Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Lifehouse of Riverside Healthcare Center
Docket No. A-15-85
Decision No. 2774
March 3, 2017

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Lifehouse of Riverside Healthcare Center (Lifehouse or Petitioner) appeals the May 8, 2015 decision of an Administrative Law Judge (ALJ). *Lifehouse of Riverside Healthcare Center*, DAB CR3845 (2015) (ALJ Decision). The ALJ Decision upheld the determination of the Centers for Medicare & Medicaid Services (CMS) to impose on Lifehouse, a skilled nursing facility (SNF), (1) a per-instance civil money penalty (CMP) of $2,500 for abuse of a resident in violation of 42 C.F.R. § 483.13(b) and 483.13(c)(1)(i); and (2) per-day CMPs of $850 for the period from May 16, 2014 through July 1, 2014 for failure to take reasonable measures to protect another resident against an accident in violation of 42 C.F.R. § 483.25(h). For the reasons set out below, the Board upholds the ALJ Decision.

Legal background[1]

To participate in the Medicare program, a long-term care facility, such as a SNF, must be in "substantial compliance" with Medicare participation requirements in 42 C.F.R. Part 483. 42 C.F.R. §§ 483.1, 488.400. Under agreements with the Secretary of Health and Human Services, state survey agencies conduct onsite surveys of facilities to verify compliance with the requirements. 42 C.F.R. §§ 488.10(a), 488.11; *see also* Social Security Act (Act) §§ 1819(g)(1)(A), 1864(a).

[1] On October 4, 2016, CMS issued a final rule that amended Medicare requirements for long-term care facilities. Final Rule, *Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities*, 81 Fed. Reg. 68,688 (Oct. 4, 2016). The Final Rule included revisions to 42 C.F.R. § 483.13 (re-designated as 42 C.F.R. § 483.12) and 42 C.F.R. § 483.25. *Id.* at 68,855, 68,860. We rely on the prior regulations in effect on the date when the state agency performed the survey(s) that formed the bases for CMS's determination of noncompliance. *Carmel Convalescent Hospital*, DAB No. 1584, at 2 n.2 (1996) (the Board applies the regulations in effect on the date of the survey and resurvey).

A state survey agency reports any "deficiencies" it finds in a Statement of Deficiencies (SOD), which identifies each deficiency under its regulatory requirement and the corresponding "tag" number. A "deficiency" is any failure to comply with a Medicare participation requirement, and "substantial compliance" means "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 (also defining "noncompliance" as "any deficiency that causes a facility to not be in substantial compliance").

Part 483, subpart B regulations include requirements for the prevention of abuse of long-term care facility residents. As pertinent here, section 483.13 provides, in part:

> (b) *Abuse.* The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.
> (c) *Staff treatment of residents.* The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
> (1) The facility must—
> (i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion[.]

Also at issue are the quality-of-care regulations in section 483.25, which state in part:

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.
>
> * * *
>
> (h) *Accidents.* The facility must ensure that—
> (1) The resident environment remains as free of accident hazards as is possible; and
> (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

Under authority of the provisions in 42 C.F.R. Part 488, subpart F, CMS enforces compliance with Part 483, subpart B requirements. Enforcement "remedies" for facilities found to be not in substantial compliance with those requirements include a per-instance CMP in an amount that falls within the range of CMP amounts designated for per-

instance CMPs and/or per-day CMP(s) in amounts that vary depending on the level of noncompliance CMS finds. A per-day CMP may accrue from the date the facility was first out of substantial compliance until the date it is determined to have achieved substantial compliance. 42 C.F.R. § 488.440(a)(1), (b). CMS's determination on the level of noncompliance is upheld unless it is clearly erroneous. 42 C.F.R. § 498.60(c)(2).

Case background[2]

A. *State agency surveys*

On September 20, 2013, Lifehouse reported to the state agency an instance of suspected abuse of a resident by a staff person. CMS Ex. 14, at 2. The state agency completed a complaint survey on January 23, 2014. CMS Ex. 1. The incident, which occurred on September 18, 2013, involved Resident 1 (R1), an 85-year-old incontinent woman whose care plan provided for staff assistance to use the restroom. ALJ Decision at 2, citing CMS Ex. 2, at 1, 5, 12, 18, 36; CMS Ex. 1. Based on the survey, CMS alleged that a Lifehouse certified nursing assistant (CNA 1), responding to R1's call between 2 a.m. and 3 a.m. asking for help to use the restroom, reportedly told R1 to "go" in her incontinence brief, and then pulled R1 out of bed by her left arm, causing R1 to cry out in pain. ALJ Decision at 2, citing CMS Exs. 8, at 5, 6; 14, at ¶ 10. CMS also alleged that, after taking R1 to the restroom, CNA 1 took R1 back to bed, grabbed R1's arm and pulled it downwards toward the bed, causing R1 to again cry out in pain. *Id.*, citing CMS Exs. 1, at 2, 3; 14, at ¶ 13. CMS found Lifehouse out of compliance with 42 C.F.R. § 483.13(b) and (c)(1)(i) (Tag F223), cited a deficiency at the actual harm ("G") level, and imposed a per-instance CMP of $2,500.[3] CMS Exs. 1, 6, 11, 27.

On March 9, 2014, Lifehouse reported to the state agency another incident, involving another resident. The state agency completed a complaint survey on May 16, 2014. CMS Ex. 29, at 1; CMS Ex. 15. The incident, which occurred on March 8, 2014, involved Resident A (RA), a 90-year-old woman whose diagnoses included muscle spasms, muscle weakness, and contractures of joints, and who depended on staff for bed mobility. ALJ Decision at 4-5; CMS Ex. 15; CMS Ex. 17, at 1-2, 7, 15, 17-18, 19, 30. The ALJ Decision recounts that a CNA (CNA A) raised RA's bed to waist level to provide care to RA, but briefly left RA unattended in the raised bed, lying on her side and

[2] The factual information in this section is drawn from the ALJ Decision and, except where noted, undisputed facts in the record. It is presented to provide a context for the discussion of the issues raised on appeal.

[3] Following the January 23, 2014 survey, CMS also imposed on Lifehouse a denial of payment for new admissions (DPNA) effective March 22, 2014. CMS Ex. 11, at 2. However, upon a revisit on January 30, 2014, the state agency verified that Lifehouse had corrected the deficiency identified in the January 23, 2014 survey, before the effective date of the DPNA, and rescinded the DPNA. CMS Ex. 27, at 2.

not stabilized with pillows, during which time RA fell out of the bed, sustaining facial fractures. *Id.* at 5, citing CMS Exs. 15, at 4-5; 18, at 12; 23, at 2. The state agency later visited Lifehouse on July 2, 2014 and determined that Lifehouse returned to substantial compliance effective that day. Based on the survey findings, CMS determined that Lifehouse was out of compliance with 42 C.F.R. § 483.25(h) (Tag F323), a deficiency at the actual harm ("G") level, and imposed per-day CMPs of $850 for the period beginning May 16, 2014 through July 1, 2014. CMS Exs. 15, 27. Thus, the total amount of the per-day CMPs assessed against Lifehouse is $39,100 ($850 a day for 46 days, May 16-July 1, 2014). CMS Ex. 27, at 3.

B. *ALJ's findings and conclusions*

The ALJ held a hearing on February 10, 2015, at which Lifehouse cross-examined three CMS witnesses (T.W., O.F. and K.F.) whose written direct testimonies were of record as CMS Exhibits 14, 29, and 30.[4] On May 8, 2015, the ALJ issued a decision upholding CMS's enforcement actions.[5] ALJ Decision at 1, 2. Below we summarize the ALJ's analysis on each of the two incidents, on September 18, 2013 and March 8, 2014.

1. *September 18, 2013 incident - 42 C.F.R. § 483.13(b), (c)(1)(i)*

The ALJ determined that the evidence "clearly" and "convincingly" demonstrated verbal and physical abuse of R1 on September 18, 2013 in violation of 42 C.F.R. § 483.13(b) and 483.13(c)(1)(i). *Id.* at 2, 3. CNA 1, the ALJ stated, "demean[ed] [R1] by telling her to relieve herself in her incontinence brief" and "deliberately manhandl[ed] her not once, but twice." *Id.* at 2. The ALJ rejected Lifehouse's arguments questioning R1's ability to accurately recount the incident due to confusion and possibly due to dementia, noting that while R1 had been assessed as having episodes of confusion and described as "moderately impaired," there is also contrary evidence of R1 assessed as "not displaying any memory impairment," as well as the consistency in R1's recollection and reporting of the incident. *Id.* at 3, citing CMS Exs. 1, at 2; 2, at 31; 8, at 6; 14, at ¶¶ 10, 14. The ALJ

[4] T.W. is a state agency surveyor who participated in the survey of the September 18, 2013 incident. CMS Ex. 14. O.F. and K.F., also state agency surveyors, were involved in the survey of the March 8, 2014 incident. CMS Exs. 29, 30. Lifehouse proposed two witnesses, D.O., the CNA involved in the March 8, 2014 incident, and O.G., Lifehouse's administrator. By an October 22, 2014 order, the ALJ precluded Lifehouse from calling D.O. and O.G. to testify at hearing because Lifehouse failed to comply with his prior orders directing the parties to first file written direct testimonies of their proposed witnesses. On appeal, Lifehouse makes no argument concerning the ALJ's orders or the ALJ's determination to preclude Lifehouse from calling D.O. and O.G. at hearing as a sanction for failure to comply with his orders.

[5] By a July 29, 2014 order, the ALJ consolidated two appeals docketed under numbers C-14-850 (appeal of deficiency finding based on a violation of 42 C.F.R. § 483.13(b), (c)(1)(i)) and C-14-1378 (appeal of deficiency finding based on a violation of 42 C.F.R. § 483.25(h)) under docket number C-14-1378.

found, too, "significant corroboration" "in almost every detail" of R1's hearsay account, based on the statements of R1's roommate (referred to as Resident 2 in the record) consistent with R1's statements. *Id.*, citing CMS Exs. 1, at 2; 5; 7, at 1, 9; 8, at 6; 14, at ¶ 13. The ALJ noted that the record did not evidence memory problems or confusion in R1's roommate. The roommate, the ALJ also noted, was "sufficiently concerned about the events . . . as to report them voluntarily"; considered trustworthy given that she was elected president of the Resident Council of Lifehouse; and in a position to understand the significance of the incident given her prior experience as a nursing assistant. *Id.*, citing CMS Exs. 3, at 1, 3; 8, at 1. The ALJ found the roommate's accounting of the incident "credible and reliable." *Id.*

The ALJ also found physical evidence that supported the accounts of the incident given by R1 and her roommate concerning the bruises sustained by R1. The ALJ noted that, on interview of R1 on September 20, 2013, two days after the incident, Lifehouse's executive director observed two red bruises on R1's arm, consistent with the accounts of R1 and her roommate about R1 being grabbed by CNA 1. *Id.*, citing CMS Exs. 5; 7, at 9; 8, at 6. The ALJ noted, moreover, that a surveyor observed the bruised areas a week later. *Id.*, citing CMS Exs. 9; 14, at ¶ 11. The ALJ rejected Lifehouse's argument that intervening events might account for the bruises observed by the surveyor a week after the incident, noting that the executive director observed the same bruises "nearly contemporaneously" with the incident reported by R1. The ALJ found the bruises documented as having been observed by the executive director consistent with what R1 claimed had occurred and provided "important corroboration of her assertions." *Id.* at 4. The ALJ noted, also, that while CNA 1 denied abusing R1, she admitted that she committed verbal abuse since she admitted to telling R1 to relieve herself in her incontinence brief and to grabbing her arm. *Id.*, citing CMS Ex. 8, at 5. While CNA 1 said she grabbed R1's arm to stabilize her, this statement, the ALJ observed, "self-serving as it is, actually does more to corroborate [R1's] assertions than to undercut them." *Id.* Moreover, the ALJ observed that Lifehouse's management found CNA 1 not credible and discharged her after she gave her statement that she grabbed R1's arm to stabilize her, which to the ALJ indicated that Lifehouse found the abuse allegations credible and substantiated. *Id.* at n.1, citing CMS Ex. 5, at 3.

The ALJ determined that a per-instance CMP of $2,500, "only one-quarter the maximum per-instance [CMP] that CMS could have imposed," was an "entirely reasonable," "quite modest" amount in light of the seriousness of abuse. *Id.*

2. *March 8, 2014 incident - 42 C.F.R. § 483.25(h)*

The ALJ noted that Lifehouse decided to manage RA's risk for falls – assigned a score of 22 on a scale in which any score higher than a 10 was considered a fall risk – in part by placing RA in a bed that could be lowered to within six inches from the floor, with the intent to leave the bed in a lowered position so that should she fall out of the bed while unattended she would not fall far. *Id.* at 5, citing CMS Exs. 15, at 2, 4, 6; 5, at 15, 19, 30; 17, at 84. The ALJ noted, too, that RA's physical limitations were such that she had to be positioned while she was in bed, could not tolerate lying on her back, and was incapable of maintaining her position independently when she was on her side. Lifehouse's "solution to this problem," the ALJ noted, was to place RA in the center of the bed to prevent her from rolling off the bed and to stabilize her position, on her side, with pillows. *Id.*, citing CMS Ex. 15, at 3-4.

The ALJ found that, on March 8, Lifehouse did not adhere to the fall risk management procedures it adopted for RA. That day, CNA A (five feet, eight inches tall) raised RA's bed to waist level (which the ALJ inferred to mean that the bed was raised to about three feet above the floor) to provide care to RA, but left RA unattended for a brief period, lying on her side, not stabilized. *Id.*, citing CMS Ex. 15, at 4-5. While unattended, RA fell out of the bed and sustained facial fractures. *Id.*, citing CMS Exs. 18, at 12; 23, at 2.

Lifehouse, the ALJ said, denied neither that it attempted to address RA's fall risk by putting her in a bed that could be lowered, nor that it intended to keep the bed in a lowered position while RA was left unattended, but asserted that it would have been impossible to provide her care while the bed was in a lowered position and that it was necessary to raise the bed on March 8. *Id.* To this, the ALJ said, "If it was necessary to raise the bed in order to provide care to [RA], then the staff never should have left [RA] unattended while the bed was raised. The CNA invited the accident that did occur by walking out of [RA's] room into the bathroom and leaving her unattended in a raised bed." *Id.* The ALJ also rejected the argument that the regulations do not specifically require Lifehouse to put RA in a lowered bed or stabilize her, reasoning that while they do not prescribe specific accident-prevention measures, they do require a facility to take "reasonable and necessary measures," and once Lifehouse decided to manage a known risk to RA by lowering the bed and stabilizing RA, it "was obligated . . . to provide those protections until and unless it determined either that they were unnecessary or that alternative measures needed to be employed." *Id.* at 6. The ALJ concluded that leaving RA "unprotected in a raised bed and without stabilization" under these circumstances is "obvious noncompliance." *Id.* The ALJ also rejected the argument that it was reasonable to leave RA not stabilized since CNA A had determined that it was necessary to leave RA not stabilized while he provided care. The ALJ reasoned that CNA A was not providing care when RA fell and, in that circumstance, the ALJ said, CNA A should have stabilized RA, or, Lifehouse should have had RA observed by someone who could protect her. *Id.*

The ALJ sustained the duration of the noncompliance (May 16-July 1, 2014) and the per-day CMP amount of $850 for this period in the absence of any argument that, if noncompliant, the deficiencies were corrected before July 1, 2014, or that the amount of the per-day CMP is unreasonable. *Id.*

Standard of review

The Board's standard of review on a disputed conclusion of law is whether the ALJ's decision is erroneous. The Board's standard of review on a disputed finding of fact is whether the ALJ's finding is supported by substantial evidence in the record. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs* (*Guidelines*), accessible at http://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/index.html?language=en.

Analysis

Lifehouse disputes the ALJ's finding of a violation of 42 C.F.R. § 483.13(b) and (c)(1)(i) on various evidentiary grounds, arguing, among other things, that the ALJ based his decision on unreliable evidence. Lifehouse disputes the ALJ's finding of a violation of section 483.25(h), asserting, among other things, that it was wrongly held to taking certain accident-prevention measures the regulation does not mandate. Brief in support of request for review (RR). The arguments have no merit. We uphold the ALJ Decision.

Lifehouse raises no argument about the ALJ's determinations that the per-instance CMP of $2,500 assessed for a violation of 42 C.F.R. § 483.13(b) and (c)(1)(i) is reasonable, or that the violation of section 483.25(h) lasted from May 16 through July 1, 2014 and that the per-day CMP of $850 for this period is reasonable. Since Lifehouse does not raise any argument about the ALJ's determinations on the penalties,[6] we summarily affirm those determinations.

[6] Lifehouse does say that the "'G' scope and severity for the Citation is unwarranted." RR at 20. We do not construe this non-specific statement, not supported by any reasoned explanation or citation of authority, as a dispute specifically on the ALJ's determinations concerning the penalties assessed. In any case, the scope and severity of the deficiencies are not at issue here. Lifehouse may challenge the scope and severity of the deficiencies only if a successful challenge would affect the range of CMP amounts assessed or if there was a finding of substandard quality of care that resulted in the loss of its nurse aide training program. 42 C.F.R. § 498.3(b)(14). The $850 per-day CMP imposed for the violation of 42 C.F.R. § 483.25(h) is within the low range of per-day CMP amounts ($50-$3,000) permitted in accordance with 42 C.F.R. § 488.408. As for the per-instance CMP of $2,500 imposed for a violation of 42 C.F.R. § 483.13(b) and (c)(1)(i), this amount is within the amounts between $1,000 and $10,000 permitted under § 488.438(a)(2) for per-instance CMPs. Since challenging the level of noncompliance would not change the applicable range of either CMP, that exception does not apply. Also, Lifehouse has not shown that it was subjected to a finding of "substandard quality of care" (as defined in 42 C.F.R. § 488.301) that led to a loss of a nurse aide training program.

A. ***The ALJ's finding that Lifehouse was not in substantial compliance with 42 C.F.R. § 483.13(b) and (c)(1)(i) is supported by substantial evidence and is free of legal error.***

1. *We defer to the ALJ's assessment of the evidence.*

Lifehouse first raises arguments primarily about the ALJ's assessment of the evidence. According to Lifehouse, the ALJ erred by relying on unreliable hearsay evidence in the form of statements about the incident, in particular those of R1, who was documented by an interdisciplinary team a few days after admission to Lifehouse as confused and alert and oriented only to herself. Lifehouse also argues that the ALJ did not consider certain evidence, in particular evidence Lifehouse says shows inconsistent, and therefore unreliable, accounts about the incident. RR at 2, 5-13. For instance, Lifehouse states that on September 20, 2013, R1 informed Lifehouse staff that there were two CNAs in her room but could not recall which CNA was involved in the incident, but in a statement to her daughter a few days later R1 did not specifically mention that two CNAs were present. *Id.* at 9, citing P. Exs. 1 and 7. It also asserts that there are numerous, and inconsistent, accounts about what happened. It states that R1 reported on September 20, 2013 that the CNA pulled her toward the bathroom, but did not again provide such a description in September 24, 2013. *Id.* at 9, 12-13 (asserting that it not clear whether the CNA pulled her out of bed or pulled her towards the bathroom, or when being assisted out of the bathroom the CNA grabbed R1's arm downward to the bed); P. Ex. 1, at 3 (noting that Lifehouse questioned a discrepancy about whether the CNA pulled R1 up from the bed or pulled down from the bed). Lifehouse also states that R1 stated on September 20, 2013 that the room was dark at the time, but the ALJ did not consider whether lighting conditions might have affected R1's and her roommate's perception of the incident, or R1's cognitive or visual impairment, or whether the roommate had impaired sensory perception. *Id.* at 8-11. In addition, Lifehouse questions the reliability of statements of R1's daughter and R1's roommate on hearsay grounds, and questions the reliability of the statements of the daughter and caretaker as they did not personally witness the incident. *Id.* at 7-8, 10-11.[7]

Lifehouse further asserts that the ALJ erred in not considering evidence suggesting that there could be other, intervening causes of R1's bruises, not attributable to the September 18, 2013 incident. For instance, Lifehouse suggests that R1's daughter could have caused the bruises on R1's arm because she allegedly was previously observed pulling on her mother's arms, and raises the possibility that the bruises were present earlier, upon R1's admission to Lifehouse, or were the result of certain medications R1 was taking or "her pre-existing fragile skin or skin tears." RR at 2, 5-7, 12.

[7] Lifehouse states that the surveyors "made no effort to interview Resident 2 [R1's roommate] . . . ." RR at 10. This is inaccurate. Resident 2 was interviewed on September 24, 2013. P. Ex. 1, at 2; CMS Ex. 1, at 2-3.

Lifehouse unsuccessfully tries to undermine the factual foundation for the ALJ's decision by largely repeating the arguments it raised before the ALJ. The arguments, in essence, amount to another attempt, before the Board, to cast doubt on the reliability of certain evidence on various grounds – hearsay grounds or because an individual did not personally witness the event; by questioning the cognitive ability of the resident who complained of abuse; and by arguing that there are inconsistencies in reporting in terms of certain details about the incident.

We reject Lifehouse's arguments and defer to the ALJ's assessment of the evidence. In general, the Board does not disturb the ALJ's determinations concerning the credibility and weight to be accorded to evidence unless there is compelling reason to do so. *Community Northview Care Ctr.*, DAB No. 2295, at 28 (2009). The Board has also recognized that hearsay – which is admissible in Part 498 proceedings such as this case even if it is inadmissible under the rules of evidence applicable to court proceedings – does present inherent reliability concerns since the declarant is not subject to the safeguard of cross-examination. However, hearsay evidence may constitute substantial evidence of noncompliance if sufficient indicia of reliability are found. *Florence Park Care Ctr.*, DAB No. 1931, at 10 (2004), citing *Pacific Regency Arvin*, DAB No. 1823, at 14 n.6 (2002). The weight to be accorded to hearsay evidence is determined by the degree of reliability based on relevant indicia of reliability and whether it is corroborated by other evidence in the record as a whole. *Community Northview Care Ctr.* at 28.[8] To the extent the ALJ relied on hearsay evidence (which he may do), the ALJ explained why he found it sufficiently reliable and corroborated and how he weighed that evidence. Nothing that Lifehouse has said in an attempt to raise questions about the reliability of certain evidence the ALJ properly considered comes close to a compelling reason for us not to defer to his assessment of the evidence. Lifehouse does not explain specifically how and why the ALJ's weighing of evidence, including hearsay evidence, amounts to an abuse of discretion such that we should take the exceptional action in not deferring to the ALJ's assessment of the evidence.

[8] A number of factors may be considered to evaluate the reliability of hearsay statements. Among them are whether: (1) the hearsay declarant is biased and has an interest in the result of the case; (2) the opposing party has the means to obtain the information contained in the statement and to verify its accuracy; (3) the opposing party can subpoena the declarant; (4) the statement is corroborated or contradicted by other evidence; (5) the statement is consistent with other statements made by the declarant; (6) the statement is signed or sworn to; and (7) the declarant is available to testify. *Florence Park Care Ctr.* at 10.

Lifehouse's arguments alleging discrepancies about reporting of the event are in this case ultimately inconsequential distractions. While R1 may not have consistently reported all details about the episode when recounting the event multiple times (such as whether there were one or two CNAs in the room),[9] on September 20, 2013, Lifehouse's own staff interviewed R1, and the notes from that interview state that R1 reported to staff that a CNA was "very rough" in handling her arm and "jerked" her arm. P. Ex. 7, at 1. At bottom, the statements of R1 two days after the incident and subsequent statements of the roommate, daughter, and caretaker are consistent in terms of reporting that a CNA had handled R1 in such a way that R1 protested and complained of pain. *See* P. Ex. 1 at 1-2. These statements corroborate the account given by R1 as recorded by Lifehouse staff. We therefore see no basis to disturb the ALJ's finding R1's account of the incident credible and corroborated.

Equally unavailing is the suggestion that there could be other, intervening causes of bruising not attributable to the CNA. Lifehouse does not explain why the ALJ could not rely on the presence of bruising in places consistent with the resident's account as physical evidence that further corroborates R1's account. Lifehouse's argument instead appears to assume erroneously that there must be proof that a resident sustained injury (such as bruising) attributable to facility staff wrongdoing to support a finding of noncompliance with section 483.13's abuse prohibition requirements. The express terms of 42 C.F.R. § 483.13(b) and (c)(1) state nothing about proof necessary for purposes of establishing abuse, let alone specific proof of injury and causation of that injury attributable to the facility.[10] Rather, these regulations generally prescribe that the facility must develop and implement policies and procedures to prevent resident abuse (and neglect). Therefore, the question for the ALJ and the Board is whether the facility has established and implemented appropriate policies and procedures, with the overarching goal of such policies and procedures being that residents are not abused (or neglected). As the Board said:

[9] We also question whether not consistently reporting a specific detail about an event like whether there were two CNAs in the room when describing the incident to multiple individuals necessarily makes the resident's accountings of the incident inconsistent, as Petitioner argues.

[10] We are not stating that evidence of injury and its causation are irrelevant considerations. Of course, in the context of abuse allegations, evidence of injury and causation are important considerations. We are simply stating that Lifehouse raises an unsuccessful challenge by asserting lack of evidence that the observed injury (manifested by bruising) was attributable to facility staff when the regulations do not specifically require such evidence for purposes of finding a violation of section 483.13.

> The goal of section 483.13(b) is to keep residents free from abuse. This goal cannot be achieved if a facility could be found in compliance even though it failed to take reasonable steps to protect residents from potentially injurious acts which it knew or should have known might occur and which might be willful . . . .

Honey Grove Nursing Ctr., DAB No. 2570, at 3 (2014), quoting *Western Care Management Corp., d/b/a Rehab Specialties Inn*, DAB No. 1921, at 14 (2004), *aff'd, Honey Grove Nursing Ctr. v. HHS*, 606 F. App'x 164 (2015). The ALJ found, and we agree, that the goal of section 483.13's abuse prohibition requirements was not met on September 18, 2013. The evidence, in the form of first-hand accounting of rough handling of R1 by a CNA given by R1 as amply corroborated by other evidence that includes consistent reports of rough handling as told by other individuals, plainly describes abuse and, as the ALJ said, "describes it convincingly." ALJ Decision at 3.

2. *Evidence of specific intent to harm is not required to support a violation of section 483.13's abuse-prohibition provisions.*

Lifehouse asserts that a deficiency finding for a violation of the abuse-prohibition requirements of section 483.13 may not be grounded on a record that, as here, includes no affirmative evidence that staff willfully intended to harm a resident. RR at 13-16.

We reject the argument as meritless. Lifehouse appears to misconstrue the meaning of "abuse" for purposes of section 483.13. The term "abuse" means "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." 42 C.F.R. § 488.301. The phrase "willful infliction" in section 488.301 means *deliberate* conduct, not conduct undertaken with specific intent to inflict harm. Accordingly, while there is an element of intent in the word "abuse" for purposes of section 483.13 in the sense that the actor must have done something with deliberation, that deliberation need not rise to the level of specific intent to harm to support a violation of the abuse regulation. *See, e.g.*, *Merrimack County Nursing Home*, DAB No. 2424, at 4-5 (2011) (specific intent to harm not required to support a violation of section 483.13(b)). Therefore, here, neither the ALJ nor the Board need find evidence that the CNA acted with intent to hurt R1 (or by omission or failure intended for harm to befall R1) to uphold an abuse deficiency finding.[11]

[11] We note, as the ALJ did, that the CNA initially denied abusing R1, stating that she grabbed R1's arm only to stabilize her (ALJ Decision at 4; P. Ex. 13), which Lifehouse says occurred when the CNA took R1 to the bathroom and points to as indicative of lack of intent to harm. RR at 14, 15. However, it is not disputed that the CNA handled R1 in such a way as to elicit a protest from R1 a second time, when R1 was returned to bed. Based on the evidence presented here, we find no error in the ALJ's characterization of the CNA's action as "deliberate[] manhandling" "not once, but twice" and that it falls within the meaning of "abuse" under the regulation. ALJ Decision at 2.

We note, moreover, that Lifehouse raises no dispute about a core fact found by the ALJ – that the way in which the CNA handled R1's arm, once to take R1 to the restroom and once to return her to bed after toileting, caused R1 to protest both times that the CNA was hurting her. Lifehouse points to no evidence indicating that proper handling of R1 under these circumstances could reasonably have been expected to result in pain so as to cause R1 to cry out. And, aside from physical action by the CNA, as the ALJ rightly said, the CNA's initial, verbal response to R1's call for help for toileting by telling R1 to "go" in her incontinence brief (CMS Ex. 8, at 5), another fact that Lifehouse does not dispute, is plainly "demeaning" verbal abuse that section 483.13 prohibits. ALJ Decision at 2.[12] Whether or not the CNA specifically intended to injure R1 is ultimately inconsequential.

3. *Lifehouse's allegations of survey deficiencies are misplaced.*

Lifehouse takes issue with the survey itself, alleging that the investigation of the incident was "deficient" in many ways, e.g., the surveyors failed to interview certain individuals including CNA 1 and other staff who provided R1 care, and failed to consider whether there were possible causes of injury other than CNA 1's action. RR at 2, 5, 6, 10-13. A survey rife with deficiencies, Lifehouse says, "does not create a prima facie case that [its] staff abused [R1]." *Id.* at 7.

We reject the premise that the viability or validity of CMS's enforcement action against a SNF for alleged violation of Medicare participation requirements stands or falls on the quality of the underlying state agency survey. Facilities' compliance with Medicare participation requirements is determined through the survey and certification process in Part 488, subpart E. In general, state agencies conduct surveys under agreement with CMS. In issuing a SOD following a survey, the state agency is making recommendations to CMS. *See* 42 C.F.R. §§ 488.11, 488.12. It is for CMS to then decide whether to pursue enforcement action against the facility based on the survey findings. *See Fairfax Nursing Home, Inc.*, DAB No. 1794, at 16 (2001) ("Under the regulations, surveyors make only recommendations with respect to compliance of Medicare facilities – HCFA [CMS's predecessor agency] is not bound by those recommendations."), *aff'd*, *Fairfax Nursing Home v. HHS*, 300 F.3d 835 (7th Cir. 2002).

[12] The ALJ also found that the fact that Lifehouse discharged the CNA indicates that it "originally found the abuse allegations . . . credible and substantiated." ALJ Decision at 4 n.1. (Lifehouse suspended CNA 1 pending investigation of the incident and, on September 25, 2013, terminated CNA 1. P. Ex. 3, at 1; P. Ex. 4, at 1; CMS Ex. 5, at 3.) Lifehouse does not specifically dispute the ALJ's assessment of the evidence concerning its personnel action immediately after the incident as indicative of its own determination that the abuse allegations were credible and substantiated.

Once CMS determines that there is a basis for pursuing enforcement action and takes that action, on any further appeal to an ALJ, CMS bears the initial burden to establish a prima facie case. Meaning that, CMS must "com[e] forward with evidence related to disputed findings that is sufficient (together with any undisputed findings and relevant legal authority)" to support a decision in its favor absent an effective rebuttal. *Oaks of Mid City Nursing & Rehab Ctr.*, DAB No. 2375, at 12 (2011). "Once CMS has made a prima facie showing of noncompliance, however, the SNF 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." *Id.* (internal quotation marks omitted). *See also Claiborne-Hughes Health Ctr.*, DAB No. 2223, at 4 (2008) (once CMS makes its prima facie case, the facility must then carry its burden to show by a preponderance of the evidence, i.e., it is more likely than not, that it was in substantial compliance), *aff'd*, *Claiborne-Hughes Health Ctr. v. Sebelius*, 609 F.3d 839 (6th Cir. 2010), *rehearing denied* (Aug. 20, 2010).[13] The ALJ then decides the case de novo based on a review of the evidence presented on appeal, not merely on the evidence in the SOD.

Thus, the ultimate question is not whether the survey was performed correctly but whether the evidence collected at the survey, along with all other evidence presented on appeal, establishes noncompliance. Thus, as the ALJ correctly indicated in page 2 of his decision, the correct inquiry was whether "Petitioner failed to comply substantially with Medicare participation requirements," i.e., section 483.13's abuse-prohibition requirements. In addition, as the Board previously stated, "'As a matter of law, inadequate performance of a survey does not excuse a [SNF] from its duty to comply with regulatory requirements.'" *Rosewood Care Ctr. of Swansea*, DAB No. 2721, at 7 (2016), quoting *Rosewood Care Ctr. of Swansea*, DAB CR4408, at 7 (2015). The SNF "has the ultimate burden to show that it was in substantial compliance with section 483.13 . . . [and] [t]hat burden endures even if [the Board] were to conclude . . . that the survey process was flawed." *Id.* (citations omitted). Lifehouse has not shown that any alleged flaws in the survey undercut the reliability or credibility of the evidence presented to the ALJ. Accordingly, we need not (and do not) decide here whether there were shortcomings in the survey.

[13] On a related point, the Board has made clear that the SOD does not dictate what evidence may be admitted related to a cited deficiency. Rather, the question is whether the facility cited with the deficiency has been given notice and opportunity to respond to any allegation in the SOD. *See, e.g., NHC Healthcare Athens*, DAB No. 2258, at 17 (2009). During the ALJ proceedings Lifehouse was given, and availed itself of, the opportunity to challenge the allegations in the SOD and raise a dispute about the survey itself to the extent Lifehouse believed the survey was deficient in some way. *See* Lifehouse's pre-hearing brief. We also note in particular that Lifehouse was given an opportunity to cross-examine three surveyors who were involved in the surveys in question and to supplement its case with briefing concerning the witnesses' testimony, as evidenced by the transcript of the hearing and Lifehouse's post-hearing brief. We therefore find no merit to Lifehouse's complaint alleging defects in the SOD as indicative of survey or surveyor shortcomings. RR at 6 (The "investigators omitted material testimony from the report and failed resolve the discrepancies identified in the [SOD].").

B. ***The ALJ's conclusion that Lifehouse was not in substantial compliance with 42 C.F.R. § 483.25(h) is supported by substantial evidence and is free of legal error.***

1. *The ALJ did not misread or misapply section 483.25(h).*

Lifehouse first reprises its argument that section 483.25(h) does not require Lifehouse to lower a resident's bed when providing care. It argues that the ALJ erred to the extent he interpreted the regulation otherwise to hold Lifehouse to such an action. RR at 16. Lifehouse disputes in particular the following discussion in the ALJ Decision:

> Petitioner . . . asserts that there is no regulatory requirement that [RA] be in a lowered bed or be stabilized with a pillow. From that, it seems to argue that the staff was not remiss . . . when it failed to lower the bed or stabilize [RA]. That argument avoids the fact that it was Petitioner's *own staff* that determined that lowering the bed and stabilizing [RA] were necessary.

Id., quoting ALJ Decision at 6 (ALJ's emphasis).

Lifehouse says that RA's physician did not specifically order staff to lower the bed while providing care, but rather ordered staff to use a Hoyer lift for transfers and to apply a non-skid pad to RA's wheelchair. Consistent with the physician's orders, Lifehouse also says, on January 8, 2014, staff implemented the care plan for fall prevention and safety, which included keeping RA's bed in a low position for transfers. The care plan does not state that staff are to lower RA's bed "at any time she was left unattended." *Id.* at 18, citing P. Ex. 22, at 2; *id.* at 19, citing P. Ex. 23; *id.* at 2 (disputing the ALJ's statement that Lifehouse "never should have left [R1] unattended while the bed was raised," ALJ Decision at 5). Lifehouse surmises that had the physician believed RA was at risk for falls he would have ordered staff to lower the bed and asserts that the absence of such an order suggests that the physician did not foresee a fall. *Id.* at 18-19. Thus, Lifehouse argues, RA's "fall from bed while [RA] was stationary was not a known or foreseeable risk." *Id.* at 18. According to Lifehouse, the ALJ erred in "import[ing] language" into section 483.25(h) to hold it to a violation based on failure to lower the bed, and in "adopt[ing]" and "improperly credit[ing] [CMS's] illegal amendment to the Citation [in stating] that staff should have positioned [RA] in the middle of the bed and used pillows to position her more securely." *Id.* at 16 (citing P. Ex. 21, at 1-2), 17-18.

In essence, Lifehouse argues that the ALJ misread or misapplied section 483.25(h) to hold it to certain actions the regulation does not mandate. Lifehouse misconstrues the ALJ's analysis. The ALJ correctly read and applied section 483.25(h).

Initially, we note that the question is not whether section 483.25(h) expressly requires a facility to adjust a resident's bed height or even more generally employ one safety measure or another. The regulation does not prescribe any specific accident-prevention method. As Board precedent discussed below explains, however, facilities are held to safety outcomes under section 483.25(h). To say that a facility is not responsible for negative outcomes that it could have reasonably foreseen and taken steps to prevent only because section 483.25(h) does not spell out specific resident safety measures a facility must or should take would render the regulation's intent meaningless, and strip it of its intended effect.

In interpreting what section 483.25(h) requires, the Board has stated that, while the regulation broadly prescribes outcomes facilities must meet, facilities have flexibility to choose the specific methods as appropriate to their circumstances and to employ reasonably necessary measures to comply with the regulation. *See, e.g.*, *Azalea Court*, DAB No. 2352, at 9 (2010), *aff'd, Azalea Court v. HHS*, 482 F. App'x 460 (11th Cir. 2012); *Briarwood Nursing Ctr.*, DAB No. 2115, at 11 (2007); *Aase Haugen Homes, Inc.*, DAB No. 2013 (2006); *Woodstock Care Ctr.*, DAB No. 1726 (2000), *aff'd, Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 (6th Cir. 2003). In this context, facilities are held to anticipating reasonably foreseeable risk of accidents in choosing appropriate accident prevention methods. *Glenoaks Nursing Ctr.*, DAB No. 2522, at 8 (2013) (a facility "is obligated to anticipate reasonably foreseeable accidents that might befall a resident and take steps – such as increased supervision or the use of assistance devices, for example – calculated to prevent them"); *see also Briarwood Nursing Ctr.* at 5 and *Century Care of Crystal Coast*, DAB No. 2076, at 6-7 (2007), *aff'd, Century Care of Crystal Coast v. Leavitt*, 281 Fed. App'x 180 (4th Cir. 2008) (similar discussion in both Board decisions).

Once a facility determines the methods appropriate for purposes of achieving section 483.25(h) outcomes, it is held to following through on them. The failure to do so, itself, may be a basis to support a finding of noncompliance. For example, in *Azalea Court*, a case involving resident elopement risk and safety of wheelchair-bound residents who smoke, the facility, like Lifehouse here, asserted that section 483.25(h) did not require it to take specific accident prevention measures. There, the Board rejected the facility's argument, and held that a facility's "failure to take measures that are reasonably necessary, under the circumstances, to achieve an outcome required by the regulation . . . is indeed evidence of noncompliance, even though the regulation does not specify the particular measures that the facility must or may take to achieve these outcomes." *Azalea Court* at 9. The Board went on to say, "The fact that the regulations do not specify that a particular type of care is necessary to meet a requirement does not prevent a finding of noncompliance *when the facility itself has determined that type of care is necessary*." *Id.* at 15 (emphasis added).

Likewise, the Board has held that where a facility's care plan sets out the measures to be taken in caring for residents, those measures are evidence of the facility's evaluation of what must be done to attain or maintain a resident's "highest practicable physical, mental, and psychosocial well-being" as required by section 483.25. *Blossom South Nursing and Rehab. Ctr.*, DAB No. 2578, at 13 (2014). Thus, for example, where a facility developed a plan of care to prevent a resident from eloping, its failure to provide the degree of monitoring and supervision the plan of care required evidenced noncompliance with section 483.25(h). *Cedar Lake Nursing Home*, DAB No. 2288, at 6-7 & 7 n.4 (2009), *aff'd, Cedar Lake Nursing Home v. HHS*, 619 F.3d 453 (5th Cir. 2010). *See also Spring Meadows Health Care Ctr.*, DAB No. 1966, at 17 (2005) ("the clearest case of failure to meet [section 483.25] is failure to provide one of the specific services outlined in the subsections or failure otherwise to follow the plan of care based on the comprehensive resident assessment").

According to Lifehouse's Fall Management Standard, a resident whose fall risk assessment score is 10 or higher is considered "*at risk for falls*." P. Ex. 26, at 8 (emphasis in original). Lifehouse assessed RA's risk for falls as 22. P. Ex. 23, at 1; CMS Ex. 17, at 19; ALJ Decision at 5 (noting the facility determined RA was at high risk for falls). The ALJ found that Lifehouse decided to manage RA's high fall risk by putting RA in an adjustable bed that could be lowered and stabilizing her position in bed with pillows. ALJ Decision at 5. Lifehouse does not dispute this finding. In light of the Board precedent discussed above, the question is whether Lifehouse adhered to the measures it determined would be appropriate to mitigate the fall risk when those measures were needed, or at a minimum appropriate, i.e., when, as here, the caregiver left RA unattended with the bed raised. The ALJ found that Lifehouse staff did not do so. That failure is the factual basis for the ALJ's determination.

Lifehouse merely speculates about what the physician might have believed concerning RA's risk for falls without pointing to any evidence indicative of a physician's belief that the RA was at low risk (or lower than as assessed) or no risk. That aside, Lifehouse cannot reasonably or credibly argue that because a physician did not specifically direct the staff to lower the bed while providing RA care or anytime RA was left unattended it had no reason to foresee the risk of RA falling out of the bed when the record plainly establishes that Lifehouse staff assessed her to be at high risk for falls, P. Ex. 23, at 1, and

determined it would take various fall risk management precautions, to include "keep bed in low position for transfers" and "lock bed & w/c [wheelchair] when transferring," *id*. That shows that Lifehouse not only had reason to know, but actually knew, that RA was at risk for falls.[14]

We also reject as unfounded Lifehouse's suggestion that the ALJ misconstrued or misapplied section 483.25(h) by "import[ing] language" into the regulation to hold it to a violation based on a failure to lower the bed and that the ALJ somehow erred in leaving unchecked wrongful CMS action that sought to require Lifehouse to implement safety measures not required by law. The ALJ did not uphold CMS's finding because facility staff failed to lower the bed or stabilize RA with pillows. The ALJ did not state that Lifehouse must keep the bed lowered, or that it could not raise the bed if its staff determines that would be appropriate when providing RA care, or that the facility may not ever leave a resident like RA unattended. Rather, the ALJ found that once Lifehouse decided that it would manage RA's known risk for falls, which it had assessed as high, by taking certain precautions, it was "obligated, then, to provide those protections until and unless it determined either that they were unnecessary or that alternative measures needed to be employed." ALJ Decision at 6. The basis for his finding of noncompliance was that Lifehouse failed to adhere to the measures that its own staff determined would be "reasonable and necessary" for RA. *Id.* The ALJ's rationale is consistent with the regulations and applicable Board precedent, and is well supported by the evidence.

2. *A factual finding that a fall from an elevated bed caused RA's fracture injury is not necessary to support a deficiency finding.*

Lifehouse argues that it is mere speculation to assume that "if [RA] fell out of bed while the bed was in a low position, she would not have been injured." RR at 19-20.[15] Lifehouse surmises that RA likely would have sustained the facial fractures regardless of whether the bed was in a high or low position given her advanced age and osteoporosis. *Id.* at 20, citing P. Exs. 24 and 25. Moreover, Lifehouse says, it is undisputed that RA was "immobile and required assistance to reposition in bed or to transfer," and was completely dependent on assistance for bed mobility and had "'very limited'" ability to change and control her body position. According to Lifehouse, CMS did not determine,

[14] Also undercutting Lifehouse's argument that it had no reason to know about the fall risk in the absence of a specific physician order or instruction to lower the bed is undisputed evidence of a fall before March 8, 2014. *See* CMS Ex. 17, at 15, 100 (RA slid out of her wheelchair and fell, in July 2013); P. Ex. 26, at 5 (Lifehouse's Fall Management Standard, stating, "The distance to the next lower surface is not a factor in determining if a fall occurred. If a resident rolled off a (low) bed or mattress that was close to the floor, it is still a fall.").

[15] This argument seems to be at odds with Lifehouse's own determination that it would be appropriate to manage RA's fall risk by taking certain safety measures, like using a bed that can be raised and lowered.

and the evidence does not show, that the CNA's positioning of RA was "improper in any fashion or caused [RA's] fall." *Id.*, citing P. Exs. 21 and 25. Therefore, Lifehouse asserts, CMS's conclusion that the failure to lower the bed caused her to fall and sustain injuries is "unfounded and cannot provide a proper basis" for a deficiency finding for violation of section 483.25(h). *Id.* at 2-3, 20.

Lifehouse mistakenly focuses on RA's injury and whether RA's facial fractures were actually shown to have resulted from the failure to lower the bed. Such a showing is not required. First, nothing in the language of section 483.25(h) requires either that an accident have occurred or that it have resulted in an injury. The Board has rejected the argument that proof of an "accident" is a prerequisite to showing a violation of section 483.25(h); rather, there must be a showing that the facility failed to take reasonable steps to protect a resident from foreseeable risk of harm. *See, e.g.*, *West Texas LTC Partners, Inc., d/b/a Cedar Manor*, DAB No. 2652, at 11 (2015); ***Western Care Management Corp., d/b/a Rehab Specialties Inn*** at 15; *Clermont Nursing & Convalescent Ctr.*, DAB No. 1923 (2004), *aff'd*, *Clermont Nursing & Convalescent Ctr. v. Leavitt*, 142 F. App'x 900 (6th Cir. 2005). Indeed, Lifehouse's own Fall Management Standard expressly provides that injury is not a condition precedent for determining whether a fall occurred, as it states: "The presence or absence of a resultant injury is not a factor in the definition of a fall. Fall without injury is still a fall." P. Ex. 26, at 5.

Second, the ALJ did not find (and did not need to find) that the failure to lower the bed caused the fall and resulting injury.[16] As we said elsewhere, the ALJ's determination is grounded in his finding that Lifehouse did not adhere to its own fall risk management measures, not specifically on the fact of the fall or the resulting injury. In addition, we observe that Lifehouse's argument to the effect that RA likely would have sustained facial fractures regardless of the position of the bed, high or low, given her age and osteoporosis not only misses the point for the reasons we have given, but undercuts its own case. From our perspective, the very fact that the facility assessed RA to be at high risk for falls and of significant injury from any fall, in light of her age and other relevant considerations like osteoporosis and limited mobility (also known to the facility), would be all the more reason for staff to be vigilant and consistent in implementing the safety measures the facility designed for RA.

[16] Lifehouse's focus on the height of the bed's position in arguing that without evidence that the failure to lower the bed caused the fall and injury there is no basis for a deficiency finding is also perplexing. The facility's own fall management policy states, "The distance to the next lower surface is not a factor in determining if a fall occurred. If a resident rolled off a (low) bed or mattress that was close to the floor, it is still a fall." P. Ex. 26, at 5.

3. *The ALJ did not hold Lifehouse to a strict liability standard.*

Lifehouse suggests that the ALJ found it "*per se* liable" for a violation of section 483.25(h) "because [RA] fell at a time when she was not being provided with a low bed and supporting pillows." RR at 20. It faults the ALJ for upholding CMS's determination when CMS, Lifehouse says, "must prove that the failure to provide the interventions actually caused [RA's] fall" but failed to do so. *Id.* For its part, Lifehouse says, its staff "acted reasonably by not ordering [RA's] caregivers to lower her bed while unattended." *Id.* at 21. Citing state law, Lifehouse says the California Supreme Court has recognized what Lifehouse calls a "reasonable licensee defense" intended to relieve a licensee like it from strict liability. *Id.* at 20-21, citing *California Health & Safety Code* § 1424 and *California Ass'n of Health Facilities v. Dept. of Health Services*, 16 Cal. 4th 284 (1997).

State law has no bearing in this case where we (and the ALJ) determine whether Lifehouse violated federal regulations concerning nursing homes that participate in federal health care programs. More to the point, the Board has long rejected the argument that a deficiency finding under section 483.25(h) is based on the application of a "strict liability" rule.[17] *See, e.g., Tri-County Extended Care Ctr.*, DAB No. 1936, at 7 (2004); *Odd Fellow and Rebekah Health Care Facility*, DAB No. 1839, at 6 (2002); *Price Hill Nursing Home*, DAB No. 1781, at 8 (2001); *Koester Pavilion*, DAB No. 1750, at 25 (2000). "[T]he statute and regulations hold facilities to meeting their commitments to provide care and services in accordance with the high standards to which they agreed but do not impose strict liability, i.e., they do not punish facilities for unavoidable negative outcomes or untoward events that could not reasonably have been foreseen and forestalled." *Tri-County Extended Care Ctr.* at 7; *see also Woodstock Care Ctr.* at 25 (section 483.25(h)(2) does not make nursing facilities "guarantors of favorable outcomes").

Nothing in the ALJ Decision suggests that the ALJ held Lifehouse to a strict liability standard. Contrary to Lifehouse's apparent belief, RR at 20, the ALJ did not uphold the deficiency finding based on the fact of occurrence of the accident per se. Rather, the ALJ found that Lifehouse must follow through on safety measures it adopted based on known risk of harm.[18] The failure to do so is the basis for finding noncompliance.

[17] Moreover, as a general matter, the Board has questioned whether the concept of strict liability even has any relevance in nursing home cases such as this case because the concept lies in tort law, not in federal regulation of nursing homes that receive federal funding. *See, e.g., Springhill Senior Residence,* DAB No. 2513, at 14 (2013); *Briarwood Nursing Ctr.* at 11 n.8.

[18] Strict liability, in essence, means that the individual or entity found liable bears liability without question of negligence or fault. On the contrary, the ALJ found Lifehouse at fault in the sense that he found that it did not adhere to its own fall risk management measures.

Conclusion

Based on the foregoing reasons and bases, the Board upholds the ALJ Decision.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Susan S. Yim
Presiding Board Member