

Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Charlotte Harbor Healthcare
(CCN: 10-5859),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-09-612

Decision No. CR2284

Date: November 30, 2010

DECISION

In this appeal Petitioner, Charlotte Harbor Healthcare, contests a determination by the Centers for Medicare and Medicaid Services (CMS) that it was not in substantial compliance with participation requirements in the Medicare and Medicaid programs. Below, I sustain CMS's determination that Petitioner was not in substantial compliance with participation requirements. I sustain also the remedies imposed by CMS: a civil money penalty (CMP) of \$8,000 per day for one day of immediate jeopardy on May 28, 2009; a \$5,050 per day CMP from May 29, 2009 through June 18, 2009; a \$500 per day CMP from June 19, 2009 through July 18, 2009; and a denial of payment for new admissions (DPNA) from June 14, 2009 through July 18, 2009. CMS Exhibits (CMS Exs.) 2, 31; CMS Post-Hearing Brief (CMS Br.) at 2-3.

I. Background

Petitioner is located in Port Charlotte, Florida, and is authorized to participate in Medicare as a skilled nursing facility and in the Florida Medicaid program as a nursing facility. The Florida Agency for Health Care Administration (state agency) surveyed

Petitioner from May 27 through 28, 2009. Surveyors found Petitioner out of substantial compliance with the following participation requirements: 42 C.F.R. §§ 483.10 and 483.75(l)(4), at a scope and severity level (ss)¹ K (F Tag 164);² 42 C.F.R. § 483.15(h)(1), ss L (F Tag 252); and 42 C.F.R. § 483.75, ss L (F Tag 490). By letter dated June 12, 2009, CMS notified Petitioner of the remedies imposed: termination of Petitioner's provider agreement, if Petitioner did not remove immediate jeopardy by June 20, 2009; a per-day CMP of \$8,000 for the period of immediate jeopardy effective May 28, 2009; and a DPNA effective June 14, 2009, if Petitioner was still out of substantial compliance on that date. CMS Exhibit (Ex.) 2, at 1-3. Petitioner was notified that it might also lose its authority to conduct a nurse aide training and competency evaluation program (NATCEP).³ CMS Ex. 2, at 3.

By letter dated July 17, 2009, CMS notified Petitioner that a revisit survey on June 19, 2009, found that immediate jeopardy had been removed but that Petitioner still remained out of substantial compliance. CMS notified Petitioner that the \$8,000 CMP was in effect from May 28, 2009 through June 18, 2009, and that a \$500 CMP was in effect from June 19, 2009, until Petitioner attained substantial compliance with participation requirements. The DPNA was noted to have become effective as of June 14, 2009. CMS Ex. 31.

Petitioner achieved substantial compliance on July 19, 2009. CMS Br. at 2. In its brief, CMS noted that based on the surveyor's testimony at the hearing (Transcript (Tr.) at 309, 311), it was reducing the immediate jeopardy CMP to \$5,050 per day effective May 29, 2009. Thus, the remedies imposed are: an \$8,000 CMP for one day, May 28, 2009; a \$5,050 per day CMP effective May 29 through June 18, 2009; and a \$500 per day CMP effective June 19 through July 18, 2009. The total CMP comes to \$129,050. *Id.* at 2-3.

¹ CMS and a state use scope and severity levels when selecting remedies. The scope and severity level is designated by an alpha character, A through L, which CMS or the state agency selects from the scope and severity matrix published in section 7400E of the State Operations Manual (SOM). The matrix, 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, i.e., whether a deficiency is isolated, part of a pattern, or widespread. Scope and severity levels J, K, and L are deficiencies that constitute immediate jeopardy to resident health and safety. 42 C.F.R. § 488.301.

² An F Tag designation refers to the section of the SOM, Appendix PP, which gives guidance to state agency surveyors regarding specific regulatory requirements and the investigation of compliance with those requirements. The statement of deficiencies (SOD) sets out deficiencies by F Tag.

³ The parties did not present evidence with regard to the possible NATCEP, and I do not address it here.

Petitioner requested a hearing by letter dated July 24, 2009. I held a hearing in Sarasota, Florida, from February 8 through 11, 2010. A 963-page transcript of the hearing was prepared. Testifying at the hearing were: Carol Brown Herbert, R.N., a surveyor for the state agency (Surveyor Herbert); Donna Houk, R.N., a surveyor for the state agency (Surveyor Houk); Patricia Kaczmarek, R.N., a surveyor for the state agency (Surveyor Kaczmarek); Odel Ruano, M.D., a physician certified in internal medicine and Petitioner's medical director (Dr. Ruano); Harold D. Williams, a field office manager for the state agency (Surveyor Williams); Gary Furdell, a fire protection specialist surveyor for the state agency (Surveyor Furdell); Manish Kapadia, M.D. (Dr. Kapadia), a physician board certified in internal medicine, pulmonary medicine, critical care medicine and sleep medicine, who testified for Petitioner; Patricia Ann Feeney, R.N. (RN Feeney); David Pitney, a certified indoor environmentalist (Mr. Pitney); Karl Wolf, Petitioner's Director of Mechanical Engineering (Mr. Wolf); Stephen French, an environmental consultant with a specialty in mold and water damage (Mr. French); Steven Lipson, an industrial hygienist and director of technical services for Air Quality Consulting Incorporated (Mr. Lipson); Mary Rose, R.N., Petitioner's Director of Nursing (DON Rose); Thomas Bell, Petitioner's Administrator (Administrator Bell); and James F. Hill, who was employed in Petitioner's building maintenance department at the relevant time (Mr. Hill).

I admitted CMS Exs. 1-67 and Petitioner's Exhibits (P. Exs.) 1-29. The parties submitted briefs (CMS and P. Br.) and response briefs (CMS and P. Response).

II. Issues

The issues before me are:

1. Whether Petitioner was in substantial compliance with Medicare and Medicaid participation requirements; and
2. Whether the remedies proposed are reasonable.

III. Controlling Statutes and Regulations

Sections 1819 and 1919 of the Social Security Act (Act) and the regulations at 42 C.F.R. Part 483 govern Petitioner's participation in Medicare and Medicaid. Sections 1819 and 1919 of the Act authorize the Secretary to impose remedies, including CMPs, against long-term care facilities for failure to comply substantially with participation requirements.

The regulations define the term "substantial compliance" to mean:

[A] level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

42 C.F.R. § 488.301.

The Secretary has delegated to CMS and the states the authority to impose remedies against long-term care facilities not complying substantially with federal participation requirements. State survey agencies, on behalf of CMS, may survey facilities participating in Medicare and Medicaid to ascertain whether the facilities are complying with participation requirements. 42 C.F.R. § 488.10-28. The regulations contain special survey conditions for long-term care facilities. 42 C.F.R. § 488.300-335. Under Part 488, a state or CMS may impose a CMP against a long-term care facility if a state survey agency ascertains that the facility is not complying substantially with participation requirements. 42 C.F.R. §§ 488.406, 488.408, and 488.430. The CMP may begin to accrue as early as the date that the facility was first substantially out of compliance and may continue to accrue until the date the facility achieves substantial compliance or until CMS terminates the facility's provider agreement. 42 C.F.R. § 488.440.

The regulations specify that, if a CMP is imposed against a facility on a per-day basis, it must fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP, from \$3,050 per day to \$10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. § 488.438(a)(1)(i), (d)(2). The lower range of CMP, from \$50 per day to \$3,000 per day, is reserved for deficiencies that do not constitute 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).

"Immediate jeopardy" is defined as:

[A] situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

42 C.F.R. § 488.301.

A facility may challenge the scope and severity cited by CMS only if a successful challenge would affect the range of CMP amounts that CMS imposed or would affect the facility's nurse aide training program. 42 C.F.R. § 498.3(b)(14), (d)(10)(i). CMS's determination as to the scope and severity of noncompliance "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). This includes CMS's finding of immediate

jeopardy. *Woodstock Care Center*, DAB No. 1726, at 9 (2000), *aff'd*, *Woodstock Care Center v. U.S. Dept. of Health and Human Servs.*, 363 F.3d 583 (6th Cir. 2003).

The Departmental Appeals Board (Board) has long held that the net effect of these regulations is that a provider has no right to challenge the scope and severity assigned to a noncompliance finding, except where that finding was the basis for an immediate jeopardy determination. *See, e.g., Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). Since the scope and severity of Petitioner's alleged noncompliance is cited and sanctioned at a level of immediate jeopardy between May 28 and June 18, 2009, the scope and severity of that alleged noncompliance is properly before me.

When a penalty is imposed and appealed, CMS has the burden of coming forward with evidence related to disputed findings that is sufficient, together with undisputed findings and relevant legal authority, to establish a prima facie case of noncompliance with a regulatory requirement. If CMS makes this prima facie showing, then a petitioner must carry its ultimate burden of persuasion by showing, by a preponderance of the evidence on the record as a whole, that it was in substantial compliance during the relevant period. CMS makes its prima facie showing if the evidence it relies on is sufficient to support a decision in its favor absent an effective rebuttal. A petitioner can overcome CMS's prima facie showing by rebutting the evidence upon which that case rests or by proving facts that affirmatively show substantial compliance. An effective rebuttal of CMS's prima facie case would mean that the petitioner had shown that the facts on which its case depended were supported by a preponderance of the evidence. *Evergreene Nursing Care Center*, DAB No. 2069, at 7 (2007).⁴

IV. Discussion

I make numbered findings of fact and conclusions of law (Findings) to support my decision. I set them forth below as separate headings in bold and italic type and discuss each in detail.

⁴ Petitioner disputes this allocation of the burden of proof and asserts that CMS should be required to prove its case by a preponderance of the evidence. It asserts that the Administrative Procedure Act (APA) has been held to apply to these proceedings, and it is contrary to the APA that a regulated entity be required to "prove its innocence" to avoid a CMP (citing *Crestview Parke Care Center v. Thompson*, 373 F. 3d 743 (6th Cir. 2004)). I note Petitioner's objection for the record. P. Br. at 1-2.

1. Petitioner failed to comply substantially with the participation requirements at 42 C.F.R. §§ 483.10(e) and 483.75(l)(4) (F Tag 164, ss K), and CMS’s determination that the noncompliance constitutes immediate jeopardy is not clearly erroneous.

42 C.F.R. § 483.10(e) requires that a “resident has the right to a dignified existence, self-determination, and communication with and access to persons and services outside the facility. A facility must protect and promote the rights of each resident. . . .” The subsection at 483.10(e) recites specifically that:

The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. (1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident; (2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility; (3) The resident’s right to refuse release of personal and clinical records does not apply when-(i) The resident is transferred to another health care institution; or (ii) Record release is required by law.

42 C.F.R. § 483.75(l)(4) requires that “[t]he facility must keep confidential all information contained in the residents records, regardless of the form or storage method of the records, except when release is required by – (i) Transfer to another health care institution; (ii) Law; (iii) Third party payment contract; or (iv) The resident.”

The SOD asserts that, based on surveyor observation during the survey and interviews with staff, residents and/or their legal representatives, and review of resident records, the surveyors determined that Petitioner failed to maintain the residents’ right to personal privacy by:

. . . failure to notify 8 of 26 sampled residents who currently reside in the facility or their legal representative . . . and obtain consent to install Digital Video Recorded Cameras in resident rooms. This breach of resident privacy is likely to cause psychosocial harm to the resident once the resident or their legal representative has knowledge the resident’s actions are being secretly watched and recorded.

CMS Ex. 1, at 3. This noncompliance was found to constitute immediate jeopardy. *Id.* at 1.

Administrator Bell did not dispute that he had video surveillance cameras installed in three resident rooms in November 2007, following reports of thefts in the facility. *Tr.* at

837-38. Nor did Bell dispute that Petitioner did not obtain permission to install the cameras from the residents of those rooms or their families. Tr. at 838. The cameras were located above residents' beds. Tr. at 38-39; 129. The monitor for the cameras was in Bell's office. On the first day of the survey, May 27, 2009, the surveyors went to Bell's office to observe the monitor. The door to his office was open, and no one was in the office. They observed the monitor was located on the wall by the door to the corridor and could be viewed by anyone entering the office. CMS Ex. 1, at 4; Tr. at 40. The monitor was split into four sections, one for each camera. CMS Ex. 1, at 4; Tr. at 41. Surveyor Herbert testified that a:

. . . resident was in bed. The resident had some sort of coverings . . . across her chest, bandages of some sort, did not have a gown on . . . [t]here was a sheet . . . It wasn't pulled up over the bandages . . . starting at the waist.

Tr. at 41; *see* CMS Ex. 4, at 7. Surveyor Houk observed the monitor the next day. She testified that the door to Administrator Bell's office was open, and the monitor was visible when she stepped into the room. She saw a resident sitting in a wheelchair next to the resident's bed. Tr. at 128; CMS Ex. 4, at 1; CMS Ex. 1, at 5.

The surveyors interviewed affected residents and/or family members who informed them that they were not aware that cameras were being utilized. CMS Ex. 1, at 6-7; CMS Ex. 4, at 5, 9, 27, 29. Resident 2 told Surveyor Herbert, "I don't want anybody watching me when I am taking off my clothes." CMS Ex. 4, at 9; Tr. at 48. Resident 1 told Surveyor Herbert "[t]hey wouldn't have done it if I had known about it." CMS Ex. 4, at 9. Resident 3's family member told Surveyor Furdell that he wanted the camera removed immediately. CMS Ex. 4, at 29.

Surveyor Houk testified that placing video cameras in resident rooms without a resident's knowledge and consent was likely to result in serious psychological and emotional harm. She testified:

I think that if, okay, I had to put myself in that position as a resident before I really realized how serious this was. Because if I were laying there and found out later that somebody had watched what everybody had done with me, I would have been extremely upset. And to me that's harm, a psychological harm. So, these residents or their families would also have been very upset had they realized without their knowledge their loved one was being monitored with a camera.

Tr. at 138. Surveyor Houk testified that her opinion was based upon her knowledge as a registered nurse of the kinds of care that residents receive in bed, which includes body baths, incontinent care, wound care, and undressing and changing clothes. Tr. at 138-39. Surveyor Kaczmarek testified that as a registered nurse:

I would be devastated if that was a family member and no one had contacted me that there was surveillance going on during the care . . . [t]he administration of any type of care at bedside, bed bath, pericare, mouth care.

Tr. at 165.

Petitioner concedes that it should not have installed the cameras without residents' consent but asserts that the cameras were disconnected on May 28, 2009, and that there was no evidence that they were, or would be, reconnected. Moreover, Petitioner asserts that there was no evidence of actual harm as a result of the cameras and no harm at all after the cameras were disconnected. Further, as of May 28, 2009, when it disconnected the cameras, Petitioner asserts it was in substantial compliance, and no penalty should be imposed. P. Br. at 4; P. Response at 1-2.

Petitioner has not shown that CMS's determination of noncompliance at the immediate jeopardy level is clearly erroneous. Petitioner concedes that it should not have installed the cameras without consent. Moreover, CMS has shown that projecting images of residents during personal care, where anyone entering Administrator Bell's office could see images of that care, is likely to constitute serious psychological harm to residents and/or their family members.

With regard to the length of the immediate jeopardy noncompliance under this section of the regulations, CMS notes that because Surveyor Williams testified that he had no knowledge that anyone would reconnect the cameras after the survey team left, nor could he say it was likely the cameras would be reconnected, CMS was reducing the CMP after May 28, 2009, from \$8,000 to \$5,050. CMS. Br. at 2-3, 54. I infer from this that the reduction in CMP for dates after May 28 is because CMS found Petitioner was in substantial compliance with this particular participation requirement after that date. However, Petitioner was out of substantial compliance with the participation requirement on May 28, as on that date the cameras were still on. A higher amount of CMP for that date is warranted given the noncompliance. I discuss the reasonableness of the CMP below.

2. Petitioner failed to comply substantially with the participation requirement at 42 C.F.R. § 483.15(h)(1) (F Tag 252), and CMS's determination that the noncompliance constitutes immediate jeopardy is not clearly erroneous.

This section of the regulations is under the quality of life participation requirements, which requires generally that “[a] facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident’s quality of life.” The subsection at 483.15(h)(1) requires that the facility must provide “[a] safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.”

The SOD alleges that based on surveyor observations during the survey, staff interview and record review, Petitioner:

. . . failed to ensure the resident environment remains free of hazards to the extent possible, which includes environmental hazards that are likely to cause serious and immediate harm resulting in Immediate Jeopardy to residents exposed to bio-growth/molds, especially to residents with diseases of the respiratory system.

This is evidenced by mold in mechanical rooms A, B, C, and D.

The pervasive presence of mold and accumulations of dust and dirt on multiple surfaces in resident rooms, Heating, Ventilating, and Air Conditioning (HVAC), and common areas is likely to adversely impact the health of residents, and places all residents in immediate jeopardy.

Review of Pharmacy Diagnosis and Medication lists provided by the facility reveal that 77 (including Residents #1, #4, #5, #6, #8, #9, #10, #13, #14, #15, #18, and #23) of 170 residents are at elevated risk levels due to respiratory diagnoses, and have a physician's order for routine or as needed medications used to treat residents with the following medical conditions: Shortness of Breath/Wheezing, Chronic Obstructive Pulmonary Disease (COPD), Asthma, Respiratory Distress, and Hypoxemia (insufficient oxygenation of the blood).

Observation and review of the Roster/Sample Matrix provided by the facility revealed that 34 residents have a physician's order for routine or as needed Oxygen. According to the Centers for Disease Control (CDC)'s website, . . . residents with chronic respiratory disease such as chronic obstructive pulmonary disorder, asthma may experience difficulty breathing when exposed to mold. The CDC also states that people with allergies may be more sensitive to molds and immunocompromised persons and persons with chronic lung diseases like COPD are at an increased risk for opportunistic infections and may develop fungal infections in their lungs.

Observations of common areas such as corridors, the beauty shop, and the classroom demonstrate the residents have free access to areas with thriving mold and mildew. According to the CDC website . . . "If HVAC systems are not properly cleaned and disinfected to prevent the dissemination of mold and other debris throughout a building, bioaerosols of mold and other microorganisms might exist and can cause a variety of adverse health effects to the building's occupants."

Mold from the Heating, Ventilating, and Air Conditioning systems spreads mold throughout the facility exposing all building occupants. The Centers for Disease Control web site indicates that people with allergies or immune suppression or underlying lung disease are more susceptible to fungal infections. These people

may experience symptoms such as nasal stuffiness, eye irritation, wheezing, or skin irritation and severe reactions would include fever and shortness of breath. Immunocompromised persons and persons with chronic lung diseases like COPD . . . are at increased risk for opportunistic infections and may develop fungal infections in their lungs. FEMA’s website . . . states, “The potential for health problems occurs when people inhale large quantities of the airborne mold spores. For some people, however, a relatively small number of mold spores can cause health problems. Infants, children, immune-compromised patients, pregnant women, individuals with existing respiratory conditions, and the elderly are at higher risks for adverse health effects from mold.”

CMS Ex. 1, at 8-10.

Below, I find that CMS presented a prima facie case that Petitioner has failed to rebut. I also find that CMS’s determination of immediate jeopardy is not clearly erroneous.

A. Mold is recognized as an indoor air pollutant, and controlling water and moisture in buildings is the key to preventing mold.

In its brief, CMS cites extensively to publications from respected health organizations showing that mold⁵ is recognized as a significant indoor air pollutant. CMS Br. at 8-13. 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.⁶ The WHO Guidelines note the most important health effects are increased prevalences of respiratory symptoms, allergies and asthma as well as perturbation of the immunological system. Exposure may also increase the risk of rare conditions such as hypersensitivity pneumonitis, allergic alveolitis, chronic rhinosinusitis, and allergic fungal sinusitis. CMS Exs. 34, 35.

CMS asserts that controlling water and moisture is the key to mold prevention. CMS Br. at 11. The WHO Guidelines note that most moisture enters a building through the building envelope or occupants’ activities. Persistent dampness and microbial growth on interior surfaces and in building structures should be avoided or minimized, as they may lead to adverse health effects. Indicators of dampness and microbial growth include condensation on surfaces or in structures, visible mold, perceived moldy odor and a history of water damage, leakage or penetration. Thorough inspection and, if necessary, appropriate measurements, can be used to confirm indoor moisture and microbial growth.

⁵ During the hearing, I asked Petitioner’s witness, Mr. Lipson, about the difference between mold and mildew. He stated that all mildews are molds, although not all molds are mildew. Mildew refers specifically to slimy molds. Tr. at 779.

⁶ The WHO Guidelines use an alternative spelling for mold – “mould.”

No quantitative health-based guideline values or thresholds can be recommended for acceptable levels of contamination with microorganisms. It is recommended that dampness and mold related problems be prevented and remediated when they occur because of the increased risk of hazardous exposure to microbes and chemicals. Well-designed, constructed, and maintained building envelopes are critical to the prevention and control of excess moisture and microbial growth as they prevent thermal bridges and entry of liquid or vapor phase water. Moisture management requires proper control of temperatures and ventilation to avoid excess humidity, condensation on surfaces and excess moisture in materials. Ventilation should be distributed throughout spaces and stagnant air zones should be avoided. CMS Ex. 34, at 16-17.

The National Academy of Sciences Institute of Medicine (Institute) recommends that:

The most effective way to manage mold in a building is to eliminate or limit the conditions that foster its establishment and growth. Every organism has strategies for locating a hospitable environment, obtaining water and nutrients, and reproducing. Intervention in one or more of those strategies can improve the resistance of the environment against microbial contamination.

CMS Ex. 53, at 283.⁷

B. Surveyor Furdell is qualified to testify as an expert.

CMS asserts that Petitioner failed to do all it could to prevent the growth of mold in the facility. In explaining why Petitioner failed to do all it could, CMS refers principally to the testimony of Surveyor Furdell. Petitioner argues vehemently that Surveyor Furdell was not qualified to identify mold by visual inspection, which is the only way he identified mold during the survey. Petitioner asserts that, while Furdell testified he had attended some classes on “mold problems,” had attended yearly talks given by an industrial hygienist to state agency staff, and had seen pictures of mold in a Petri dish, this did not qualify him to identify mold. Petitioner argues that Furdell does not have a university degree, is not an industrial hygienist or certified in air quality inspection, has no certifications in mold or mold remediation or engineering, has never been a contractor or built a commercial building, and did not review or conduct tests with regard to mold or air intrusion at Petitioner’s facility. P. Br. at 6-7. And, Petitioner asserts that at hearing

⁷ CMS also notes that the Institute found that serious respiratory infections resulting from exposure to a variety of fungi are common in people who undergo high dose chemotherapy, are recipients of solid organ transplants, or are otherwise immune-compromised. CMS notes that individuals in poor health tend to reside inside and thus come in contact with fungi in an indoor environment. However, the Institute states that it is less clear in these situations that the fungal exposure is related to the presence of moisture and I make no findings based on this. CMS Br. at 10; CMS Ex. 53, at 248.

Furdell's testimony was impeached with prior inconsistent testimony given under oath during a November 20, 2009 deposition, in that Furdell stated then that he could not identify mold by visual inspection but then testified at hearing he could. P. Br. at 7-10; P. Ex. 28, at 38-39; Tr. at 473-74. Petitioner argues that Furdell attempted to explain this allegedly contradictory testimony by claiming he spoke with an industrial hygienist at the state agency who told him he could identify mold based on his training and experience. From this, Petitioner asserts that Surveyor Furdell's testimony is unreliable. P. Br. at 7-11.

During the November 20, 2009 deposition, and the allegedly impeaching exchange, Surveyor Furdell testified in response to Petitioner's questions:

Q. Okay. Do you have - - is photo 14 a photo of what you describe on Exhibit B as mold - "B wing mold on HVAC"? Is that what I'm looking at on photo 14?

A. Photo 14 would be the base of the HVAC unit in B wing mechanical room. And all those black/green spots and films/growths that are on the equipment is what led me to request that the facility follow the agency protocol by getting a environment hygienist to test.

Q. But you wrote it down as mold?

A. I wrote in my notes what the potential for what I saw was. I can't tell you what mold is.

Q. Okay. And in C wing you also say "mold on HVAC." And is that depicted on photo 7?

A. Inside the air handler of C wing is photo 7. Photo 7 is a picture of the wall inside that HVAC unit with growth that has been there long enough to start peeling and falling off untouched.

Q. That peeling stuff you believe to be growth?

A. I don't.

Q. Or do you have any opinion as to what that stuff that looks like it's peeling is? Is that some kind of liner or is that some kind of growth on - -

A. I can't answer that. I just know that if that is a liner or something, it has a film or bio-growth or microbial matter attached to it. What strain or genus I don't know.

Q. And photo 8 says "fan and fan motor for HVAC unit," but it does not say what wing. Can you tell me today what - -

A. Well, can I tell you absolutely for sure? No. But the only one that's not listed is D.

Q. So you believe that to be D?

A. I believe it is.

Q. And I understand you're - -

A. I believe it is, but I can't guarantee that that's the fact.

Q. Okay.

A. My answer is based on their - - it's not the only one listed.

Q. But to be clear, when you use the word “mold” in your notes, you are not making a statement that you determined in fact that what you saw was mold; is that correct?

A. That is correct?

P. Ex. 28, at 38-39. During the hearing, Surveyor Furdell testified

Q. Okay. Do you recall your deposition being taken on November 20th of last year?

A. Yes.

Q. Do you recall telling me that you were not able to identify mold? And if you need to be refreshed, I would ask you to look at Petitioner Exhibit 28, pages 48 and 49, or pages 38 and 39.

A. I’m sorry, exhibit?

Q. 28, page 38, line 14 and 15.

A. I’m sorry?

Q. Page 38, line 14 and 15, I can’t tell you what mold is.

A. That’s correct.

Q. Okay, and on page 39, the question was, to be clear, when you use the word mold in your notes you are not making a statement but you determined in fact that what you saw was mold, is that correct. Answer, that is correct.

A. That is correct. That was my understanding at the time.

Q. Okay, so since November you’ve learned that you can tell what mold is by looking at it?

A. Yes, by a industrial hygienist that is a consultant to the Agency for Health Care Administration. As a result of our deposition, I called and asked some questions and I was told by a certified industrial hygienist that I can, in fact, identify something as being mold based on my training and experience. However, I cannot identify what species, genus or, what species or genus the mold may be. However, I can say with, I can say that it is in fact mold.

Q. Okay, so at the time your deposition was taken you agreed you could not identify it, but somebody told you that in fact you were able to identify mold without testing.

A. Yes, ma’am. You made me believe you could not –

Q. Okay, so you lied on your deposition?

A. No I did not.

Petitioner’s argument that this statement shows that Surveyor Furdell could not identify mold by visual inspection is overbroad. The gist of Furdell’s testimony is that while he could not identify the type of mold at Petitioner’s facility by species or genus, he could identify that the substance he saw was in fact mold. Asserting at his deposition that he could not “guarantee” what he saw was mold is not the same as stating he could not

identify mold by visual inspection – he believed it was, but he could not “guarantee that that’s the fact.”

Petitioner argues also that Surveyor Furdell’s testimony about his conversation with this industrial hygienist constitutes impermissible hearsay and is unreliable. First of all, it is plain that the conversation between Furdell and the industrial hygienist was not intended to prove anything at all about the existence of mold in Petitioner’s facility, but was instead offered to explain the alleged changes in the surveyor’s testimony about his capacity to identify mold. It simply did not constitute hearsay testimony. Petitioner did not have the opportunity to cross-examine this unknown witness, and Petitioner complains of having been surprised by the change in Furdell’s testimony. But the surveyor’s explanation more than satisfies the classic response to cross-examination about an allegedly-inconsistent statement, and Petitioner was not entitled to call and question the industrial hygienist. However, as I note above, Petitioner’s argument is largely beside the point, since the gist of Furdell’s testimony in these two exchanges is that he could not guarantee what he saw was mold – not that mold could not be identified by visual inspection. Below, Petitioner’s own witnesses testify that mold can be identified (and then remediated) by visual inspection without testing it first.

Petitioner notes that I accepted Surveyor Furdell as an expert. I found at hearing that there was a reliable body of scientific, technical, and specialized knowledge on the subject of mold control that, despite differences of opinion, would assist me in understanding the evidence at hearing. I found Furdell qualified as an expert by his knowledge, skill, experience, training, and education to testify about the general question of mold identification, remediation, and related topics, including moisture incursions and the maintenance of an air conditioning system in the context of mold remediation and prevention. Tr. at 347-48; *see* Tr. at 327-33, 340-46. His testimony with regard to the mold issues is consistent with my finding. Tr. at 327-410, 470-532.

C. Petitioner failed to prevent the growth of mold in the facility.

To control mold, it is necessary to control the amount of moisture in a building. Surveyor Furdell testified that mold needs three things to grow: food, temperature, and moisture. Building materials can be, and often are, sources of food for mold, and mold grows between 40 and 100 degrees Fahrenheit. Nursing facility temperatures are between 71 to 81 degrees Fahrenheit. Thus, the only thing a nursing facility can do to prevent mold is to control moisture. Tr. at 331.

Moisture can enter a building in many ways. Surveyor Furdell testified that moisture can enter by water intrusion (such as roof leaks, unsealed wall penetrations like window sills, or any opening that would allow water to wick or travel through building materials). Tr. at 332. Another way for moisture to enter a building “would be for a heating, ventilating and air conditioning system to not function as it’s designed, and therefore not evaporate

the water from the air, which we would call humidity, but it's water latent vapor or air. And as it goes through the heating, ventilation and air conditioning system, part of the process of cooling the air to resupply it to the building is that it is evaporated." Tr. at 332. A third way moisture can enter a building is:

. . . if the atmospheric pressure inside the building does not match the atmospheric pressure outside the building, where the atmospheric pressure is actually higher on the outside, or to say that the pressure inside the building would be negative, less pressure than the outside. Then water latent vapor can pass through the walls and enter into the facility, because the pressure outside is greater than the pressure inside.

Tr. at 333.

Surveyor Furdell testified that he saw indications of water intrusion at the facility by window ledges, discolorations on wallcoverings at the ceiling level, and a roof leak. Tr. at 350-51. He noted high humidity levels in the facility and explained that the "heating, ventilating and air conditioning system was inconsistent." Tr. at 387. He testified that if the system was working correctly "[i]t is designed to reduce the humidity level in the air to an acceptable level." Tr. at 388.

Surveyor Furdell also testified that he found negative air pressure inside the building. He testified that a rough way to determine whether there is negative air pressure in a building is for an observer to open the door to the outside a tiny bit. If the air pressure inside the building is negative, the observer will feel the hot air coming in. If the air pressure is neutral, the observer will feel nothing and will note no air flow in either direction. And, if the air pressure in the building is positive, the observer will feel the cooled controlled-temperature air leaving the building. Tr. at 389. Furdell stated that the engineering company Petitioner retained after the survey to report on the performance of Petitioner's HVAC system agreed with his conclusion that there was negative pressure and that the pressure in the building was supposed to be neutral. Tr. at 390, 529.

Entech Consulting Engineers (Entech) is the company retained by Petitioner to observe and report on Petitioner's HVAC system. Entech representatives made a site visit on June 5-6, 2009. The visit confirmed Surveyor Furdell's testimony with regard to negative air pressure and his testimony that the facility was originally designed for a neutral pressure relationship to the outside. It noted that the negative pressure was allowing moisture to enter the building and confirmed the presence of mold. It also noted that humidity levels in the building were between 54 to 80% where levels in buildings are generally in the range of 50 to 60%. It suggested twelve corrective actions that the facility could take to remedy its problems. CMS Ex. 65; *see* CMS Ex. 54.

Surveyor Furdell testified that the construction of the building, the exterior finish insulating system (EFIS), combined with the negative air pressure created by the facility's HVAC system, allowed moisture into the facility. Tr. at 391. Furdell testified that the vinyl wallcovering used at the facility acted as a vapor barrier, such that the moisture passing in because of the negative pressure stopped at the back of the paper and caused mold to grow on the food source – glue or drywall. Tr. at 359. Although Petitioner asserts, and I accept, that the building construction and vinyl wallcovering were perfectly appropriate and “to code” (P. Response at 5), those facts are not the end of the inquiry, or really even its starting-point. The important question is not whether Petitioner should have used these materials. Instead, the critical fact is that negative pressure and moisture, when these materials are employed, is conducive to the growth of mold, and the fundamental issue is how Petitioner dealt with the problem created by those materials and their reaction to mold and moisture.

The survey team noted water and moisture problems in the facility. Surveyor Furdell documented standing water on the floor in four mechanical rooms. In one mechanical room, the reheat coil was halfway open and leaking. CMS Ex. 4, at 31. Furdell documented that the air conditioning supply vents in the kitchen were “condensating and dripping.” CMS Ex. 4, at 35. Surveyor Herbert noted that an air conditioning vent in Room 320 was moist. CMS Ex. 5, at 8. The survey team noted musty odors in the facility. Tr. at 53 (Surveyor Herbert), 137 (Surveyor Houk), 166 (Surveyor Kaczmarek), 385 (Surveyor Furdell).

The survey team observed mold throughout the facility. Surveyor Furdell found mold in and on the HVAC system. He toured the four mechanical rooms on each wing of the facility (A, B, C, and D). Furdell testified that he saw mold on the air handler units, inside the air handler units, on the motor and on the shroud that covers the units. Tr. at 353-55, 369-70; CMS Ex. 66, at 8.⁸ He saw mold on the fan and fan motor for the HVAC unit. Tr. at 370-71; CMS Ex. 66, at 9. He saw mold on the air conditioning duct in the B wing mechanical room. Tr. at 371-72; CMS Ex. 66, at 11. He saw mold on the fan motor in the B wing mechanical room and testified that page 12 of CMS Exhibit 66 depicted:

⁸ CMS Ex. 66 is an 18-page exhibit. The first page is an e-mail dated September 18, 2009, to Surveyor Williams and Surveyor Houk from Surveyor Furdell. Pages 2 through 18 of CMS Ex. 66 are pictures taken by Furdell regarding what he testified about as areas of mold within the facility. The e-mail refers to the pictures described in the e-mail as pictures 1 through 17. However, CMS Ex. 66 identifies pictures 1 through 17 as CMS Ex. 66, pages 2 through 18, and Furdell's e-mail as CMS Ex. 66, page 1. When I refer to the pictures, I refer to them as they are identified in CMS Ex. 66, as pages 2 through 18, not pictures 1 through 17.

. . . a close up of the same discolorations and growth that we are describing in our 2567 as mold. And the significance of this is that we're at a point in the air handler in this air chamber where air, this is the last place air is prior to going through the duct and to the supply vents throughout the facility.

Tr. at 372. He saw mold on the base of the HVAC unit in the B wing mechanical room. He testified that water had formed on the outside metal of the unit and was dripping down. And the water was so prevalent that there were areas of rust, which indicated to him that the problem had been ongoing for some time. Tr. at 373; CMS Ex. 66, at 13. He saw mold on the fan motor unit in the A wing mechanical room. Tr. at 373-74; CMS Ex. 66, at 14. Surveyor Furdell saw mold and wet floors on the HVAC unit in the B wing mechanical room. Tr. at 375-76; CMS Ex. 66, at 15. Furdell saw mold on the AC supply duct in the C wing mechanical room. Tr. at 378-79; CMS Ex. 66, at 16. Furdell saw mold on the access door to the B wing air handler. Tr. at 380-81; CMS Ex. 66, at 17. Furdell testified that CMS Ex. 66, at 18, was another picture of the B wing air handler showing mold on the unit and on the white insulation covering the piping. Tr. at 381-83.

Surveyor Furdell also testified that he took a picture of the hot water coil valve and actuator in the C wing mechanical room, which showed stalactite looking, pale yellow or champagne color drips. CMS Ex. 6, at 7; Tr. at 366-68. He testified that a "functional heat actuator would not look like this. This is all the products of leaking. And once they don't function anymore they tend to leak, and these are all by products of that. I mean it's nonfunctional. It doesn't work anymore, and these, it's just falling apart. It's disintegrating." Tr. at 368.

Surveyor Furdell also observed mold in 15 resident rooms, including on a window ledge, in the shower area, on shower area wallpaper, by an air conditioner, on shower grout, behind the tile behind the shower seat, behind a vinyl wallcovering border, on a wall expansion joint in the shower room, in a closet, at the top of a wall, on carpet, and behind vinyl cove molding. CMS Ex. 1, at 13-14; CMS Ex. 4, at 33-34. Surveyor Herbert testified she saw what she thought was mold in Resident 15's room and told Furdell. Tr. at 71. Surveyor Houck testified that she thought she saw mold in two HVAC rooms, on wallpaper in one resident room and on a windowsill in another. Tr. at 131. Facility staff were with her but did not state that what she was seeing was not mold. Tr. at 131-32.

Surveyor Furdell took photographs of mold in four resident bathrooms. CMS Ex. 66, at 4, 5, 6, 10; Tr. at 362-66, 383-84. He found mold in the beauty shop on the window ledge, on the wall at the floor and vinyl cove molding, on the air conditioning vent, on the ceiling, and in all four light lenses in the ceiling. Approximately 25 residents a week receive services in the beauty shop. CMS Ex. 4, at 33; Tr. at 73, 484. Furdell testified that he observed mold on the ceiling tiles in the classroom and on the ceiling by the air conditioning vent. There was a musty odor in the room. Residents sometimes use the classroom. CMS Ex. 4, at 35; Tr. at 484-85. Furdell testified that he took pictures of

mold behind vinyl cove base molding by the C wing nurse's station. He testified further that it was near where the staff puts carts and medical supplies, so he did not pull the vinyl wallcovering back, because he wanted to avoid further exposure to possible mold spores. CMS Ex. 66, at 1, 2, 3; Tr. at 356-57; 360-62. Furdell also testified that he observed mold in the corridors by the crown molding and where two vinyl wallcoverings overlapped. Tr. at 479-80. In answer to a question as to why noting the mold by the crown molding might not have been identified in the survey report or his notes, Furdell testified:

[i]f we were to take . . . like a crime scene look at something . . . where we would have identification and, of ever[y] . . . single thing that there was, but we don't have a total, we sample everything and we sample evidence and show what we have . . . could I have taken 2,400 pictures during that survey? Sure. Could I have made 50 more pages of notes? Yes, I believe I could. However, we took and found evidence and looked at the data that we needed to look at to make the determinations we made.

Tr. at 480-81. Surveyor Furdell testified that during the survey a wet and moldy wall was being remediated in a mechanical room. Tr. at 385-86. When Surveyor Williams toured the building he noted mold behind the wallpaper behind one of the nursing stations. Tr. at 303.⁹

The surveyors were not the only ones who noted mold issues at the facility. Brian Stout, Petitioner's head of maintenance at the time of the survey,¹⁰ told Surveyor Williams that after the surveyors left the building on May 28, 2009, staff were cleaning "like a chicken with [its] head cut off." Surveyor Williams understood this to mean that Petitioner's staff was "cleaning very vigorously." Mr. Stout told Williams that he and Mr. Hill cleaned all the air handlers on the A, B, C, and D units and also cleaned the condensing units. He described the air handlers to Williams as "mold city." CMS Ex. 33, at 4; Tr. at 296-97.

⁹ The surveyors also noted dusty conditions in 35 resident rooms, and on air conditioner and humidifier vents. CMS Ex. 1, at 14-15; CMS Ex. 5, at 4-5, 8, 12-13. Dust is a common allergen and also contributes to indoor air pollution. CMS Ex. 35, at 3; CMS Exs. 51, 52.

¹⁰ Mr. Stout resigned from the facility under threat of termination on June 8, 2009. Surveyor Williams testified that Mr. Stout had been paid a sum of money and had agreed not to talk to anyone about the survey findings and work done after the survey to address mold problems in the facility. Tr. 291, 294, 296. Administrator Bell testified that Mr. Stout's severance pay was contingent on his agreeing not to disparage the facility. Tr. at 891-93. Whether Mr. Stout received compensation at the time of his termination in exchange for not discussing the survey is not relevant to my decision.

Surveyor Williams testified that Mr. Hill, who was employed in Petitioner's maintenance department at the time of the survey (and later transferred to housekeeping), told the surveyors that he and Mr. Stout immediately began to clean the air handlers after they left. Williams testified that Mr. Hill informed him that Administrator Bell asked them to remove and replace the insulation in the air handlers, but they informed him they did not have time. They worked in the HVAC unit rooms, the AC unit, the classroom and other areas for a week, with long hours. Tr. at 288; CMS Ex. 33, at 3. Mr. Hill stated that Petitioner was trying to get as much cleaned up as possible before the air testing was done. CMS Ex. 33, at 3; Tr. at 288-89, 406. Mr. Hill said that they cleaned the coils in the AC unit three different times, that there was something like mud coming from the HVAC systems, and that he and Mr. Stout wore protective gear and respirators while cleaning. CMS Ex. 33, at 3; Tr. at 289. Mr. Hill stated that Petitioner brought in two extra men to remove wallpaper, replace ceiling tile, and repaint areas in the B hallway right after the survey. They worked non-stop, sometimes until 10:00 p.m. CMS Ex. 33, at 3; Tr. at 290. Mr. Hill told Williams that he thought the air testing at the facility was done on June 6. *Id.*

Surveyor Williams testified that Jason Hatt, the maintenance director who replaced Mr. Stout, told Williams that the C wing was the primary area of concern and the first area targeted for remediation, although Petitioner planned to remediate the entire building. CMS Ex. 33, at 6; Tr. at 301-02.

During the revisit survey on June 19, 2009, Surveyor Furdell testified that Petitioner had hired a full time HVAC mechanic to help resolve the issues that the engineering firm identified and to maintain the systems once Petitioner achieved compliance. The maintenance crew described the repairs and stated that they followed the state agency's infection control risk assessment (ICRA) protocol for mold remediation and to rectify problems they found. Two- and three-man crews worked 12 to 15 hours a day to remediate. Tr. at 393-97.

D. Petitioner's witnesses corroborate that there were mold and moisture problems at the facility.

CMS asserts that Petitioner's witnesses corroborate the presence of mold and moisture problems at the facility. While Petitioner's witnesses may disagree with CMS as to the seriousness or pervasiveness of the mold within the facility, Mr. Pitney, Mr. French, and Mr. Lipson all testified that there were mold and moisture problems at the facility that required remediation.

Petitioner hired Mr. Pitney to perform mold remediation. On his first visit, he toured the facility with Mr. French and Administrator Bell "to kind of review the total facility very quickly." Tr. at 565, 572. On direct examination, Mr. Pitney testified that he did not see "pervasive mold," instead describing "minor" spots of mold from different causes and

testifying that he did not see dust or dirt or mold growth inside wall cavities or smell an odor associated with a pervasive mold problem. Tr. at 565-67, 569. He did not explain his understanding of what the word “pervasive” meant. He testified that the mold he saw was caused by different sources, some from moisture coming through the exterior wall, some from air conditioner condensation. Tr. at 567. He testified that he did not do remediation on his first walkthrough but came back later to do the remediation. On cross-examination, he testified that, when he came back for the first time, he came with a crew of six and stayed two days. They came back two or three more times, as they found more areas that needed remediation. For those times, he brought four to six people, and they stayed about two days. He did not give a report after the remediation.¹¹ Tr. at 572-74. His employees used respirators and gloves, because “mold will break down your immune system. Minor repeated exposure, the longer you’re exposed to it the less resistance you have to it.”¹² Tr. at 574. He also testified that, in remediating the mold, he used containment procedures – Petitioner itself set up containment barriers at the hallways leading to the area they would be working in, and Mr. Pitney’s crew set up individual containment at each doorway of the room they worked in. Tr. at 574-75. He testified that he did not remediate HVAC systems, because a specialist certified to do that work was needed. Tr. at 577. He also reviewed CMS Exhibit 66, which includes pictures of the HVAC system that Surveyor Furdell took. Mr. Pitney testified that, if the black and discolored areas in the photo were in fact mold, he would be concerned, because mold can cause health problems to at risk individuals. Tr. at 580-84. He also testified that if the air handler was full of mold his concern would be greater. Tr. at 584. Mr. Pitney also testified that if he actually looked at the air handler, he could “give you a pretty reasonable answer” on whether the substance shown in the photo was mold, but that to positively identify it laboratory analysis is necessary. Tr. at 586.

Mr. French testified that he is an environmental consultant with a specialty in mold and water damage. He does not do remediation but instead assesses problems in buildings with regard to water in liquid or vapor form, control of which is the single most important thing that can be done to prevent mold. Tr. at 684, 709-10. Administrator Bell, who wanted him to come to the facility immediately, initially contacted him, but he did not visit the facility until a day or two later, on a Saturday morning at the end of May. I take notice that the last Saturday in May 2009 was May 30. Mr. Pitney accompanied him. Tr.

¹¹ CMS estimates that at the least Mr. Pitney and his crew spent 272 man hours doing mold remediation at Petitioner’s facility. CMS Br. at 32 n.27.

¹² On re-direct he qualified his statement, testifying that it would not be reasonable to compare the amount of mold his workers come in contact with to the amount of mold a person living in an area that might have a spot of mold on the wall is exposed to. He was not asked about exposure to mold from the HVAC system. Tr. at 587-88.

at 685-86. It was a cursory inspection. Tr. at 690. Mr. French did not find “significant great problems” but found instead “little things that needed to be addressed.” Tr. at 686. He did not find “pervasive” mold (asserting that of the 3100 projects he has worked on, on a scale of one to ten, he would rate Petitioner’s facility about a one to a one point five). Tr. at 687. He did not amplify his understanding of the word “pervasive.” Tr. at 690. He found only one significant problem, an area by a nurse’s station which was being repaired when he returned on the next Monday to begin his inspection. Tr. at 690, 692.

Mr. French submitted a report to Petitioner on June 11, 2009, suggesting remedial measures. In it, he noted that “[a] visual inspection is the single most important step in identifying a possible mold problem” with regard to microbial assessment and identification and identifying sources of water intrusion. P. Ex. 64, at 4; *see* Tr. at 721.¹³ With regard to Petitioner’s facility, the schedule he suggested for remediating resident rooms was:

- a. Perimeter walls
 - i. Remove and replace drywall 3 feet from the floor on perimeter wall
 - ii. Remove and replace cove molding
- b. Interior Walls
 - i. Remove wallpaper on affected walls only and paint using paint approved by AHCA Office of Plans and Construction
 - ii. Remove and replace cove base molding on affected walls only.
- c. Remove and replace all stained ceiling tile

For resident bathrooms, he suggested:

- i. Remove all wallpaper
- ii. Remove and replace drywall 3 feet from the floor on perimeter wall
- iii. Remove and replace only damaged drywall on interior bathroom walls
- iv. Remove and replace tile and green board in showers to existing tile line for affected shower areas only.

CMS Ex. 64, at 7; *see* Tr. at 723-26. Although Mr. French later testified that he “rolled some of our recommendations back” there is no documentary evidence that he did so and Mr. French did not explain what he meant by rolling back his recommendations other than asserting the severity of the situation was less than it first appeared. Tr. at 732.

¹³ In his direct testimony, in answer to a question as to whether he could determine by visual inspection of an air handler whether a substance was dirt or mold, he testified that he could not determine what it was without laboratory analysis. Tr. at 700; *see* Tr. at 713. This answer appears to contradict both his testimony on cross-examination and in his report that visual inspection is the most important step in identifying mold.

Mr. French took air quality samples and testified that he only found significant problems near the nurse's station, where cabinetry and drywall had been removed and spores inside the wall had been released. Tr. at 692-93. Otherwise, he testified he found the air to be within acceptable ranges and at low levels, and he testified that he did not think there was a problem with the HVAC system air handlers. Tr. at 692-95. He looked at the photos taken by Surveyor Furdell in CMS Exhibit 66 but did not find anything to concern him. Tr. at 697-703. Mr. French testified with respect to the air handlers that whatever was there "gets distributed quickly and doesn't reproduce itself fast enough to create an issue." And, although it could cause an air quality problem, he did not find evidence of a problem. Tr. at 701-02.

On cross-examination, Mr. French testified that he took samples to test, and the results of the tests were given to Administrator Bell. Tr. at 706. He took samples from all wings of Petitioner's facility and also tested air inside the HVAC rooms and inside the handler itself. Reports of those tests were generated. He did not recall the exact numbers found, nor does he recall the type of mold found. He remembered only that the results varied from sample to sample. The first test was taken on the Monday after his initial visit, and others were taken over the two month period he was there. He re-tested areas and saw a decrease in the number of spores. However, Petitioner did not introduce any test reports with regard to tests Mr. French (or anyone else) may have taken inside the handler itself.¹⁴ Tr. at 706-09. Mr. French also admitted that he had no training or expertise to say whether particular mold problems are likely to result in adverse health consequences for individuals with respiratory conditions or who are immune compromised. Tr. at 728.

Mr. Lipson is an industrial hygienist retained by Petitioner in July 2009 to do a walkthrough and inspection of the facility, and to review reports, procedures, and protocols. He reviewed Mr. French's work and the test results prior to visiting the facility on July 20, 2009. Tr. at 734-39. He did a walkthrough of the facility, interviewed a few people, and wrote a letter. Tr. at 758. Mr. Lipson determined that Petitioner had "minor issues that were abated." He did not see issues caused by the four major air handlers. Tr. at 739-40. In looking at CMS Exhibit 66, he said the conditions depicted would likely shorten the life of the air handling unit, and noted it would be good to remove any indoor related mold growth. Tr. at 741-47. He also stated that he would have to survey the whole facility to determine whether mold in the mechanical room

¹⁴ Air Quality Environmental, Inc., prepared a laboratory analysis report on June 7, 2009. It indicated that testing on the A wing hallway showed total spore counts in two resident rooms varied from 371 in one room to 11,766 in another. CMS Ex. 62, at 7. Testing on the D hallway and two resident rooms showed that total spore counts varied from 53 in the hallway to 1,696 in a resident room. CMS Ex. 62, at 8. The report indicates that HVAC pans in the B wing and C wing were tested, but not the air handler units. CMS Ex. 62, at 13, 15. Petitioner submitted a laboratory report from 2005. P. Ex. 7. The total spore count in resident rooms was higher in 2009 than it was in 2005. CMS Br. at 37.

could become airborne to determine whether there could be an effect on residents, but it was not likely that what he saw in the pictures would cause a general air quality problem. Tr. at 747-48.

On cross-examination, Mr. Lipson indicated that fungal and chronic moisture within an occupied building can potentially be a serious health issue for individuals at risk and must be diligently prevented. Tr. at 755-56. He agreed that there is no way to say that a safe and permissible level of mold exists, even though there are no standards. Tr. at 756. He testified on re-direct that there is also no way to determine an unsafe level of mold spores. Tr. at 777. He further testified that it was his job to ensure that the remediation being done at the facility accorded with standard practices within the field, because improper remediation can cause more problems than it corrects. Tr. at 762. He concluded by noting that in his opinion some of the remediation taking place was not necessary, such as removing three feet of drywall throughout the facility. Tr. at 763. He would not have done that until he had surveyed and evaluated wall cavity interiors and taken samples to see if that needed to be done. Tr. at 764.

E. Petitioner did not take measures to prevent moisture and mold problems prior to the survey.

CMS asserts that Petitioner knew that mold may have been in the facility for some time. Mr. Hill testified that he told Administrator Bell prior to the survey that there was an indoor air quality problem and mold. Tr. at 911-12. CMS asserts that what Petitioner should have done, but did not do until after the survey, was to address the water and moisture problems in the facility that, according to CMS, allowed the mold to grow.

CMS asserts that Petitioner does not dispute that the facility was designed to have neutral air pressure, but had negative air pressure instead. Nor does Petitioner dispute the conclusion reached by Surveyor Furdell and Entech that negative air pressure within the facility contributed to moisture within the facility. Petitioner was not prevented or impeded at any point from correcting the air-pressure problem. CMS notes that Petitioner retained Entech in response to the survey report and asked it to observe and report on the operation and condition of the HVAC systems as they related to the survey findings. Entech conducted a site visit on June 5-6, 2009, and faxed a report to Administrator Bell on June 17, 2009. Entech concluded:

The building was observed to be -0.011" w.c. negative in pressure relationship to the outside. Review of the original design construction documents found the building to be designed for a neutral pressure relationship to the outside. The building's negative pressure relationship is allowing moisture to enter the building through infiltration through doors, windows, cracks, etc. The moisture is condensing at locations whose temperature is below dewpoint throughout the building. In our opinion, the number of locations is mild to moderate based on our

experience of buildings of the same age and condition which we have observed in the past. In order to fully understand and correct the cause and to develop a correction plan for the building negative pressure, a complete and in depth survey of the entire HVAC systems should be completed by an independent testing and balancing agency, such as Southern Independent Testing Agency, Inc. Once the survey is completed we can issue a plan of correction to resolve the building negative pressure. Once the corrections are implemented, the HVAC systems will need to be balanced to provide a neutral to slight positive pressure relationship to the outside. The report also listed locations where mold was observed during the survey and listed possible remedial measures including more thorough housekeeping, correction of the building pressurization, more frequent filter changes, more thorough and frequent preventative maintenance programs for the inside of the air handlers, and reconstruction of the condensate drain trap to resolve standing water.

CMS Ex. 65, at 1-3.¹⁵ The Entech report also noted:

During our testing, we measured relative humidity levels at various locations throughout the building and found readings between 54% to 80%. Generally, humidity levels in the range of 50-60% are desired for both human comfort and indoor air quality concerns. The building negative pressure is supporting an increased humidity level in the building. The correction of the building negative pressure should lower the humidity levels into the acceptable range.

Id. at 3. On June 18, 2009, Entech provided Petitioner with a list of twelve things that should “be addressed as soon as possible and will have a significant impact on the air balance in your Center.” CMS Ex. 54. According to CMS, these corrections would impact ventilation, air balance, humidity, and moisture. CMS Br. at 40.

Mr. Wolfe began working for Petitioner on June 8, 2009. Tr. at 594. He was hired into a new position to oversee the maintenance and upkeep of the air conditioning and mechanical systems in the building. Tr. at 592, 617. Mr. Wolfe worked with the company attempting to balance the air flow in the building, adjusting belts and filters and replacing drain lines, among other things. Tr. at 618-21. In answering a question about

¹⁵ Petitioner retained Southern Independent Testing Agency, Inc., and testing took place on June 6, 2009. Page 2 of CMS Exhibit 54 reflects testing in the A, B, and D units. It was found that, although the design was for neutral air pressure, the actual air pressure was negative. *Id.*

whether he was going through this equipment in response to the mold issues, he testified, “I would certainly expect so.”¹⁶ Tr. at 622-23.

Administrator Bell testified that he was not aware of pervasive mold prior to May 2009. Tr. at 845. He believed that there were only “housekeeping issues.” Tr. at 852. I do not find his statement credible. Bell understood that vinyl wallcovering can act as a moisture barrier. Tr. at 878, 880. Bell knew that there were a large number of potential entry points for water and that Petitioner needed to be diligent in addressing moisture problems. Tr. at 860. He admitted that the facility had “wetted and stained materials.” Tr. at 880. He admitted that Mr. Stout had identified “different areas that he considered to be mold at different times, for many various reasons. Leaking sinks, leaking PTAC unit.” Tr. at 881. He testified that he did not know the air handlers had to be cleaned for black mold. He just understood that the cleaning was typical maintenance, and he testified that Mr. Stout and Mr. Hill never “specifically” told him about the mold. Tr. at 880.

Administrator Bell testified that he knew, however, that his staff made repairs prior to the survey for what they believed to be mold. Tr. at 881, 883. He testified specifically that:

I remember them saying they took out drywall because what they perceived to be mold. Yes, ma’am. But I don’t know that it was mold and I know that they don’t know it was mold. It was wetted building materials and beyond that, we had no specific knowledge that it was mold.

Tr. at 883. When asked why he did not get it tested for mold, Administrator Bell testified:

Let me tell you why we didn’t get it tested. Okay. My understanding is that unless you’ve got some reason and something to compare your results to, that testing is not even a good idea. When I first met with Steve French, he indicated that testing before doing remediation isn’t advised. I think that the CDC guidelines indicate that testing isn’t necessarily advised. The New York City Department of Health has indicated that it’s not necessarily advised to do any testing before remediation. And the reason is that the action that you take is identical in either instance.

Tr. at 883-84. Administrator Bell also testified that appropriate protections needed to be put in place for residents and those handling the material and also testified that taking

¹⁶ CMS. Ex. 55 was created by a team that worked on different remediation efforts. It delineates work assigned to Mr. Wolf, Mr. Hill, and Jason Hatt based on advice given to Petitioner’s employees by consultants including Mr. French, Mr. Pitney, and Entech. Tr. at 871-73.

care of mold, unless over a certain scope, is appropriately handled by maintenance staff. Tr. at 884. However, Bell did not state when he came to this understanding of mold issues, and his answer does not explain when he came to that understanding. Bell also asserts that he did not know whether the areas cleaned by his staff were actually mold, as there was no positive identification of mold in those areas. This answer conflicts, however, with his statement that areas do not have to be tested for mold prior to remediation. Tr. at 886.

Mr. Hill, who was hired by Petitioner to do building maintenance in 2007, testified that he had informed Administrator Bell prior to the survey that Petitioner had an indoor air quality and mold problem caused by moisture intrusion. He told Bell that the air conditioning units needed major work because of mold and that fire retardant was coming loose in fibers. Tr. at 913. I find Mr. Hill's testimony to be entirely credible.

Administrator Bell did not act on staff recommendations prior to the survey. However, Bell did take quick action following the survey to remediate any potential mold issues. He directed his staff to immediately begin cleaning and repairing affected areas (the air handlers were cleaned the first weekend after the survey).¹⁷ Tr. at 866. Insulation inside the air handlers was quickly replaced. Tr. at 897. He hired Mr. French and Mr. Pitney, received reports from companies such as Entech, and followed their recommendations. However, the actions that Bell took following the survey were actions he could and should have taken prior to the survey, when staff brought the moisture and mold problems at the facility to his attention.

F. Petitioner cared for residents at significant risk of complications from mold exposure.

CMS asserts that Petitioner cared for many at risk residents, including many residents with respiratory diagnoses, which included shortness of breath, wheezing, COPD, asthma, pneumonia, respiratory distress, and hypoxemia. The SOD referred to 26 residents with such conditions. CMS Ex. 1, at 16.

Dr. Kapadia testified that he visited the facility in June of 2009. Tr. at 453, 461. He did not physically examine any residents. Tr. at 453. Dr. Kapadia stated that patients with an underlying condition, such as asthma or COPD, can be put at risk of an exacerbation of their condition if they have a significant exposure to mold. Exposure to mold can also exacerbate bronchitis and pneumonia. Tr. at 449, 455. Individuals can die from exacerbations of asthma and COPD and may die from pneumonia. Tr. at 456. On direct

¹⁷ CMS views Administrator Bell's actions in setting his maintenance staff immediately to cleaning the mold as evidence that he was trying to hide a mold problem prior to testing. I do not take such a negative view. Once the mold was identified, it was appropriate for Administrator Bell to try to remediate the situation as quickly as possible.

examination, Dr. Kapadia testified that he toured the facility and that, while he saw areas of mold and mildew, his opinion was that the residents were not “at risk.” Tr. at 450-51. He admitted on cross-examination, however, that he did not look at the medical and nursing charts of the residents but was instead given a piece of paper by facility staff which noted the resident’s age, gender, and medical history. Tr. at 454. On re-direct exam he reiterated that he visited every room in the facility on his walk and saw no residents in physical distress nor any indication that residents were suffering from mold exposure. Tr. at 467.

Dr. Kapadia testified on cross-examination that he agreed that the World Health Organization, the Centers for Disease Control, and the National Institute of Health all consider indoor dampness and mold to be a serious health risk, depending on how serious it is and how long and substantial the exposure. Tr. at 457-58. He agreed that the immuno-compromised elderly, or elderly persons with chronic lung problems, are more at risk from mold exposure and dampness. Tr. at 458. Dr. Kapadia testified that if there is a serious and immediate risk, any facility should be diligent in addressing mold problems. Tr. at 459. To determine if a risk is serious and immediate, Dr. Kapadia agreed that he would pay attention to who was living in the facility and whether there were a lot of residents living in the facility with respiratory conditions or who had compromised immune systems. Tr. at 459-60.

Dr. Ruano, Petitioner’s medical director and the treating physician for Residents 1, 4, 5, 6, 8, 9, 10, 13, 14, 15, 18, and 23, admitted that the majority of Petitioner’s residents are immuno-compromised at any given point in time. Tr. at 229, 247. On direct examination, Dr. Ruano testified that if there were air quality or mold problems in the facility, he would have expected to see adverse affects on his population of residents. Tr. at 234. On cross-examination, he agreed that mold, dust, and insect parts could adversely affect residents and that asthma and COPD are serious medical problems. He noted that mold can exacerbate asthma and COPD, medical conditions that he agreed could lead to death, and that exposure to mold can lead to fungal infection in the lungs. Tr. at 237-40, 245, 274.

Dr. Ruano testified that he would suspect that a patient had a mold allergy if the patient had nasal secretions, post-nasal drip, or shortness of breath lasting more than two weeks, because, in such a case, he would not think the cause was viral and would look at other possible causes, including environmental causes. Tr. at 264-65. Dr. Ruano also testified that he would be concerned if mold was being transmitted through air conditioning units. Tr. at 271. He never spoke to Mr. Hill or Mr. Stout about mold problems in the facility. Tr. at 270. He testified that he did not think the mold in the facility was significant, because “I should have noted that at least one of the residents will not improve with the antibacterial medicines that I treated them when they have their respiratory problems exacerbated.” Tr. at 274.

Dr. Ruano testified about the conditions of residents he treated that did not suffer exacerbation of their respiratory disease at the facility, but he did not testify with regard to the two residents, Residents 5 and 23, noted by CMS in its briefing to have possible exacerbations of their disease. Tr. at 230-234. Nor did Petitioner refer to either of these residents in its briefing, although their examples were included in the SOD and referenced later in DON Rose's testimony. CMS Ex. 1, at 18, 22. CMS asserts that Resident 5 and Resident 23 both had exacerbations of their respiratory conditions, but there is no evidence that Petitioner's staff assessed them for mold exposure. P. Br. at 45.

Resident 5 was admitted to Petitioner's facility on October 26, 2010. P. Ex. 15, at 1. Her diagnoses included COPD. *Id.* at 2. Nurse's notes dated March 13, 2009, show that Resident 5 was experiencing wheezing and chest congestion. *Id.* at 3. On March 17, 2009, Dr. Ruano ordered Robitussin for her. *Id.* at 4, 8. On April 11, 2009, over three weeks later, Dr. Ruano diagnosed Resident 5 as having acute bronchitis and cough and ordered medication including an antibiotic and a prednisone taper. *Id.* at 10-11. Nurse's notes show that on May 13, 2009, Resident 5 was still experiencing wheezing. *Id.* at 12. DON Rose, testified that Resident 5's nebulizer treatment was changed from routine to as needed on April 2, and that the only time it was used again was on May 13. However, DON Rose did not discuss the other medications prescribed by Dr. Ruano. Tr. at 805-06. DON Rose also admitted that the diagnosis of bronchitis was a new diagnosis for this resident. Tr. at 827. DON Rose testified that Resident 5's "issues" resolved while at the facility but does not explain how, when, or in response to what. Tr. at 831.

Resident 23 was admitted to Petitioner's facility on January 29, 2009. P. Ex. 23, at 1. She had no respiratory diagnoses. *Id.* at 1-2; *see* Tr. at 824-25. Dr. Ruano diagnosed Resident 23 as having acute bronchitis on February 17, 2009. He ordered an antibiotic, Robitussin, Mucinex, and nebulizer treatments. *Id.* at 6. As of May 2, 2009, Resident 23 still required Robitussin and nebulizer treatment. *Id.* at 18. DON Rose testified that Resident 23's condition improved enough that she was no longer using oxygen at two liters per minute, and the nebulizer order was changed to PRN. However, the February 18, 2009 order referred to was a clarification of oxygen orders from February 16, 2009, to "as needed." Tr. at 815-16; P. Ex. 23, at 14, 16. The orders for the nebulizer were also changed to "as needed." Tr. at 816.

As CMS has noted, there is no evidence that anyone on Petitioner's staff assessed Residents 5 and 23 (or any other resident) to determine whether their new problems had anything to do with moisture and mold problems at the facility. DON Rose testified that no one in the maintenance department told her there was an on-going mold problem at the facility until the survey. Tr. at 830. As CMS has noted, insofar as she remained unaware of a mold risk, there is no way she or anyone at the facility could have thoroughly assessed the residents with reference to a risk of which they were unaware.

G. Petitioner's noncompliance constitutes immediate jeopardy.

Petitioner does not dispute that a reasonable suspicion of mold in a nursing facility warrants inspection and cleaning, and that if mold is found, its prompt removal is required. It does not dispute that the existence of a substantial air quality problem has a potential to affect residents and employees. Petitioner argues, however, that the surveyors, especially Surveyor Furdell, did not act responsibly or conduct an objective evaluation of the issues. Petitioner argues that CMS did not show that the presence of mold was definitive; did not show that the mold was pervasive; and did not show that there was a likelihood that this pervasive mold would cause serious and immediate harm. P. Br. at 4-5. Petitioner also asserts that Surveyor Furdell took no air quality samples for testing, and, thus, CMS cannot establish that suspected mold in the facility was a danger to residents through possible inhalation. P. Br. at 12.

CMS has put forward a *prima facie* case that Petitioner was noncompliant with this participation requirement, and Petitioner did not prove by a preponderance of the evidence that it was in compliance. First, although the substances identified by Surveyor Furdell and others (including Petitioner's employees) as mold were not analyzed in a laboratory, there is a consensus, even among Petitioner's witnesses, and including Administrator Bell himself, that visual inspection can detect the likely presence of mold. That substances identified by Furdell were mold was later confirmed by laboratory analysis. However, laboratory analysis was not necessary to make CMS's *prima facie* case that there was mold at the facility. Given the evidence in the record, if Petitioner expected to prevail on the question of the exact nature of the widespread mold-like substances, Petitioner was obliged to submit evidence showing that the substances found from resident rooms to HVAC air handlers were not mold. Petitioner failed to provide this evidence. And there is no evidence that Petitioner addressed moisture problems in the facility conducive to the growth of mold, such as the negative air pressure in the building, until after the survey raised concerns about mold.¹⁸

Second, the areas of mold that the surveyors identified fit within a definition of the word "pervasive." The dictionary definition of pervasive is "having the quality or tendency to pervade or permeate," and the definition of pervade is "to spread through; be present throughout; permeate." The American Heritage Dictionary of the English Language, New College Edition, Houghton Mifflin Co. (1976). Surveyors found mold throughout

¹⁸ Petitioner notes that Surveyor Furdell surveyed the facility in January and February 2009, but did not cite it for deficiencies regarding mold, casting doubt that there were prior mold and mildew problems that Administrator Bell should have investigated. P. Br. at 28, 29. However, whether Petitioner was cited for mold problems in other surveys is irrelevant. Mr. Hill's testimony and statements made by Mr. Stout show that Administrator Bell was aware of problems at the facility related to mold and moisture prior to the survey.

the facility, including resident bedrooms, resident bathrooms, the beauty shop, hallways, near a nurse's station, and in HVAC rooms.

With regard to the issue of immediate jeopardy, CMS's determination is not clearly erroneous. 42 C.F.R. § 498.60(c)(2) states that CMS's finding regarding the level of noncompliance "must be upheld unless it is clearly erroneous." In *Daughters of Miriam Center*, DAB No. 2067 (2007), the Board found that CMS did not have the burden to make a *prima facie* showing that immediate jeopardy existed. CMS's determination of immediate jeopardy is presumed to be correct, and it is a petitioner's heavy burden to show that CMS's determination was clearly erroneous. The Board stated:

. . . immediate jeopardy exists in either of the following two general circumstances. First, immediate jeopardy exists if the SNF's noncompliance has caused death or "serious" harm to one or more residents. (For discussion purposes, we use the word "harm" as shorthand for the regulatory terms "injury, harm, or impairment."). Second, immediate jeopardy exists if the SNF's noncompliance is or was "likely to cause" death or serious harm.

Daughters of Miriam Center, DAB No. 2067, at 8. The facility has the burden to rebut the presumption by showing that the harm or threatened harm did not meet any reasonable definition of serious. The Board defined the term "likely" to be:

. . . "likely" is ordinarily or commonly used to describe an outcome or result that is "probable" or "reasonably to be expected" though "less than certain." Webster's New World Dictionary (2nd College Ed.); see also The American Heritage Dictionary of the English Language (4th ed.); Black's Law Dictionary (5th ed.) (defining "likely" to mean "probable"). Also the term "likely" – and its synonym "probable" – suggest a greater degree of probability that a particular event will occur than the terms "possible" or "potential." See Webster's New World Dictionary (2nd College Ed.) (definition of "probable"); Black's Law Dictionary (5th ed.) (defining "probable" as "having more evidence for than against," and defining "possible" as "capable of existing" and "free to happen or not"). In this regard, we have emphasized that a "mere risk" of serious harm is not equivalent to a likelihood of such harm. Innsbruck Healthcare Center, DAB No. 1948 (2004).

Daughters of Miriam Center, DAB No. 2067, at 10. In *Innsbruck Healthcare Center*, the Board stated that immediate jeopardy also exists where serious injury or harm is the likely consequence of a deficiency, even when no actual harm has occurred. *Heritage Healthcare & Rehab. Center*, DAB CR2116 (2010).

Petitioner asserts that it showed that its noncompliance was not likely to cause serious harm. Petitioner asserts that the WHO Guidelines discuss only increases of risk, not a "likely to cause" risk. The Institute of Medicine materials simply refer to sufficient

association between mold in a damp indoor environment and cough, wheeze and asthma symptoms in sensitized asthmatic people. Petitioner asserts that “association” is not the same as “likely to cause.” P. Br. at 20-22. In speaking about these and other publications relied on by CMS, Petitioner asserts with regard to CMS Exs. 34-53,

Most of these documents address, at some point, the effect mold can have on people. In each and every one of the documents, the writings refer to the proposition that mold “can” or “may” have any one of many different impacts on people. At times, certain writings discuss mold creating an “increased risk” of certain ailments. But, in none of these exhibits is it stated that mold is “likely to cause” “serious harm.” . . . Some species of mold, but not all, can have infectious or noninfectious health effects. It is not known whether concentrations of mold toxins are high enough to cause human disease, and no health effects from airborne exposure to mold related toxins are proven . . . [t]he surveyors in this case decided to issue an immediate jeopardy citation, without knowing whether mold was present, the species of mold that was present, and making the assumption that mold toxins, of a species that could cause health issues, were circulating in the facility.

P. Br. at 23-24.

Petitioner asserts that Drs. Kapadia and Ruano testified only that an exacerbation of respiratory problems “can” lead to death. Petitioner argues that “can” is the same as “capable of existing” and that is not the same as “likely” to lead to serious harm. P. Response at 6.

I disagree with Petitioner’s restrictive and somewhat forced conclusion, and reject its effort to define itself into compliance with standards so clearly related to residents’ health and safety. An increase in risk or an exacerbation of respiratory problems that “can” lead to death satisfies me that mold in a facility is likely to lead to serious harm in a compromised population of individuals who suffer from respiratory problems or who have compromised immune systems. I understand Petitioner’s argument that some types of mold are more toxic than other types – but Petitioner misapprehends its burden if it believes that it was CMS’s burden to test the substances it found. It has been Petitioner’s burden to rebut CMS’s *prima facie* case with evidence that the substances found were not mold or were otherwise not a risk to compromised individuals, and it has failed to do so.

In arguing that immediate jeopardy existed at the facility, CMS submitted evidence from respected organizations that documented the risks of mold exposure to individuals who are immune-compromised or have respiratory problems, risks that Drs. Kapadia and Ruano did not dispute. CMS notes that Petitioner cared for many such at-risk individuals, and gave specific examples of two residents who may have been harmed by mold and were never evaluated for mold or environmentally-related problems. CMS

asserts that Petitioner was aware that, at the very least, it *might* have had mold problems prior to the survey, but it did not investigate or address them until after the survey. Petitioner never considered that mold could have played a part in the two residents' illnesses. Petitioner did not evaluate the risk to compromised individuals until after the survey. As CMS notes, caring for a compromised population requires a facility to be vigilant in reducing moisture and preventing mold. Petitioner was not vigilant, and because it was not, it was not in compliance with applicable standards.

3. Petitioner failed to comply substantially with the participation requirement at 42 C.F.R. § 483.75 (F Tag 490), and its noncompliance constitutes immediate jeopardy.

The regulation at 42 C.F.R. § 483.75 requires 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.

As has been shown above, Petitioner's administration put video cameras in resident rooms without the consent of the residents or their responsible parties. Petitioner does not deny doing so. Moreover, there is no evidence that Petitioner's administration took any measures to protect the privacy of the residents receiving care in those rooms. These facts point to a particularly-close nexus between the gravamen of the citation and the administration's active role in causing it, and demonstrate the validity of the citation.

Petitioner's administration was aware that the facility had a mold problem. Administrator Bell knew, or should have known, that the resident population at the facility was particularly vulnerable to mold. However, Administrator Bell failed to take all reasonable steps to eliminate the mold and prevent it from recurring prior to the survey. While the administration's role in this situation is more passive than active, the nexus is just as plain between the gravamen of the citation and the administration's failure to act.

Petitioner has not shown that CMS's determination is clearly erroneous.

4. The remedies imposed for Petitioner's noncompliance are reasonable.

CMS imposed CMPs and a DPNA from May 28, 2009 through July 18, 2009. I find the remedies imposed to be reasonable.

The permissible range of immediate jeopardy level penalties is from \$3,050 to \$10,000 per day. 42 C.F.R. § 488.438(a)(1)(i). The permissible range of non-immediate jeopardy level penalties is from \$50 to \$3,000 per day. 42 C.F.R. § 488.438(a)(1)(ii). There are regulatory criteria for deciding what a reasonable penalty amount is that falls within either of these two penalty ranges. These criteria include: the seriousness of a facility's

noncompliance; its culpability; its compliance history; and its financial condition. 42 C.F.R. § 488.438(f)(1) – (4) (incorporating 42 C.F.R. § 488.404 by reference into 42 C.F.R. § 488.438(f)(3)).

Petitioner has not provided me with evidence regarding its financial condition, and CMS has not alleged that Petitioner's past compliance history was negative. I find that the noncompliance is serious, in that Petitioner's facility houses a compromised population that is likely to be affected by mold in the facility. And, Petitioner installed video cameras in resident rooms without the consent of those residents and in such a way that intimate and potentially-embarrassing views of those residents and their activities could be seen by persons having no business or reason to do so. That lapse was not only serious, but Petitioner was culpable in committing it. Moreover, I find Petitioner additionally culpable, because its maintenance staff raised moisture and mold as troubling concerns prior to the survey but those concerns were not promptly or carefully addressed.

Because Petitioner's noncompliance is serious, and I find Petitioner to be culpable, I cannot find that the \$8,000 CMP for one day of noncompliance on May 28, 2009, for all three F Tags cited, is in any way unreasonable. Further, I find the CMP of \$5,050 for the period from May 29, 2009 through June 18, 2009, based on F Tags 252 and 490, to be reasonable, as it is in the middle of the permissible range of CMP for immediate jeopardy level CMPs. Finally, in the absence of any argument from Petitioner other than that the "CMP should not have been levied at all" and was "excessive" (P. Response at 9), I sustain the imposition of the \$500 CMP from June 19, 2009 through July 18, 2009.

CMS's June 12, 2009 notice letter announced that it was imposing a discretionary DPNA effective June 14, 2009, if Petitioner was still out of compliance on that date. Petitioner was out of compliance on that date, and the DPNA was imposed through July 18, 2009. The regulation at 42 C.F.R. § 488.417 authorizes imposition of the discretionary DPNA.

V. Conclusion

For the foregoing reasons, I conclude that there is a basis for imposition of the CMPs of: \$8,000 per day for one day of immediate jeopardy on May 28, 2009; \$5,050 per day for immediate jeopardy from May 29, 2009 through June 18, 2009; and \$500 per day from June 19, 2009 through July 18, 2009. I also uphold CMS's imposition of a discretionary DPNA from June 14, 2009 through July 18, 2009.

/s/

Richard J. Smith
Administrative Law Judge