) of the mold species and mycotoxins. ALJ Decision at 13. While he mentions Dr. Laumbach’s assessment that the mold that was present was not widespread, the ALJ dismisses this as inconsistent with the finding of “mold or suspected mold” in 21 different rooms or areas, without considering the claims made by Dr. Laumbach that the areas of mold outside the Shower Room were very small and unlikely to have any serious health impacts. *Id.* at 14. To evaluate the weight to give to Dr. Chiodo’s opinions, the ALJ needs to first reach findings as to the actual extent of mold and/or mycotoxins and resident exposure. While the ALJ on remand is free to choose how much credit to give to the statements of the witnesses, disregarding or discounting the assertions of Franklin’s expert was necessarily an exercise in the assessing the credibility of, relative expertise of, and appropriate weight to accord to witnesses. Such an exercise precludes summary judgment.

At the same time, we decline Franklin’s request that CMS’s immediate jeopardy determination be overturned as clearly erroneous. Reply at 11. Franklin acknowledges that the regulation does not require that actual harm be proven to have occurred, but rather contends that CMS failed to show a causal connection between the facts and circumstances relating to its facility’s condition and a likelihood (or probability) of serious harm. *Id.* at 11-12. The ALJ rejected Dr. Laumbach’s contentions that no causal association between mold and particular health conditions has been proven scientifically, on the grounds that CMS need not show that a deficiency caused actual harm but only a likelihood of serious harm. ALJ Decision at 19-20. But the ALJ went on to find that it is “widely accepted” that mold contamination in buildings is a “potential threat.” *Id.* at 19. Franklin is correct that a potential threat is not equivalent to a likelihood of serious harm, so the ALJ erred in conflating the standards in granting summary judgment. The ALJ is nevertheless correct that CMS need not prove actual harm to an individual resident in order to find immediate jeopardy, and that on review of the full record, he may consider all cited conditions in the facility (including the remediation measures actually used and

effects of the roof leaks beyond mold) in assessing whether CMS clearly erred in determining that a likelihood of serious harm existed. *Id.* at 20-21.

The Board has explained the correct analysis as follows:

Immediate jeopardy is defined in 42 C.F.R. § 488.301 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.” Thus, in the absence of evidence that the deficiency has caused serious harm to a resident, a determination of immediate jeopardy requires a showing that serious harm is likely, not merely that a risk of serious harm exists. *Innsbruck HealthCare Ctr.* DAB No. 1948 (2004). In reviewing an immediate jeopardy determination, the reviewing body must consider the facts upon which CMS relied in making the determination, as well as any evidence presented at the hearing. *Id.* Because the definition of “immediate jeopardy” requires that there be some causal connection between the facility’s noncompliance and the existence of serious injury or a threat of injury, the nature and circumstances of the facility’s noncompliance are of obvious importance to the evaluation.

Spring Meadows Health Care Ctr., DAB No. 1966, at 36 (2005). The Board has not held that summary judgment is necessarily inappropriate in reviewing an immediate jeopardy determination, contrary to Franklin’s arguments at the oral argument. Tr. at 9. We do conclude that it was inappropriate here where evidentiary disputes exist about the underlying facts and the degree of harm that was likely. Our conclusion that summary judgment for CMS on the immediate jeopardy determination, however, in no way implies that Franklin has demonstrated that the determination was wrong, much less clearly erroneous. We conclude only that it was premature to resolve the question on summary judgment. On remand, the ALJ is free to review the record as a whole, weigh conflicting evidence and evaluate testimony to reach conclusive findings as to the actual conditions, such as the extent and location of leaks and mold, the types of mold present, the vulnerabilities of particular residents, and other relevant facts.

The immediate jeopardy determinations relating to Tags F493 and F520 are essentially derivative here of the same facts on which the immediate jeopardy determination under Tag F323 was made, i.e., that the environmental conditions, particularly the roof leaks and mold, created a likelihood of serious harm to residents. *See* ALJ Decision at 16-18 (findings supporting noncompliance under these tags). The focus of the tags under 42 C.F.R. 483.75 differs only in emphasizing the responsibility of management and quality assurance to administer facility resources and monitor its performance to achieve compliance. Our discussion of the need to remand to determine the level of noncompliance under Tag F323 applies equally to the other tags.

In light of our conclusion that the case must be remanded for record development and resolution of the level of noncompliance, it would be premature to rule at this stage on Franklin's arguments that the amount of the CMP imposed by CMS was unreasonable. As to this question as well, disputes of fact remain for the ALJ to resolve. For example, it is undisputed that the second floor of the facility was closed to residents since 2007 and that the facility's roof above the second floor has at least recurrent problems with leaking requiring repeated repairs. *See, e.g.*, P. Ex. 9 (notice of closure for renovations); P. Ex. 28 (invoices for roof repairs in 2011-2014); P. Ex. 63, at 1 (Medical Director aware of problems with roof "in recent years"). CMS's characterizations of "longstanding roof leaks" to which the facility made only an "'ad hoc' response . . . by placing garbage cans and aluminum cans around the facility" cannot be fairly said to be undisputed, as CMS asserts. CMS Br. at 1. Franklin proffered evidence of work done on the roof and testimony which, if credited, tended to show that the needed repairs were made when leaks occurred. Reply at 7, and record citations therein; P. Ex. 63, at 1 (Medical Director states roof problems "diligently remedied" when they appeared). Determining whether the roof was actively repaired or neglected for years may be relevant to the ALJ's evaluation of the reasonableness of the amount of the CMP and therefore these and related disputes of fact are material.

Conclusion

For the reasons explained above, the case is remanded to the ALJ for further action consistent with this decision.

/s/

Christopher S. Randolph

/s/

Constance B. Tobias

/s/

Leslie A. Sussan
Presiding Board Member