Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Silsbee Oaks Health Care, L.L.P.,
(CCN: 67-6008),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-361

Decision No. CR4323

Date: October 16, 2015

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) that Silsbee Oaks Health Care, L.L.P. (Petitioner or the facility) was not in substantial compliance with the Medicare participation requirement at 42 C.F.R. 483.25(h). I also find as reasonable CMS's imposition of a per-instance civil money penalty (CMP) of $8,250, directed in-service training, and loss of approval for Petitioner to participate in a Nurse Aide Training and Competency Evaluation Program (NATCEP).

I. Procedural Background

Petitioner is a long-term care facility in Silsbee, Texas. It participates in Medicare as a skilled nursing facility and in Medicaid as a nursing facility. On August 8, 2013, the Texas Department of Aging and Disability Services (state agency) completed a site survey to determine if Petitioner was in substantial compliance with federal Medicare requirements. By letter dated September 6, 2013, CMS notified Petitioner that it concurred with the state agency's findings, and it was imposing the following remedies: a per-instance CMP of $4,000 for the deficiency cited at F-221 (42 C.F.R. § 483.13(a)), *Right to be Free from Physical Restraints*; a per-instance CMP of $4,000 for the

deficiency cited at F-323 (42 C.F.R. § 483.25(h)), *Free of Accident Hazards/Supervision Devices*; a denial of payment for new admissions (DPNA) starting September 20, 2013; termination of Silsbee's participation in the Medicare program if the facility did not achieve substantial compliance before February 8, 2014; and directed in-service training imposed by the state agency. CMS Ex. 1. By letter dated September 10, 2013, CMS notified Petitioner that based on its administrative review it was changing the remedies and penalties imposed in its previous notice letter. CMS Ex. 2. CMS changed the per-instance CMP from $4,000 for the deficiency cited at F-323 to a per-instance CMP of $8,250 for that deficiency. *Id.* CMS also rescinded the per-instance CMP of $4,000 for the deficiency cited at F-221. *Id.* The notice letter further provided that the proposed termination and DPNA remain unchanged. *Id.* By letter dated October 22, 2013, CMS notified Petitioner that it achieved substantial compliance with the federal requirements on September 15, 2013, and CMS rescinded the other enforcement remedies of termination and DPNA. CMS Ex. 3.

Petitioner timely requested a hearing before an administrative law judge (ALJ). In its hearing request, Petitioner sought review of all of the deficiencies cited by the state agency without regard to whether remedies were imposed based on those deficiencies: F-164 (§§ 483.10(e), 483.75(*l*)(4); F-221 (§ 483.13(a)); F-225 (§ 483.13(c)(1)(ii)-(iii), (c)(2)-(4)); F-226 (§ 483 13(c); F-241(§ 483 15(a)); F-323 (§ 483.25(h)); F-363 (§ 483.35(c)); F-365 (§ 483.35(d)(3)); F-371 (§ 483.35(i)); F-425 (§ 483.60(a)); F-441 (§ 483.65(a)); F-465 (§ 483.65); F-490 (§ 483.75); and F-498 (§ 483.75(f)). Hearing Request at 2-7.

CMS contends that Petitioner only has a right to a hearing if an enforcement remedy is imposed. CMS contends it only imposed remedies with respect to four deficiencies, and therefore Petitioner has a right to appeal only those deficiency findings. They are: the per-instance CMP of $8,250 imposed for the deficiency at F-323 (*Free of Accident Hazards/Adequate Supervision and Assistance devices*); the directed in-service training imposed for the deficiencies at F-323 and F-221 (Right to be Free from Physical Restraints); and the loss of approval to participate in a NATCEP due to the finding of substandard quality of care for the deficiencies cited at F-323, F-221, F-225 (*Failure to investigate allegations of abuse, neglect, or misappropriation of property*) and F-226 (*Failure to develop and implement policies and procedures regarding abuse and neglect*).[1]

I was assigned this case for hearing and decision. I issued a prehearing order, which included a briefing schedule, on December 6, 2013. The parties filed prehearing briefs

[1] Affirming the per-instance CMP requires me to uphold the loss of approval of the NATCEP here because sections 1819(f)(2)(B) and 1919(f)(2)(B) of the Act prohibit approval of a NATCEP if the facility has been subject to imposition of a CMP of not less than $5,000.

(CMS PH Br. and P. PH Br.) and proposed exhibits. On May 28, 2014, the parties notified me that they agreed to waive an in-person hearing and have me decide this case based on their written submissions and documentary evidence. On June 4, 2014, I issued an order scheduling final briefing based on the parties' agreement. I also admitted CMS Exhibits (Exs.) 1-81 and Petitioner's exhibits (P. Exs.) 1-35 into the record because there were no objections from either party. CMS filed a response to Petitioner's prehearing brief (CMS Br.), and Petitioner filed a responsive brief (P. Br.). Each party then filed replies (CMS Reply and P. Reply). With its response, Petitioner asked for leave to submit and, in fact, submitted additional documents in reply to CMS's arguments. Petitioner claimed that CMS created new allegations in its response brief and that it was filing the additional documents to address the modified allegations. CMS denied that it changed its arguments and created new allegations; it also objected to Petitioner's request for leave to file additional exhibits. Petitioner submitted a sur-reply. Petitioner's additional exhibits consisted of: additional pages of 240 through 295 to P. Ex. 1; the addition of page 14 to P. Ex. 3; the addition of page 138 to P. Ex. 7; the addition of pages 62 through 72 to P. Ex. 10; the addition of page 4 to P. Ex. 15; and the addition of P. Ex. 36. Given that the parties have asked that I decide this case based on the written submissions and documentary exhibits, I will grant Petitioner's request for leave to file the additional documents and do not find their inclusion prejudices CMS. I therefore admit Petitioner's additional pages to the five exhibits and P. Ex. 36.

II. Issues Presented

1. Whether Petitioner was in substantial compliance with Medicare participation requirements;

2. Whether a basis exists for the imposition of remedies; and

3. Whether the per-instance CMP is reasonable.

III. Controlling Law

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

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 applicable regulations at 42 C.F.R. pt. 488 provide that 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. §§ 488.10-488.28. The regulations contain special survey conditions for long-term care facilities. 42 C.F.R. §§ 488.300-488.335. 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 regulations specify that if a CMP is imposed against a facility based on an instance of noncompliance, the CMP will be in the range of $1,000 to $10,000 per instance, whether or not the noncompliance constitutes immediate jeopardy. 42 C.F.R. § 488.438(a)(2). CMS may impose one or more enforcement remedies against a long-term care facility including civil money penalties and directed in-service training. 42 C.F.R. §§ 488.406, 488.408.

Sections 1819(f)(2)(B) and 1919(f)(2)(B) of the Act prohibit approval of a NATCEP if: within the last two years, the facility has been subject to, among other things, an extended or partial extended survey; imposition of a CMP of not less than $5,000; or imposition of a denial of payment for new admissions.

The Act and regulations make a hearing before an ALJ available to a long-term care facility against which CMS has determined to impose one or more enforcement remedies. Act §§ 1128A(c)(2), 1866(h); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *The Residence at Salem Woods*, DAB No. 2052 (2006); *Cal Turner Extended Care*, DAB No. 2030 (2006); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Anesthesiologists Affiliated*, DAB CR65 (1990), *aff'd,* 941 F.2d 678 (8th Cir. 1991). A facility has the right to appeal a certification of noncompliance leading to an enforcement remedy. 42 C.F.R. §§ 488.408(g)(1), 488.430(e), 498.3. However, the choice of remedies, or the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may challenge the scope and severity that CMS cites only if a successful challenge would affect the range of CMP amounts that CMS imposed or would affect the facility's NATCEP. 42 C.F.R. § 498.3(b)(14), (d)(10)(i). CMS's determination as to the scope and severity of non-compliance "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 Ctr.*, DAB No. 1726, at 9 (2000), *aff'd,* 363 F.3d 583 (6th Cir. 2003); *see, e.g., Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). ALJ review of a CMP is subject to 42 C.F.R. § 488.438(e).

The standard of proof or quantum of evidence required is a preponderance of the evidence. CMS has the burden of coming forward with evidence and making a *prima facie* showing of a basis for imposition of an enforcement remedy. Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense. *Batavia Nursing & Convalescent Inn,* DAB No. 1911 (2004); *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Center v. Thompson,* 129 F. App'x 181 (6th Cir. 2005); *Emerald Oaks,* DAB No 1800; *Cross Creek Health Care Ctr.*, DAB No. 1665 (1998); *Hillman Rehab. Ctr.*, DAB No. 1611 (1997), *aff'd, Hillman Rehab. Ctr. v. United States*, No. 98-3789 (GEB), 1999 WL 34813783 (D.N.J. May 13, 1999).

IV. Findings of Fact and Conclusions of Law

1. Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h)(F-323) because it failed to provide adequate supervision and assistance devices to prevent accidents when it did not comprehensively reassess existing interventions, or consider reasonable interventions such as increased supervision, after Resident 6's repeated foreseeable falls.

The quality of care regulation set forth in 42 C.F.R. § 483.25 generally requires that a facility ensure each resident receives the necessary care and services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being in accordance with the resident's comprehensive assessment and plan of care. The regulation imposes specific obligations upon a facility related to accident hazards and accidents. It states in relevant part:

> (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.

42 C.F.R. § 483.25(h).

A facility must "take all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents." *Briarwood Nursing Ctr.*, DAB No. 2115 at 5 (2007); *Guardian Health Care Ctr.*, DAB No. 1943 at 18 (2004). The facility must anticipate what accidents might befall a resident and take steps to prevent them. A facility is permitted the flexibility to choose the methods it uses to prevent accidents, but the chosen methods

must constitute an "adequate" level of supervision under all the circumstances. *Windsor Health Care Ctr.*, DAB No. 1902 at 5 (2003).

The Statement of Deficiencies (SOD) states that based on observation, interview and record review, Petitioner did not meet this requirement because it failed to provide supervision and utilize assistance devices to prevent accidents. CMS Ex. 5 at 49-75 (Residents 6, 15, 17, 8, 36, 16 and 20); CMS Response to Petitioner's Pre-Hearing Brief at 18 n.3.[2] I only discuss, however, whether Petitioner provided adequate supervision and assistance devices to Resident 6 in order to prevent accidents as required by 42 C.F.R. § 483.25(h) because finding that Petitioner failed to provide the care required to Resident 6 under this requirement is sufficient to support the imposition of the relatively low CMP.

Resident 6

Resident 6, a 70 year-old male, was admitted to the facility on December 29, 2005, with diagnoses of, among other things, dementia, diabetes, abnormality of gait, lack of coordination, transient cerebral ischemia, and adult failure to thrive. CMS Ex. 16 at 3, 4; P. Ex. 1 at 1.

Petitioner documented that Resident 6 had at least five unwitnessed falls during the period of May 28, 2013 through July 30, 2013: on May 28, 2013, when he was found in his room with the wheelchair flipped over backwards behind him; on June 13, 2013, when he fell out of his chair trying to get into bed (he was "still halfway in wheelchair but one knee did hit the ground"); July 8, 2013, when he "slipped out from under his soft belt and was sitting in this floor"); on July 25, 2013, when he was found sitting on the floor in front of his wheelchair next to the bed with his knees to chest and leaning back against the locked wheelchair; and on July 30, 2013, when he was found lying in his room on the ground facing up. CMS Ex. 16 at 24, 26, 28, 49 and 47.

Resident 6's Care Plan dated May 29, 2013, indicated he had multiple falls because he does not use the call light and he gets up out of bed and out of his wheelchair without assistance. The interventions for addressing his falls were to check on him frequently; encourage him to attend activities to keep him occupied and "not wanting to stay in bed"; encourage him to use the call light; keep his physician and responsible party aware of his status; and use a fall mat beside his bed. CMS Ex. 16 at 104. The care plan also indicated that Resident 6 had a need for a soft belt restraint while in his wheelchair due to progressing dementia because he does not understand that he cannot stand without

[2] In its prehearing brief, CMS mistakenly identified Petitioner as being noncompliant with respect to Residents 14 and 18 under Tag F323 too. CMS included those two residents as well when it withdrew noncompliance findings under F323 for Residents 15 and 17.

assistance. The interventions for the use of the belt included: to check on the resident every hour; to release his belt and reposition him every two hours for 10 minutes; provide exercises to maintain range of motion; check with resident frequently to ascertain needs; explain procedure to resident and family to discuss possible alternatives; keep call light and most frequently used personal items within reach; and keep resident's family involved in his care plan. CMS Ex. 16 at 112. His care plan also stated Resident 6's fall risk is high and provides for interventions that Petitioner should: check on him frequently while in bed; continue to monitor incidents and update his fall risk factors every 3 months; not leave him unattended on gurney or shower chair; not leave spilled liquids on floor; ensure he wears nonskid socks or shoes; keep the call light and frequently used items within reach; keep his wheelchair in close proximity to his bed; lower his bed to lowest level to decrease distance of a potential fall; have one staff assist for transfers; and staff is to assist the resident with sitting. CMS Ex. 16 at 119. Petitioner assessed Resident 6 as needing assistance from one person when transferring, when walking in his room, and when moving in his wheelchair within his room and around the facility. CMS Ex. 16 at 194. Staff assessed him as being unsteady when he tried to move from a seated to standing position and only able to stabilize himself with the assistance of staff. CMS Ex. 16 at 195.

After his fall on May 28, 2013, the Restraint Reduction Committee evaluation found that Resident 6 knows to call for help but he wants to transfer himself because of "a need for self-proof of independence or strength." P. Ex. 1 at 66. The Committee noted that previous attempts with a lap buddy failed because Resident 6 refuses it. *Id.* Resident 6 also refuses chair/bed alarms, and physical therapy for strengthening. *Id.* The Committee stated that Resident 6 "knows how to take off the soft belt" and "wants it." After consulting with the physician, family and resident, the Committee recommended to continue using the soft belt with the following interventions: to observe Resident after lunch because he attempts to go to bed after lunch; to encourage activities after lunch; encourage him to stay in open areas; and to encourage him to ask for assistance. *Id.*

After his fall on June 13, 2013, the Restraint Reduction Committee again reviewed his fall. P. Ex. 1 at 64. He apparently fell while trying to transfer himself in the afternoon. *Id.* He had been in an open area after lunch and then went to his room. The Committee noted that staff tried to assist him but he refused. *Id.* Later on rounds, he was found "slipping to one knee to floor trying to transfer" himself to bed. His soft belt was untied and off. *Id.*. The Committee again recommended that the soft belt be continued as he refuses other devices; to continue to encourage him to visit in open areas; to increase his activities especially after lunch and dinner; and to continue to offer to assist him. *Id.*

The Restraint Reduction Committee reviewed Resident 6's fall on July 8, 2013. P. Ex. 1 at 61. Again the fall apparently occurred when Resident 6 returned to his room after lunch and tried to transfer by himself from his wheelchair. *Id.* The Committee noted that the resident continues to refuse therapy and to refuse a "lap buddy." *Id.* The Committee

opined that over the last two months the care plan and recommendations appear to be working because Resident 6 lets staff assist him more often than not. *Id.* The Committee together with the family, physician, and resident agreed to continue with the current care plan and the soft belt because it does not agitate him like the alarm. Further, Resident 6 stated the lap buddy is like a high chair, and he is not a baby. *Id.* The Committee further noted the resident could remove the soft belt, he had been without serious injury, and he requested and preferred the soft belt reminder. *Id.*

Although Resident 6 had a fall on July 25, 2013, there are no Restraint Reduction Committee notes regarding this fall. However, there are notes from the Committee concerning his July 30, 2013 fall. P. Ex. 1 at 57. The Committee noted that the resident had a fall without injury while trying to transfer by himself. The Committee again opined that reminders to the resident have been successful because he has been letting staff assist him for the most part. *Id.* He continued to be able to remove his soft belt without problems, and the resident, family and Committee continued to prefer using the soft belt while he was in his wheelchair. *Id.* It further noted that Therapy evaluated Resident 6 but he refused further physical therapy and that the fall mat is continued to be placed by his bed. *Id.* The Restraint Reduction Committee therefore recommended that staff continue to: observe the resident; encourage the resident to attend activities after meals; encourage resident to ask staff for assistance; and encourage resident to visit at the nurses' station. *Id.*

Resident 6's physician testified that Petitioner informed him that Resident 6 "occasionally removed the soft belt and tried to transfer on his own, which resulted in falls. This usually happened one to two times a month, but the belt was successful in reminding him to seek assistance the remainder and majority of the time." P. Ex. 29 at 1-2; P. Br. at 4.

Considering Petitioner's responsive actions and his physician's testimony, I find Petitioner, knowing that Resident 6 was a repeated fall risk, did not take all reasonable steps to prevent his falls, and its chosen methods were not adequate to provide the level of supervision or assistance under all circumstances. Resident 6's repeated falls within such a short time period demonstrate that the intended supervision and interventions in Resident 6's care plan were either not adequate or not adequately implemented in violation of the regulatory requirement. Moreover, the record does not show that Petitioner even tried to review Resident 6's care plan or tried to implement any new interventions to address his repeated falls. A comparison of his care plan dated May 29, 2013 with his care plan dated August 14, 2013, shows that no new interventions were planned or implemented prior to the survey to address these falls. CMS Ex. 16 at 104, 112, 119; P. Ex, 1 at 35, 43, 47. As for the reports from the Restraint Reduction Committee after each of Resident 6's falls, they do not evaluate his falls and whether other interventions or assistance devices should be attempted. The Committee was only considering the narrow issue of whether the restraint, i.e., the soft belt, was still

warranted and appropriate under the circumstances. What is clear is that each of Resident 6's falls occurred in his room, usually after meals, when he attempted to transfer himself from his wheelchair to his bed. What is also clear is that Petitioner was well aware of this, knew that Resident 6 would remove the soft belt in order to transfer from his wheelchair, yet it did not try to attempt other interventions, perhaps one-on-one supervision after meals, more frequent checks on the resident when he is in his room, or to have a staff member accompany the resident to his room after meals and remain for a period of time to assist him. To continually allow the same foreseeable and dangerous resulting falls on multiple occasions without interdisciplinary reassessment or implementing increased supervision was not providing the requisite care for Resident 6. I conclude, therefore, that Petitioner was not in substantial compliance with the Medicare participation requirement at 42 C.F.R. § 483.25(h) because Petitioner did not provide Resident 6 with adequate supervision to prevent the foreseeable risk of harm from falls.

2. A basis exists for imposition of remedies against Petitioner.

Each of the remedies CMS imposed relied upon the issue of whether Petitioner was in substantial compliance with the requirements for accident prevention at 42 C.F.R. § 483.25(h) (F-323). Therefore, CMS had the authority to impose one or more of the enforcement remedies listed at 42 C.F.R. § 488.406, which include imposition of civil money penalties as well as directed in-service training here.

CMS solely based the per-instance CMP of $8,250 on Petitioner's failure to be in substantial compliance with the care requirement at F-323, and the loss of NATCEP must occur whenever a CMP of at least $5,000 is imposed. Thus, considering that Petitioner was not in substantial compliance with this care requirement, I need only determine if the evidence supports the per-instance CMP of $8,250, which I do conclude. *See* Act §1819(f)(2)(B)(iii)(I)(c) (42 U.S.C. §1395i-3(f)(2)(B)(iii)(I)(c)).

I do not review CMS's immediate jeopardy scope and severity finding here. An ALJ may review CMS's scope and severity findings (which include a finding of immediate jeopardy) only if: (1) a successful challenge would affect the range of the CMP; or (2) CMS has made a finding of substandard quality of care that results in the loss of approval of a facility's nurse aide training program. Here the penalties imposed are per-instance CMPs for which the regulations provide only one range ($1,000 to $10,000) so the level of noncompliance does not affect the range of the CMP. 42 C.F.R. § 488.438(a)(2). Additionally, CMS's scope and severity finding does not affect approval of a nurse aide training program because I uphold the assessment against the facility of a CMP of $5,000

or more which precludes state agency approval of a nurse aide training program. Act § 1819(f)(2)(B) (42 U.S.C. § 1395i-3); 42 C.F.R. § 483.151(b)(2)(iv).

3. The $8,250 per instance CMP is reasonable.

CMS must consider several factors when determining the amount of a CMP (factors an ALJ considers de novo when evaluating the reasonableness of the CMP that CMS imposed): (1) the facility's history of noncompliance; (2) the facility's financial condition, i.e., its ability to pay the CMP; (3) the severity and scope of the noncompliance, the "relationship of the one deficiency to other deficiencies resulting in noncompliance," and the facility's prior history of noncompliance; and (4) the facility's degree of culpability. 42 C.F.R. §§ 488.438(f), 488.404(b), (c). In addition, the "absence of culpability is not a mitigating circumstance in reducing the amount of the penalty." 42 C.F.R. § 488.438(f)(4).

The Board has repeatedly held that "an ALJ or the Board properly presumes that CMS considered the regulatory factors and that those factors support the amount imposed." *See, e.g., Pinecrest Nursing & Rehab. Ctr.*, DAB No. 2446, at 23 (2012). Thus, CMS did not need to present evidence regarding each regulatory factor. Instead, the burden was on Petitioner "'to demonstrate, through argument and the submission of evidence addressing the regulatory factors, that a reduction is necessary to make the CMP amount reasonable.'" *Id.* (quoting *Oaks of Mid City Nursing & Rehab. Ctr.*, DAB No. 2375, at 26-27 (2011)).

The $8,250 per-instance CMP imposed in this case is in the mid-to high level of the available per-instance CMPs which may range from $1,000 to $10,000 per instance. 42 C.F.R. § 488.408. It is nevertheless a relatively small penalty (as compared to the potential cumulative effects of a per-day CMP for a violation that could continue over an extended time period of the successive falls). The lack of supervision of this resident and the apparent tolerance of a certain number of falls per month handily support a per-instance CMP of $8,250. However, CMS recognized that Petitioner had no history of serious noncompliance and must have clearly mitigated the penalty by only imposing a per-instance CMP.

Also, Petitioner did not argue that its financial condition affects its ability to pay the penalty. Although Petitioner contends it was not culpable, I found the evidence suggests otherwise. Petitioner knew Resident 6 fell five times in a short period of time. It knew when the falls were likely and usually resulted when Resident 6 returned to his room after meals and tried to transfer himself from his wheelchair to bed. Yet Petitioner failed to try any other interventions or provide more supervision to Resident 6. Instead, Petitioner relied on the use of the soft belt to act as a reminder to the resident that he was not to transfer by himself. While that may have been useful in part, it should not have been the only method of supervision because it obviously did not work in all circumstances.

Further, the manufacturer for the soft belt restraint also recommended that a facility should monitor residents to ensure that they cannot slide down or pull the restraint over their head. CMS Ex. 63 at 2. Therefore, in light of the factors and circumstances here, I find that the per-instance CMP imposed is reasonable, and I believe would be reasonably commensurate to an effort to produce a corrective action of adequately increased supervision to stop repeated and foreseeable resident falls.

V. Conclusion

I conclude that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h); a basis exists for the imposition of a per-instance CMP, directed in-service training, loss of NATCEP; and the $8,250 per-instance CMP CMS imposed is reasonable.

/s/
Joseph Grow
Administrative Law Judge