Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Franklin Care Center,
(CCN: 31-5151),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-2515

Decision No. CR4922

Date: August 15, 2017

DECISION

Franklin Care Center (Petitioner or facility) is a skilled nursing facility (SNF) that participates in the Medicare program. Based on a survey completed on November 3, 2014, the Centers for Medicare & Medicaid Services (CMS) determined that Petitioner was not in substantial compliance with the following Medicare program participation requirements: 42 C.F.R. §§ 483.25(h), 483.75(d)(1)-(2), and 483.75(o)(1). CMS imposed a $10,000 per-day civil money penalty (CMP) on Petitioner, effective October 30, 2014 through November 24, 2014, and $350 per-day CMP effective November 25, 2014 through December 22, 2014, for a total CMP of $269,800.00.

Petitioner requested a hearing to appeal CMS's determination that the deficiencies posed immediate jeopardy, and the amount of the $269,800 CMP. CMS moved for summary judgment, which Petitioner opposed. I conclude that summary judgment is appropriate in this case because the undisputed facts (and disputed facts viewed in a light most favorable to Petitioner) establish that: (1) Petitioner did not substantially comply with the Medicare participation requirements found at 42 C.F.R. §§ 483.25(h), 483.75(d)(1)-(2), and 483.75(o)(1); (2) CMS did not clearly err in determining that Petitioner's noncompliance with 42 C.F.R. §§ 483.25(h), 483.75(d)(1)-(2), and 483.75(o)(1) posed

immediate jeopardy to resident health and safety; and (3) the proposed CMPs are reasonable in amount and duration. Therefore, I grant CMS's motion for summary judgment.

I. Background

The Social Security Act (Act) sets forth requirements for the participation of a SNF in the Medicare program and authorizes the Secretary of Health and Human Services (the Secretary) to promulgate regulations implementing those statutory provisions. 42 U.S.C. § 1395i-3. The Secretary's regulations are found at 42 C.F.R. Parts 483 and 488. To participate in the Medicare program, a SNF must maintain substantial compliance with program participation requirements. To be in substantial compliance, a SNF's deficiencies may "pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301.[1] A deficiency is a violation of a participation requirement established by sections 1819(b), (c), and (d) of the Act, 42 U.S.C. § 1395i-3(b), (c), and (d), or the Secretary's regulations at 42 C.F.R. pt. 483, subpt. B. "Noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." 42 C.F.R. § 488.301. A facility may violate a statutory or regulatory requirement, but it is not subject to enforcement remedies if the violation does not pose a risk for more than minimal harm. 42 C.F.R. §§ 488.402(b), 488.301.

The Secretary contracts with state agencies to conduct periodic surveys to determine whether SNFs are in substantial compliance. 42 U.S.C. § 1395aa(a); 42 C.F.R. § 488.10. The Act also authorizes the Secretary to impose enforcement remedies against SNFs that are not in substantial compliance with the program participation requirements. 42 U.S.C. § 1395i-3(h)(2). The regulations specify the enforcement remedies that CMS may impose. 42 C.F.R. § 488.406. Among other enforcement remedies, CMS may impose a per-day CMP for the number of days a SNF is not in substantial compliance or a per-instance CMP for each instance of the SNF's noncompliance. 42 C.F.R. § 488.430(a). A per-day CMP may range from either $50 to $3,000 per day for less serious noncompliance, or $3,050 to $10,000 per day for more serious noncompliance that poses immediate jeopardy to the health and safety of residents. 42 C.F.R. § 488.438(a)(1).[2]

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[1] All citations to the Code of Federal Regulations are to the version in effect at the time of the incident at the heart of this decision unless otherwise indicated.

[2] CMS recently increased the CMP amounts to account for inflation in compliance with the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015, 104 Pub. L. No. 114-74, 129 Stat. 584, 599. The new adjusted amounts apply to CMPs assessed after August 1, 2016, for deficiencies occurring on or after November 2, 2015. *See* 81 Fed. Reg. 61,538 (Sept. 6, 2016). As the deficiencies alleged in this case occurred prior to November 2, 2015, the increased CMP amounts do not apply in this case.

"Immediate jeopardy" exists when "the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301.

If CMS imposes a CMP based on a noncompliance determination, then the facility may request a hearing before an administrative law judge (ALJ) to challenge the noncompliance finding and enforcement remedy. 42 U.S.C. §§ 1320a-7a(c)(2), 1395i-3(h)(2)(B)(ii); 42 C.F.R. §§ 488.408(g), 488.434(a)(2)(viii), 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *CarePlex of Silver Spring*, DAB No. 1683 (1999) (holding that ALJs hold *de novo* hearings based on issues permitted under the regulations and ALJ review is not a quasi-appellate review); *see also Claiborne-Hughes Health Ctr. v. Sebelius*, 609 F.3d 839, 843 (6th Cir. 2010) (The Departmental Appeals Board (DAB) "reviewed the finding under the *de novo* standard that the ALJ would have applied."). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); *see also* 42 C.F.R. §§ 488.330(e), 498.3. However, CMS's choice of remedies and the factors CMS considers when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2).

In regard to the burden of proof, CMS must make a *prima facie* case that the SNF failed to comply substantially with federal participation requirements and, if this occurs, the SNF must, in order to prevail, prove substantial compliance by a preponderance of the evidence. *Hillman Rehab. Ctr.*, DAB No. 1611 at 8 (1997); *see Batavia Nursing & Convalescent Inn*, DAB No. 1911 (2004); *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 F. App'x 181 (6th Cir. 2005); *Emerald Oaks*, DAB No. 1800 (2001).

Petitioner is an SNF that operates in Franklin Park, New Jersey. Surveyors from the New Jersey State Department of Health and Senior Services (state agency) conducted a survey of Petitioner that concluded on November 3, 2014. CMS Ex. 1 at 1. The state agency found that the facility was not in substantial compliance and the conditions constituted immediate jeopardy. CMS Exhibit (CMS Ex.) 1. Relevant to this case, the state agency found the following deficiencies, each at the immediate jeopardy level from October 30, 2014 through November 24, 2014:[3]

[3] The originating case decision, CMS's April 10, 2015 letter, indicates the immediate jeopardy level deficiencies related to the 42 C.F.R. §§ 483.25(h), 483.75(d)(1)-(2), and 483.75(o)(1) violations are the cause for the CMPs that accrued at $10,000 per day during the October 30, 2014 through November 24, 2014 period, with the remaining 28 days of CMPs at $350 per day due to continued noncompliance. Petitioner, in its request for hearing, appealed "CMS' decision to impose a CMP"; however Petitioner offers no argument regarding the remaining 28 days of non-immediate jeopardy deficiencies, and does not appear to dispute them.

- 42 C.F.R. § 483.25(h) (Tag F323) (accident prevention and adequate supervision) at a scope and severity level of "L":[4]
- 42 C.F.R. § 483.75(d)(1)-(2) (Tag F493) (facility policies/appoint administration, at a scope and severity level of "J";[5] and
- 42 C.F.R. § 483.75(o)(1) (Tag F520) (committee members/meet quarterly/facility policies/meet quarterly/plans) at a scope and severity level of "J."

CMS Ex. 1 at 13-32, 36-40. The deficiencies primarily resulted from a chronic problem that Petitioner had with a leaky roof, which the state agency surveyors believed to cause black substances in various rooms that turned out to be mold.

In response to the state agency findings, Petitioner filed several plans of correction ("POC"); its first plan of correction was dated October 30, 2014, which included testing the air samples through an outside contractor and transferring residents beginning October 31, 2014 due to the mold. CMS Ex. 40. Petitioner filed an updated version on the same date. CMS Ex. 41. In a November 3, 2014 revised plan of correction (POC 3), Petitioner had Robert Laumbach, MD, MPH, CIH (Dr. Laumbach) complete a walk-through of the facility, at which point he concluded "there was no immediate threat to anyone" due to the mold. CMS Ex. 42 at 1. POC 3 indicated that during the remediation, residents would be removed from the work area and environmental rounds would be completed daily, but the POC 3 does not indicate the residents would be transferred elsewhere. CMS Ex. 42 at 1. After a series of POCs, which CMS determined to be unacceptable (CMS Exs. 43-48), the parties agreed upon POC 6, which does not require evacuation of residents from the facility. CMS Exs. 49, 50.

On November 19, 2014, CMS issued an initial determination adopting the state agency survey findings and imposing a $10,000.00 per-day CMP effective October 28, 2014. CMS Ex. 2. On March 18, 2015, CMS issued another initial determination following multiple revisit surveys and concluded that the $10,000 per-day CMP would be effective October 30, 2014 and continue through November 24, 2014, and that a $350 per-day CMP would be imposed from November 25, 2014 through December 22, 2014. Petitioner filed a request for a hearing before an ALJ to dispute the March 18, 2015 initial determination, and the DAB's Civil Remedies Division docketed the case under C-15-2114. This case was assigned to me to hear and decide, and I issued an Acknowledgment and Pre-Hearing Order that established a prehearing submission schedule. However, before the parties could submit their prehearing exchanges, CMS issued another initial determination on April 10, 2015, which imposed the same CMPs as the March 18, 2015

[4] A scope and severity level of "L," indicates widespread immediate jeopardy to resident health or safety. *See* State Operations Manual ch. 7, § 7400E.

[5] A scope and severity level of "J," indicates isolated immediate jeopardy to resident health or safety. *See* State Operations Manual ch. 7, § 7400E.

determination. CMS Ex. 4. Petitioner requested a hearing related to the April 20, 2015 initial determination, and the Civil Remedies Division docketed that request under C-15-2515. The new request was assigned to me and I consolidated both hearing requests under C-15-2515, but left the original prehearing exchange schedule unchanged.

In accordance with the schedule, CMS and Petitioner filed prehearing exchanges, including prehearing briefs (CMS Br.; P. Br.; and CMS Reply Br.), exhibit and witness lists, and proposed exhibits. CMS moved for summary judgment, and Petitioner objected. CMS submitted CMS Exs. 1 to 117, and Petitioner submitted P. Exs. 1 to 65. CMS objected to Petitioner's exhibits 10-12, 19, 22, 23, 27-29, 39, 43, and 53 (CMS Objections). Petitioner Exhibit 10 consists of employment records of the employee that Petitioner assumes was the anonymous complainant. I find Petitioner Exhibit 10 to be irrelevant and decline to admit it, as this information is not related to the presence of mold in the facility, the overall condition of the facility, and whether immediate jeopardy was present. Petitioner Exhibit 27 contains letters from residents and family members protesting the evacuation of the facility. However, as there was no such evacuation and there is no dispute the facility was ultimately able to achieve substantial compliance without evacuation (following mold remediation), the documents contained in Petitioner Exhibit 27 are not relevant and I do not admit them. I will admit Petitioner Exhibit 29, the state agency informal dispute resolution results for a previous state agency survey referenced in CMS's brief, and Petitioner Exhibit 39 related to the facility's five star rating. Regarding Petitioner Exhibits 11, 12, 19, 22, 23, 28, 43, and 53, CMS has argued the exhibits are inaccurate and prejudicial summaries of exhibits already in evidence, or articles that are not from authoritative sources. CMS Objections at 7, 18. As I have ultimately found in favor of CMS's motion for summary judgment, I find CMS has suffered no prejudice by the admission of these exhibits; therefore, I will not exclude them. Therefore, I admit CMS Exhibits 1-117 and Petitioner Exhibits 1-9, 11-26, and 28-65 into the record.[6]

II. Issues

The issues are:

1) Whether summary judgment is appropriate;

2) Whether Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h) (Tag F323, relating to accident prevention and adequate supervision);

[6] Several exhibits submitted by CMS and Petitioner contain identical documents. In some instances, when referring to these documents, I have identified the document by only CMS's or Petitioner's exhibit number, and not by both exhibit numbers.

3) Whether Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.75(d)(1)-(2) (Tag F493, relating to Facility Policies/Appoint Administration);

4) Whether Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.75(o)(1) (Tag F520, relating to Committee Members/Meet Quarterly/Facility Policies/Meet Quarterly/Plans);

5) If Petitioner was not substantially compliant with 42 C.F.R. §§ 483.25(h), 483.75(d)(1)-(2), 483.75(o)(1), whether CMS's immediate jeopardy determination was clearly erroneous; and

6) Whether the CMPs that CMS imposed is reasonable.

III. Facts

1. A notice of violations from the Franklin Township Fire Prevention Department to Petitioner indicates Petitioner's facility was inspected on July 16, 2004. The notice indicated Petitioner must have all roof leaks repaired by July 30, 2004. CMS Ex. 105 part I (1 of 2) at 1-2.[7] The roof leaks were indicated to have been abated on August 19, 2004. *Id*. Subsequent notices based on inspections from December 16, 2005, April 19, 2007, January 31, 2008, again indicated Petitioner was required to repair roof leaks. CMS Ex. 105 part I (1 of 2) at 13-14; CMS Ex. 105 part I (2 of 2) at 10, 15; CMS Ex. 105 Part II (1 of 2), at 6, 8; CMS Ex. 105 Part II (2 of 2), at 5-6.

2. In September and October of 2014, the state agency received two anonymous complaints regarding the facility's roof leaks and mold contamination. CMS Ex. 20; CMS Ex. 88 at 3-5; CMS Ex. 96 at 2-3. A September 29, 2014 complaint letter indicates the roof had been neglected for years, resulting in "numerous leaks all over the building." CMS Ex. 20 at 1. The October 2014 anonymous complaint indicates "[c]eiling is falling down and is in disrepair and you can see pipes . . . Garbage cans in the halls collecting the rain that is falling in from the holes in the ceiling". CMS Ex. 20 at 20. The complaints indicate the water damage caused "ceiling tiles to become saturated with water and fall onto the floor all over the building." CMS Ex. 20 at 1. The complaints indicate ceiling tiles were replaced to hide water damage, and mold growing behind the wallpaper was removed

[7] Petitioner Exhibit 59 references penalties imposed by Franklin Township upon Petitioner for "failing to obtain permits and pass all required inspections." P. Br. at 4. Notices of previous violations are relevant to show the extended length of time Petitioner experienced problems with roof leaks, and the fact Petitioner was on notice of the roof leaks.

without proper technique or equipment. The complaints also suggested the poor conditions may have contributed to the decline in a deceased resident's health. CMS Ex. 20 at 1.

3. Photos submitted with the September 2014 anonymous complaint include pictures of a room identified as room 138, featuring a sign stating "Off Limit to All!! Room Closed for Maintenance Please Keep Door Closed". CMS Ex. 20 at 5. Further photos show what looks like mold. CMS Ex. 20 at 6-8. Subsequent photos include images of trash bins, buckets, and towels arranged on the floor amongst wet floor signs (CMS Ex. 20 at 9, 17-18); ceiling tiles in various states of disrepair including damaged, fallen, and stained examples; and areas which were missing ceiling panels entirely. CMS Ex. 20 at 10-16, 19.

4. An October 21, 2014 letter from Tracy F. Boss of Franklin Universal Building Corp. to Karine Peterside of Franklin Care Center indicates Franklin Universal Building Corp. had eliminated some roof leaks, but the roof design and materials made finding the origins of the leaks difficult. The letter concluded "[w]e are hopeful that they will be contained by the end of the week." CMS Ex. 10 at 1. An invoice from a supply company indicates Petitioner received over $8,000 in roofing supplies on June 18, 2014 and July 1, 2014. CMS Ex. 10 at 2-3. Further documentation from Petitioner indicates their history of roof repairs dating to 2011. P. Ex. 28.

5. October 23, 2014 initial visit photos by surveyor James Inman show extensive damage that Mr. Inman called "black substance," at the Petitioner's facility. CMS Exs. 13, 92. The photos appear to show extensive mold in the shower room, the beauty salon, and room 111. CMS Ex. 13 at 1-2, 5, 7, 12-14. The photos also show water damaged ceiling panels, and tarps hung from the ceiling. CMS Ex. 13 at 8-10.

6. CMS surveyors (including James Inman, Patricia Devine, Julie Baker, and Maxine Charles) held an October 28, 2014 entrance conference with Petitioner's administrator and directors of nursing. The administrator stated that the second floor of the facility was "closed for renovations due to an issue with financing." After the conference, the survey team conducted a tour of the facility common areas. The surveyors observed signs on the doors of rooms 128 and 132 that read "Room closed for maintenance – Please keep door closed." CMS Ex. 1 part I at 16. Room 138 had a sign reading: "Room closed for maintenance – Please keep door closed, Off limits to all." CMS Ex. 1 part I at 16-17. A shower room next to the nurse's station was closed and had a sign that read "closed for maintenance." CMS Ex. 1 part I at 17. The Surveyor observed stained ceiling tiles above the double doors near rooms 113 and 112. The Surveyor entered room 138, which was unlocked, and noted freshly installed sheet rock. Upon entering the shower

room next to the nurse's station, the Surveyor immediately noted a heavy, musty odor and debris on the floor from sheet rock that had been torn down. A black substance was observed on the inside of the wall frame. The room was not sealed off from the rest of the facility except by the closed door. The surveyors noted stained ceiling tiles in Rooms 29 and 22. CMS Ex. 1 part I at 17. The surveyors also noted black substance on the walls and debris in room 21. CMS Ex. 1 part I at 18. The surveyors also noted the complete lack of personal protective equipment by employees, and the fact the work areas were not enclosed in any manner to prevent contamination from spreading throughout the facility. When the physical plant surveyor asked the maintenance staff if the facility still had roof leaks, the staff replied, "yes." CMS Ex. 1 part I at 18. The surveyors observed a blue tarp and 16 garbage cans of various sizes which appeared to be used for collecting water. *Id.* The surveyors then observed similar arrangements throughout the facility, including aluminum pans set up with clear plastic tubing to drain water into larger bucket reservoirs. CMS Ex. 1 part II at 19-20.

7. On October 30, 2014, the surveyors observed that Velcro stop signs had now been placed in front of room 138 and the shower room, and an alarm system was added that would sound if anyone entered the room. The SOD indicates work areas were not sealed off in any way to prevent contamination. CMS Ex. 1 part II at 4.

8. On October 30, 2014, representatives from Advanta Clean mold remediation company indicated "it was obvious that mold was visible." CMS Ex. 1 part II at 4. The representatives found mold in all three rooms they were shown. CMS Ex. 1 part II at 4-5. The representatives identified likely mold in rooms that were used to store beds, paper goods, soda and snacks for vending machines, pillows, diapers, bibs, curtains, wheelchairs, walkers, shower chairs, electric wheelchairs, and disposable dishes and cups. CMS Ex. 1 part II at 5-6. The representatives also identified mold in the heating vents and air-conditioning unit of the occupied room 120. CMS Ex. 1 part II at 6. The facility requested a mold remediation company come to the facility, and the representative found visible mold in multiple rooms on the first floor, the ceiling on the second floor, and that there was likely mold behind the baseboard and mold growth above the ceiling tiles. CMS Ex. 1 part II at 4-5. The representative confirmed the presence of mold in the facility. CMS Ex. 1 part II at 6-7.

9. At 4:50 p.m. on October 30, 2014, the Surveyor inspection team leader told the facility they needed to enact their emergency evacuation plan. CMS Ex. 1 part II at 8.

10. The November 3, 2014 statement of deficiencies (SOD) (based upon the survey begun on October 29, 2014) indicates the surveyors observed the facility storing hazardous cleaning chemicals in an unlocked closet. CMS Ex. 1 Part I at 13-15.

The surveyors observed tarps and garbage cans arranged to collect water leaking from the ceiling. CMS Ex. 1 part I at 18-19. The surveyors noted numerous rooms which were marked "closed for renovation" but were not sealed off from the rest of the facility and still could be accessed by residents. CMS Ex. 1 part I at 20. The surveyors observed a significant amount of black substance adhered to the walls, which the facility had not identified. CMS Ex. 1 part II at 1-2. The surveyors identified additional black substance in rooms 122, 120, and 111. CMS Ex. 1 part II at 3. The rooms were noted not to be sealed from access by residents, and upon interviewing the administrator, she stated that the rooms were not locked and were not designed to be locked. Rather, the administrator would place a Velcro stop sign on the unlocked doors to prevent residents from entering. CMS Ex. 1 part II at 3. The surveyors identified seven cognitively impaired residents in the unit who would have been able to access the areas containing dangerous objects and which were contaminated with the black substance and were under construction. The surveyors identified an immediate jeopardy situation due to the presence of the black substance throughout the facility. CMS Ex. 1 part II at 3-4.

11. On October 30, 2014, surveyors spoke with employees regarding the conditions in the facility. An employee indicated "at times I can smell it [meaning the mold]," and another employee stated "seen mold, water leaks and stains." Another employee indicated there were also ceiling leaks in the dining area and that there were "always guys fixing the roof." CMS Ex. 1 part II at 7. The administrator indicated she was not familiar with mold, and she had thought it was mildew which the facility had successfully cleaned. CMS Ex. 1 part II at 8.

12. On October 31, 2014, the surveyor team returned to the facility. The facility informed the surveyors that they would not be transferring residents until November 2, 2014 and that the facility was still working on a plan. Based on documentation provided by the Director of Nursing, the surveyors identified seven residents living in the facility previously diagnosed with asthma, and three residents previously diagnosed with chronic obstructive pulmonary disease. CMS Ex. 1 part II at 9.

13. Subsequent visits by the surveyor team to the facility from November 1, 2014 through November 3, 2014 indicated the facility continued to have active ceiling leaks. CMS Ex. 1 part II at 9-11. The surveyors noted active dripping water above room 122, and visible black mold next to room 109. CMS Ex. 1 part II at 10. The surveyors observed wet ceiling tiles in the recreation room while it was being used by 28 residents. CMS Ex. 1 part II at 10-11.

14. A November 3, 2014 "certificate of mold analysis" prepared by "Pro-Lab" for Advanta Clean indicates elevated levels of mold species including chaetomium, cladosporium, memnoniella, "other ascospores", penicillium/aspergillus,

scopulariopsis, "smuts, myxomycetes", and stachybotrys. CMS Ex. 109 at 2. The "possible allergic potential" of these organisms are described as follows (CMS Ex. 109 at 8-10):

Chaetomium	Type I (hay fever and asthma) allergies.
Cladosporium	Type I (hay fever and asthma), Type III (hypersensitivity pneumonitis) allergies.
Memnoniella	Probably Type I (hay fever and asthma) allergies, but not studied.
Ascospores	Little known for most of this group of fungi. Dependent on the type (see Chaetomium and Ascotricha).
Penicillium/Aspergillus	Type I (hay fever and asthma) allergies and Type III (hypersensitivity pneumonitis) allergies.
Scopulariopsis	Very little is known regarding allergic potential, but should be considered similar to Penicillium and Aspergillus because it has a similar sized spore.
Smuts, myxomycetes	Type I (hay fever and asthma) allergies.
Stachybotrys	Type I (hay fever and asthma) allergies.

15. The certificate of mold analysis indicates the presence of unusual mold amounts in the room 122 bathroom, shower room 1, room 115 bathroom, the room 120 heating vent, and room 138. CMS Ex. 109 at 3-4. The certificate further states, under the title "**Health Related Risks**":

> Based on the Institute of Medicine and the National Academy of Sciences, dampness and mold in homes is associated with increases in several adverse health effects including cough, upper respiratory symptoms, wheeze, and exacerbation of asthma. Mold and fungi contain many known allergens and toxins that can adversely affect your health. Scientific evidence suggests that the disease of asthma may be more prevalent in damp affected buildings. Dampness and mold in homes, office buildings and schools represent a public health problem. The Institute of Medicine concluded, "When

> microbial contamination is found, it should be eliminated by means that not only limit the possibility of recurrence but also limit exposure of occupants and persons conducting the remediation. CMS Ex. 109 at 11.

16. Based on the floor plan of Petitioner's facility, the rooms state agency surveyors and Advanta cited as containing mold, including Rooms 1, 21, 22, 109, 115, 120, 128, 132, 138, and the shower room, were spread widely across the facility. CMS Ex. 9 at 1; P. Ex. 11; CMS Ex. 95 at 4-5.

IV. Conclusions of Law and Analysis

1. Summary judgment is appropriate.

Summary judgment is appropriate if there is "no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law." *Mission Hosp. Reg'l Med. Ctr.*, DAB No. 2459, at 5 (2012) (citations omitted). In order to prevail on a motion for summary judgment, the moving party must show that there is no genuine dispute of material fact requiring an evidentiary hearing and that it is entitled to judgment as a matter of law. *Id.* If the moving party meets this initial burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial . . . .'" *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986). "To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact — a fact that, if proven, would affect the outcome of the case under governing law." *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 3 (2010). In moving for summary judgment, CMS must present evidence sufficient to show, if uncontradicted, that it is entitled to judgment as a matter of law and that there are no genuine issues of material fact in dispute. *Chicago Ridge Nursing Ctr., DAB No. 2151 at 5.* If CMS makes this demonstration, the SNF can avoid an adverse summary judgment by: 1) proffering evidence that there is a genuine dispute regarding facts that are material to CMS's basis for claiming judgment in its favor, or 2) proffering evidence from which a trier of fact could conclude—if accepted as true—that the facility could carry the ultimate burden of persuasion (i.e., prove that the facility was in substantial compliance). *Id.* In evaluating an SNF's response to CMS's motion for summary judgment, the ALJ is to view the evidence in the light most favorable to the facility and is to draw all reasonable inferences therefrom in the facility's favor. *Id.*

The role of the ALJ in deciding a motion for summary judgment differs from the role of an ALJ in resolving a case after a hearing: The ALJ does not address credibility or evaluate the weight of conflicting evidence in evaluating a motion for summary judgment. *Holy Cross Village at Notre Dame, Inc.*, DAB No. 2291 at 5 (2009). Rather, in examining the evidence to determine the appropriateness of summary judgment, the

ALJ must draw all reasonable inferences in the light most favorable to the non-moving party. *See Brightview Care Ctr.*, DAB No. 2132 at 10 (2007) (upholding summary judgment where inferences and views of non-moving party are not reasonable). "[A]t the summary judgment stage the judge's function is not . . . to weigh the evidence and determine the truth of the matter but to determine whether there is a genuine issue for trial." *Anderson v. Liberty Lobby, Inc*., 477 U.S. 242, 255 (1986). However, drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions. *Cedar Lake Nursing Home*, DAB No. 2344 at 7 (2010). In supporting my decision to sustain CMS's determinations and grant its motion for summary judgment, I will first address the parties' overarching arguments regarding the state of the facility and whether those conditions posed immediate jeopardy. Then I will briefly examine the individual deficiencies and how those deficiencies were reflected in the facility's condition.

CMS submitted publications from numerous respected health organizations showing that mold is recognized as a significant indoor air pollutant. CMS Ex. 58. It cites to the World Health Organization Guidelines (WHO Guidelines) for indoor air quality, which concludes that indoor air quality is compromised by dampness and mold in indoor environments. CMS Ex. 58. The WHO Guidelines indicate:

> There is sufficient epidemiological evidence of associations between dampness or mould and asthma development, asthma exacerbation, current asthma, respiratory infections (except otitis media), upper respiratory tract symptoms, cough, wheeze and dyspnoea. There is sufficient clinical evidence of associations between mould and other dampness-associated microbiological agents and hypersensitivity pneumonitis, allergic alveolitis and mould infections in susceptible individuals, and humidifier fever and inhalation fevers. This is the only conclusion that is based primarily on clinical evidence and also the only conclusion that refers explicitly to microbial agents, as opposed to dampness-related factors.

CMS Ex. 58 at 4-5.

The New Jersey Department of Health's guidelines for mold indicate:

> Individuals at highest risk:
> - Those who have a pre-existing health condition (allergies; lung [c]onditions such as asthma or emphysema)
> - Infants
> - The elderly

> Common Health Effects Include:
> - Allergic Reactions - sneezing, nasal congestion
> - Irritation to the Nose, Throat, and Respiratory Tract
> - Asthma Attacks
> - Hypersensitivity Pneumonitis
>
> Molds emit spores and chemicals as part of their normal life cycle and some individuals may exhibit reactions when exposed to these materials. Mold spores are microscopic and, once airborne, can easily be inhaled. Spores may contain allergens that can cause irritation to the nose, throat and respiratory tract.
>
> In addition to allergens, molds may emit *microbiological volatile organic compounds (MVOC's)*. These chemicals usually have a strong and unpleasant odor and are associated with the musty smell that individuals equate to mold being present. These chemicals, when released into the air, can be inhaled, ingested or absorbed through the skin. MVOC's can act as irritants and have been linked to headaches, nausea, dizziness and fatigue.

CMS Ex. 69 at 5.

A letter from CMS's expert witness, Dr. Ernest Chiodo, described the mold contamination at Petitioner's facility as "extensive." CMS Ex. 97 at 3. Dr. Chiodo further states: "Fungal growth in buildings is undesirable and may cause health problems for building occupants. Although it may be difficult to establish that exposure to fungal aerosols occurs or that exposure presents a hazard, indoor fungal growth is inappropriate and should be removed. CMS Ex. 97 at 4. Dr. Chiodo further describes the fact that although he cannot determine whether the approximately ten patients with asthma developed that condition due to mold contamination, these patients, along with those suffering from chronic obstructive pulmonary disease, pneumonia, and pleural effusion "would also be a particularly increased risk of the adverse consequences of mold exposure." CMS Ex. 97 at 5. Regarding a patient who had four hospital admissions due to respiratory disease, Dr. Chiodo points to the fact that the patient's condition did not respond to Lasix as further evidence of a mold-induced respiratory issue. CMS Ex. 97 at 5. Dr. Chiodo identified the presence of Aspergillus as particularly concerning, as it is known to produce Aflatoxin B1, "recognized as the most potent known natural carcinogen." CMS Ex. 97 at *6.* Dr. Chiodo indicates exposure to mold mycotoxins may occur through ingestion, skin contact, or inhalation. CMS Ex. 97 at 6.

Petitioner has not come forward with any evidence that raises a dispute of material fact. While Petitioner's brief includes a list of assertions titled "Summary Judgment Should be Denied as There are Material Facts in Dispute," I conclude that none of the items listed establishes a genuine factual dispute. P. Br. at 17. Petitioner states "there are countless material facts in dispute." Petitioner argues whether the mold was widespread, as well as the mold's potential harm to the residents, stating "[i]n fact, there was a small amount of mold in isolated areas that posed no risk of imminent harm to patients." P. Br. at 17.

In their brief Petitioner argues the mold was not widespread; however, Petitioner's own submissions show mold to be present in multiple rooms, spread widely over the facility. P. Ex. 8; P. Ex. 11. Petitioner's Exhibit 11, "Findings of Mold or Black Substances by Dr. Robert Laumbach and NJ DOH/CMS," indicates the presence of "black substance," "mold," "mold-like growth," and "probable mold" in or around 21 different rooms and areas of Petitioner's facility. P. Ex. 11. Some of these rooms were actually occupied or in use at the time of the survey, including room 109, 110, 114, 119, 120, 122, 129, and the beauty salon. P. Ex. 11; CMS Ex. 18; CMS Ex. 95 at 4-5. When combined with the November 3, 2014 certificate of mold analysis showing elevated levels of numerous molds throughout the facility, Petitioner cannot reasonably deny that a significant amount of these alleged "mold-like growths" spread throughout their facility were in fact mold. P. Ex. 8; P. Ex. 11; CMS Ex. 109 at 2.

Petitioner's expert, Dr. Laumbach, stated in a letter to Petitioner, "In the vast majority of the patient rooms and other interior spaces in both the Princeton wing and the Franklin wing, I did not observe any conditions of concern related to moisture and/or mold." P. Ex. 2 at 1. However Petitioner's own summary of the amount of mold throughout the facility (which, it appears, Dr. Laumbach contributed heavily to) shows presence of mold and suspected mold in twenty-one different rooms and areas of the facility. P. Ex. 11; *see also* P. Ex. 1 at 1-3. In addition, Dr. Laumbach's letter also focuses heavily on his argument that evacuation of Petitioner's facility was not necessary; this evacuation ultimately did not occur and is not at issue in this case. P. Ex. 1 at 1, 5.

Petitioner's own admissions also indicate Petitioner did not take necessary actions to prevent residents from accessing mold-contaminated areas or to seal these areas from the rest of the facility. Initially, the Petitioner used only signage to warn residents not to access the rooms, but there is no indication the affected rooms were locked or sealed off to prevent contamination from spreading. CMS Ex. 1. The surveyors identified additional black substance in rooms, including 122, 120, and 111, which were noted not to be sealed from access by residents, and upon interviewing the administrator, she stated that the rooms were not locked and were not designed to be locked. CMS Ex. 1 part II at 3. Rather, the administrator would place a Velcro stop sign on the unlocked doors to prevent them from entering. CMS Ex. 1 part II at 3. In her written testimony in this proceeding, the administrator did not deny she made these comments to surveyors. *See* P. Ex. 59.

On October 30, 2014 the surveyors observed that Velcro stop signs had now been placed in front of room 138 and the shower room, and an alarm system was added that would sound if anyone entered the room. The surveyors noted numerous rooms which were marked "closed for renovation" but were not sealed off from the rest of the facility and could be accessed by residents. CMS Ex. 1 at 20. The SOD notes, and Petitioner does not dispute, the presence of seven cognitively impaired residents, who could have accessed the rooms. CMS Ex. 1 part II at 4. Petitioner also does not dispute the fact the areas where work was being done were not sealed off in any way. CMS Ex. 1 part II at 4. Even interpreting the facts in the manner most generous to the Petitioner, it is clear the Petitioner did not fully seal off or prevent access to the areas which were closed for renovation. Petitioner also acknowledges it did not lock (and indeed was incapable of locking) the doors to many mold-affected areas. CMS Ex. 1 part II at 3. Petitioner offers only the "Velcro stop sign" countermeasure as a means to prevent its cognitively impaired residents from entering these areas. Petitioner has made no arguments that the presence of a Velcro stop sign would be as effective as locking and sealing off the affected areas, and it is unclear that this measure would be any more effective than the previous signage. Therefore, interpreting the facts in even the most favorable light for Petitioner, Petitioner did not act to prevent its residents from accessing the mold contaminated and/or under construction areas of the facility.

CMS's photographs clearly showed mold was present under the wallpaper in multiple areas partially hidden from view. Further, evidence in the record indicates the presence of mold growing beneath, and partially hidden by, wallpaper, baseboards, and ceiling tiles. CMS Ex. 1 part II at 4-5. However, there 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. Whether or not Petitioner actively sought to conceal the presence of mold, this does not change the fact that significant mold was present in the facility.

Petitioner also disputes CMS's characterization of their compliance issues surrounding their roof leaks, stating "each roof citation and problem was fully addressed." P. Br. at 17; P. Ex. 28; *see also* P. Ex. 59 at 2-3. It is true that Petitioner had had multiple occurrences of roof leaks and water damage, which had been occurring since at least 2004, and which Petitioner was able to remediate on each occurrence. CMS Ex. 105 part I (1 of 2) at 13-14; CMS Ex. 105 part I (2 of 2) at 10, 15; CMS Ex. 105 Part II (1 of 2), at 6, 8; CMS Ex. 105 Part II (2 of 2), at 5-6; P. Ex. 28. I also note Petitioner, during a previous 2011 survey, was also cited at an "L" level of scope and severity due in part to the presence of visible leaks from the ceiling, open pools of water on the floor, and the unsafe conditions presented by Petitioner's attempted remediations – in effect, Petitioner

was previously cited for many of the exact same problems at that earlier date.[8] CMS Ex. 14. The fact Petitioner had a significant history of noncompliance is not actually in dispute. Rather, Petitioner now argues their previous efforts to address similar past deficiencies mean their previous noncompliance should not be considered. P. Br. at 4; CMS Ex. 14; CMS Ex. 105 part I (1 of 2) at 13-14; CMS Ex. 105 part I (2 of 2) at 10, 15; CMS Ex. 105 Part II (1 of 2), at 6, 8; CMS Ex. 105 Part II (2 of 2), at 5-6; P. Ex. 28. However, a significant history of similar deficiencies and problems in the past shows Petitioner should have been well aware that their roof leaked, and that the resulting damage would result in deficiencies, immediate jeopardy, and ultimately CMPs. Petitioner's assertions represent legal allegations that are based on non-factual disagreements with the state agency and CMS's ultimate legal conclusions.

For the reasons explained above, I conclude that Petitioner has not come forward with any evidence that raises a dispute of any material fact. Accordingly, summary judgment is appropriate.

2. Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h) (Tag F323), relating to accident prevention and adequate supervision) because it did not address foreseeable risks of harm from the persistent leaking roof and resulting black mold contamination.

Program requirements. Subsection 483.25(h) is part of the quality of care regulation at 42 C.F.R. § 483.25, which states that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." Subsection 483.25(h) imposes specific obligations upon a facility related to accident hazards and accidents, as follows: The facility must ensure that:

> (1) The resident environment remains as free of accident hazards as is possible; and
>
> (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

Therefore, subsection 483.25(h)(1) requires that a facility address foreseeable risks of harm from accidents "by identifying and removing hazards, where possible, or where the hazard is unavoidable because of other resident needs, managing the hazard by reducing

[8] Petitioner argues that the scope and severity level related to this deficiency is actually an "F" because an informal dispute resolution decision recommended that scope and severity of the deficiency be reduced. P. Br. at 5. Although it is unclear whether the recommendation was accepted, it makes little difference for purposes of summary judgment because the informal dispute resolution decision still upheld the underlying deficiency. P. Ex. 29.

the risk of accident to the extent possible." *Maine Veterans' Home - Scarborough*, DAB No. 1975, at 10 (2005) (explaining the inherent standard of care in section 483.25(h)(1)). The provisions of section 483.25(h) "come into play when there are conditions in a facility that pose a known or foreseeable risk of accidental harm." *Meridian Nursing Ctr.*, DAB No. 2265, at 9 (2009), *aff'd, Fal-Meridian, Inc. v. U.S. Dep't of Health & Human Servs.*, 604 F.3d 445 (7th Cir. 2010). Further, subsection 483.25(h)(2) requires that a facility take "all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents." *Briarwood Nursing Ctr.*, DAB No. 2115 at 11 (2007), *citing Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 at 589 (6th Cir. 2003)(facility must take "all reasonable precautions against residents' accidents"), *affirming, Woodstock Care Ctr.*, DAB No. 1726 (2000). Facilities are given "the flexibility to choose the methods" they use to provide supervision or assistive devices to prevent accidents, so long as the chosen methods constitute an adequate level of supervision for a particular resident's needs." *Windsor Health Care Ctr.*, DAB No 1902 at 5 (2003), *aff'd, Windsor Health Care Ctr. v. Leavitt*, 127 F. App'x 843 (6th Cir. 2005)(unpublished).

It is clear that because of Petitioner's long history of roof leaks, which included citations from government entities, Petitioner was on specific notice of a foreseeable risk of harm from roof leaks. Yet Petitioner failed to take steps to protect its residents from the serious, foreseeable harm posed by that risk. The leaks led to: falling ceiling tiles; pools of water on the facility's floor; and buckets, towels, tarps, etc. littering the facility's floors. Such an environment is rife for accidents among a population with physical and mental limitations. But it also posed a significant risk to residents' health presented by the extensive mold growth. CMS Ex. 1 part II at 12; CMS Ex. 13; CMS Ex. 20. Petitioner was therefore not in substantial compliance with 42 C.F.R. § 483.25(h) (Tag F323).

3. Petitioner was not in substantial compliance with 42 C.F.R. § 483.75(d)(1)-(2) (Tag F493, relating to Facility Policies/Appoint Administration);* and *42 C.F.R. § 483.75(o)(1) (Tag F520, relating to Committee Members/Meet Quarterly/Facility Policies/Meet Quarterly/Plans);

The regulation at 42 C.F.R. § 483.75 provides that:

> A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

The regulation also includes specific requirements to comply with federal, state, and local laws and professional standards, and in other areas, including licensure, training, registry verification, in-service education, staff qualifications, provision of laboratory, radiology

and other diagnostic services, and clinical records. 42 C.F.R. § 483.75(a)-(p). The language of section 483.75 is such that any failure of management which adversely affects a resident constitutes a violation.

42 C.F.R. § 483.75(d)(1)-(2) provides:

> (d) Governing body.
> (1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and
> (2) The governing body appoints the administrator who is—
> (i) Licensed by the State where licensing is required; and
> (ii) Responsible for management of the facility.

42 C.F.R. § 483.75(o)(1) provides:

> (o) Quality assessment and assurance.
> (1) A facility must maintain a quality assessment and assurance committee consisting of—
> (i) The director of nursing services;
> (ii) A physician designated by the facility; and
> (iii) At least 3 other members of the facility's staff.

Petitioner had a long history of compliance issues stemming from persistent roof leaks. P. Br. at 17; P. Ex. 28; *see also* P. Ex. 59 at 2-3; P. Ex. 28; CMS Ex. 105 part I (1 of 2) at 13-14; CMS Ex. 105 part I (2 of 2) at 10, 15; CMS Ex. 105 Part II (1 of 2), at 6, 8; CMS Ex. 105 Part II (2 of 2), at 5-6. In spite of these persistent and serious problems, Petitioner failed to create and maintain a functioning governing body to assess and assure compliance with the required quality standards. Instead, Petitioner continued to employ the same defective and dangerous remediation techniques leading up to the 2014 SOD, despite being on notice of the insufficiency of these practices. Petitioner therefore was not in substantial compliance with 42 C.F.R. § 483.75(d)(1)-(2) (Tag F493, relating to Facility Policies/Appoint Administration); and 42 C.F.R. § 483.75(o)(1) (Tag F520, relating to Committee Members/Meet Quarterly/Facility Policies/Meet Quarterly/Plans).

4. CMS's determination of immediate jeopardy is not clearly erroneous.

CMS asserts that Petitioner's deficiencies constituted immediate jeopardy (at the "J" and "L" scope and severity level) to resident health and safety from October 30, 2014 through November 24, 2014. Petitioner argues that if I were to find noncompliance, that such noncompliance does not constitute immediate jeopardy.

Immediate jeopardy exists if a facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. 42 C.F.R. § 488.301. The regulation does not require that a resident *actually* be harmed. *Lakeport Skilled Nursing Ctr.*, DAB No. 2435 at 8 (2012). I must uphold CMS's determination as to the level of a facility's substantial noncompliance (which includes an immediate jeopardy finding) unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board directs that the "clearly erroneous" standard imposes on facilities a heavy burden to show no immediate jeopardy and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *See, e.g., Barbourville Nursing Home*, DAB No. 1962 at 11 (2005)(*citing Florence Park Care Ctr.*, DAB No. 1931 at 27-28 (2004)).

Here, CMS's finding of immediate jeopardy is not "clearly erroneous." Petitioner has argued CMS's expert witness, Dr. Chiodo, has exaggerated the extent and severity of the mold contamination. P. Br. at 14. Petitioner argues Dr. Chiodo based his determination on outdated sources. P. Br. at 14. Confusingly, Petitioner claims there is no scientific or medical evidence that links "indoor mold" to cancer, while simultaneously stating mycotoxins, when ingested through contaminated food, are indeed carcinogenic. P. Br. at 14. Even accepting Petitioner's argument that indoor mold growth is only carcinogenic when that growth has contaminated food, those conditions were also shown to be a threat, as an area used for food storage was shown to be contaminated, and the dining area itself was also shown to have roof leaks. CMS Ex. 1 part II at 5-7. In claiming there is no scientific or medical evidence linking indoor mold to cancer and Lasix-congestive heart failure, Petitioner cites its administrator's declaration. P. Br. at 14-15; *citing* P. Ex. 59. This declaration does not make the claims that Petitioner indicates in its brief, and even if it did, the Administrator self-indicated during the survey to be "not familiar with mold," and "thought it was mildew." CMS Ex. 1 Part II, at 8. In the declaration, the Administrator cites to Dr. Laumbach's statements, which do not make the expansive claims Petitioner argues in its brief.

Petitioner cites *Spring Meadows Health Care Ctr.*, DAB No. 1966 (2005) in arguing that a determination of immediate jeopardy "requires a showing that serious harm is likely, not merely that a risk of serious harm exists." However, Petitioner has misinterpreted the requirements of 42 C.F.R. § 488.301, and its argument actually (and erroneously) suggests CMS is bound to show actual harm to residents. Petitioner has argued that the causal link between mold presence in buildings and respiratory infections has not been proven, and has offered argument from their expert witness, Robert Laumbach, to this effect. P. Ex. 52. However, the literature on mold submitted in these proceedings makes clear that, although the dangers of mold contamination in buildings is difficult to quantify, the fact that it is a potential threat is widely accepted. For example, regarding the methodological difficulties in studying mold (a form of bioaerosol) and other "sick building syndrome" (SBS) issues:

> In addition to inherent methodological limitations of cross-sectional studies, the lack of standardized health assessments and problems with exposure assessment continue to make interpretations of available studies difficult. Since SBS is by definition based on subjective symptoms and measured by self-report, some observers are skeptical that it can ever provide a reliable endpoint for study [8"]. The fundamental lack of knowledge about the nature and pathogenesis of SBS makes exposure assessment for potential causative agents challenging, since the relevance of any of a number of possible agents and exposure-time windows are unknown.

CMS Ex. 73 at 2. This article, entitled "Bioaerosols and sick building syndrome: particles, inflammation, and allergy," also acknowledges the difficulty in discerning the exact cause of respiratory illness, noting, "For example, nonspecific mucosal irritation symptoms may clinically resemble mild specific allergy, and these conditions may overlap in the same individual." CMS Ex. 73 at 2.

However, Petitioner's arguments regarding the difficulty in showing a causal link between the moisture and mold present in their facility and respiratory illness among residents are ultimately misleading. In order to show immediate jeopardy, there is no need for CMS to show actual harm.[9] Neither party disputes the fact that mold was present within the facility, mold can exacerbate respiratory problems, and that there were residents in Petitioner's facility with respiratory diagnoses. CMS Ex. 70 part I at 9; CMS Ex. 1 part II at 9; P. Ex. 11. Both ceiling leaks and a moldy odor were noted by Petitioner's employees. CMS Ex. 1 part II at 7-8. There is no requirement for CMS to directly prove any one resident's respiratory problems were caused by mold exposure; this would not only be holding CMS to the incorrect standard, it would likely be impossible. Instead, submissions from both parties have shown the mold was widespread throughout the facility, Petitioner did not isolate the mold-contaminated areas from the residents, mold is a known respiratory irritant, and that numerous residents exhibited respiratory conditions which would place them at likely risk of harm if those conditions were exacerbated.

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[9] A scope and severity level of G, H, or I indicates a deficiency that involves actual harm that does not amount to immediate jeopardy. A scope and severity level of J, K, or L indicates a deficiency that constitutes immediate jeopardy to resident health or safety. The matrix, which is based on 42 C.F.R. § 488.408, specifies which remedies are required and optional at each level based upon the frequency of the deficiency. *See* State Operations Manual ch. 7, § 7400E.

Petitioner also largely ignores the other, significant threats to residents that resulted from persistent roof leaks. P. Br. These risks include the risk of slipping and falling and the risk of injury from falling ceiling tiles. CMS Ex. 1 part II at 12. As indicated above, the roof leaks were so pervasive they had progressed beyond the unoccupied second floor, and water was leaking onto the occupied first floor. Considering the widespread leaking onto the floors and through the walls, these deficiencies alone are enough to support a finding of immediate jeopardy.

In addition to the independent threat presented by the roof leaks, Petitioner's ad hoc cleanup measures themselves presented a hazard to resident safety. Petitioner attempted to contain the leaks with an assortment of trash cans, improvised drainage devices, towels, tarps, buckets and pans, both placed on the floor and suspended in the air; on both floors of the facility. CMS Ex. 1; *see especially* part I at 18-20. As shown by the photos taken during the inspection, the abundance of these items spread throughout the hallways presented a hazard in their own right. Again, Petitioner, in their focus on the quantity and quality of mold found in the facility, has not disputed the hazard posed by the other conditions throughout the facility, despite the fact CMS explicitly cited the jeopardy posed by these substandard conditions in the SOD. CMS Ex. 1. Petitioner has offered no explanation for why I should focus only on the mold and not the jeopardy to resident safety caused by their completely insufficient attempts at remediation.

Finally, the November 3, 2014 SOD indicates the surveyors observed the facility storing hazardous cleaning chemicals in an unlocked closet. CMS stated in the SOD this deficiency placed thirteen cognitively impaired residents in immediate jeopardy, and CMS cited the deficiency first and foremost in their § 483.25(h) deficiency citation. CMS Ex. 1 part I at 13-15. Petitioner also did not address this deficiency in their arguments, and it appears to be another uncontested source of immediate jeopardy in Petitioner's facility.

5. The CMP that CMS imposed is reasonable in amount and duration.

With regard to the amount of the CMP, I examine whether a CMP is reasonable by 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) 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. The absence of culpability is not a mitigating factor. The factors listed 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.

The regulations specify that a CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408; 488.438. The upper

range of a CMP, $3,050 per day to $10,000 per day, is reserved for deficiencies that pose immediate jeopardy to a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i); 488.438(d)(2). The lower range of CMP, $50 to $3,000 per day, is reserved for deficiencies that do not pose immediate jeopardy, but either cause actual harm to residents, or cause no actual harm but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). In assessing the reasonableness of a CMP amount, an ALJ looks at the per-day amount, rather than the total accrued CMP. *See Kenton Healthcare, LLC*, DAB No. 2186 at 28 (2008). The regulations leave the decision regarding the choice of remedy to CMS, and the amount of the remedy to CMS and the ALJ, requiring only that the regulatory factors at 42 C.F.R. §§ 488.438(f) and 488.404 be considered when determining the amount of a CMP within a particular range. 42 C.F.R. §§ 488.408; 488.408(g)(2); 498.3(d)(11); *see also* 42 C.F.R. § 488.438(e)(2) and (3); *Alexandria Place,* DAB No. 2245 at 27 (2009); *Kenton Healthcare, LLC,* DAB No. 2186 at 28-29.

Unless a facility contends that a particular regulatory factor does not support the CMP amount that CMS imposed, the ALJ must sustain it. *Coquina Ctr.*, DAB No. 1860 at 32 (2002). CMS decided to impose a per-day CMP in this case, and I found that the immediate jeopardy level of noncompliance was not clearly erroneous in this case. Thus, the minimum CMP I am required to sustain is $3,050 per day. However, I conclude that the $10,000 per-day CMP CMS imposed is justified based on the extensive and long-term hazards identified by the surveyors.

I note that in evaluating the regulatory factors listed above, I conclude that Petitioner's history of noncompliance supports the CMP imposed, considering also that Petitioner was cited for three other deficiencies in the same survey, and was cited for similar issues in a 2011 survey. CMS Ex. 1; CMS Ex. 14. Based on these regulatory factors and Petitioner's continued failure to address its roof issues, in spite of repeated immediate jeopardy citations, a CMP of this amount is not unreasonable. Petitioner has not asserted that its financial condition should be considered in mitigation of the CMP. Petitioner's administrator did testify in her written direct that CMS's action in this matter caused Petitioner to lose residents and, due to Petitioner's now two-star rating, has been unable to increase the resident population. P. Ex. 59 at 12-13. However, this testimony was not directly tailored to Petitioner's ability to pay the CMP imposed by CMS and does not provide me with sufficient reason to reduce the CMP amount. Therefore, I do not consider this to be a mitigating factor.

The burden of persuasion regarding the duration of noncompliance is also Petitioner's. *Owensboro Place and Rehab. Ctr.*, DAB No. 2397 (2011). Petitioner has not made any arguments specifically regarding the duration of the period of immediate jeopardy. Petitioner has not met its burden to persuade me to find the facility returned to substantial compliance at any point earlier than the date determined by CMS.

V. Conclusion

For the reasons set forth above, I sustain CMS's determinations. I find that Petitioner was not in substantial compliance with the participation requirements at 42 C.F.R. § 483.25(h), 42 C.F.R. § 483.75(d)(1)-(2), and 42 C.F.R. § 483.75(o)(1) and that the CMP imposed, a $10,000.00 per day CMP effective October 30, 2014 through November 24, 2014, and a $350.00 per day CMP effective November 25, 2014 through December 22, 2014, is reasonable.

_____/s/_____
Scott Anderson
Administrative Law Judge