Health Facilities Association of Maryland

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Preparation and Implementation of the New Survey Process Survey and Enforcement Issues

Howard L. Sollins
BakerOber Health Law Group
www.bakerdonelson.com
www.bakeroberhealthlaw.com

CMS Tools

CMS Frequently Asked Questions Related to Long Term Care Regulations, Survey Process, and Training

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html

CMS Tools
Long Term Care Survey Process (LTCSP) Procedure Guide *Effective November 28, 2017*

- The LTCSP is a resident-centered, outcome-oriented inspection that relies on a case-mix stratified sample of residents to gather information about the facility's compliance with participation requirements.

- The LTCSP steps are organized into seven parts: 1) offsite preparation; 2) facility entrance; 3) initial pool process; 4) sample selection; 5) investigation; 6) ongoing and other survey activities; and 7) potential citations.

Process Overview

- Day 1: Initial Pool Selection and Review
  - About 70% selected offsite
    - Based on MDS
    - Includes any complaints and facility-reported incidents
  - 30% selected onsite based on surveyor observations
    - Focus on newly admitted residents, vulnerable residents, and surveyor-identified concerns
  - 5 system-selected residents for Unnecessary Medication Review may or may not be part of sample
- Day 2: Sample Selection
  - Selection from initial pool
  - Based on resident interviews and limited record review
  - Focus on concerns identified during initial review
- Remainder of Survey: Investigation and Other Activities

OFFSITE PREP

- **Step 1: Create Survey shell in ASPEN Central Office (ACO)**
- **Step 2: Export shell from ACO**
- **Step 3: Import shell into ASPEN Survey Explorer (ASE-Q)**
- **Step 4: Add team members in ASE-Q (if not completed in ACO)**
- **Step 5: Access the survey**
- **Step 6: TC completes offsite prep screen**
- **Step 7: TC makes facility unit assignments**
- **Step 8: TC makes mandatory facility task assignments**
- **Step 9: TC prints documents**
- **Step 10: TC shares offsite prep data with team members**
- **Step 11: Team reviews offsite information**

II. FACILITY ENTRANCE

- **Step 12: Enter the facility and go to each surveyor's assigned area.**
- TC: Conduct a brief **Entrance Conference** (under Survey Preparation | Entrance Conference in the Navigation menu) and then go to your assigned area.
- Note: If this is an **off-hour survey**, complete Step 12 with the designated person in charge. Conduct a follow-up Entrance Conference with the administrator, as needed, upon his/her arrival at the facility

Initial Pool

- **Step 13: Screen all residents in your assigned area and observe, interview, and complete a limited record review for initial pool residents**
- 8 Residents per Surveyor
- Each surveyor's initial pool includes some residents who are *offsite selected* based on MDS indicators. Complaint or facility-reported incident (FRI) residents also may be identified offsite and up to five (across the survey team) may be included in the initial pool.
- Surveyors select other residents in the initial pool onsite based on a brief screening and review of resident-specific data. *Onsite surveyor selected* residents may include vulnerable residents; new admissions in the last 30 days; and residents with a significant concern who do not fall into any other subgroup.

- **Ask for** a **resident roster** for your assigned area with an indicator for the **new admissions** in last 30 days and then begin your initial pool process. The facility will provide a matrix for new admission residents and then a matrix for all other residents a few hours into the survey. Do not wait for the roster or matrices to begin screening residents.
- Surveyor will also ask for list of residents who smoke and designated smoking times

- Surveyors use the survey software to complete an interview (if possible), observation, and limited record review for each initial pool resident. Surveyors indicate concerns for further investigation as they complete these activities.

Sample Selection

- After completing all initial pool activities, survey team chooses residents from the initial pool to include in the sample
- Selection is based on concerns identified from the interview, observation, and/or limited record review, and consideration of resident-specific data.
- Expected sample size is based on facility census. At the start of the survey, the offsite selected residents chosen based on MDS indicators make up 70% of the expected sample size.
- Once onsite, surveyors do not need to consider maintaining a 70/30 split between offsite and onsite selected residents; the focus is on identifying residents for the initial pool and sample based on concerns.

- **Go room to room** without staff. Initial pool selection is based exclusively on surveyor identified information and is not reliant on staff input at this point.
- Remember that **offsite selected residents and complaint/FRI residents (as indicated by your TC) in your area are required to be in your initial pool**.
- You will **choose the onsite selected residents** to include based on your **screening and review of MDS indicators and matrix information when available**.

Option A:

- **Interview and observe initial pool residents when chosen as you screen**
  - Go room to room and briefly screen residents in each room and review their MDS indicators and matrix information (when available) to identify potential concerns. Immediately decide if a resident should be in your initial pool as an onsite selected resident. If so, conduct the observation and interview (if appropriate) for the resident at that time.
  - If you have included eight residents in your initial pool (including your offsite selected residents, complaint/FRI residents, and your onsite selected residents) before you have screened all residents, you must proceed with screening all remaining residents in your area and include any other appropriate residents in the initial pool. This may require exceeding eight residents or discussing the situation with the team to determine if other surveyors can add some of the residents on your unit into their initial pool.

Option B:

- **Interview and observe offsite selected and complaint/FRI residents first, screen all other residents, and return to interview and observe your initial pool onsite selected residents after all screening is complete**
  - Conduct interviews and observations for your offsite selected and complaint/FRI residents first. If other residents are in the room, screen those residents.
  - Then go room to room, briefly screen the other residents in each room and review their MDS indicators and matrix information (when available) to identify potential concerns.
  - When you have completed your first walk through and screened all residents, consider all of your screening information and decide which residents you will include in your initial pool as onsite selected.
  - Go back to conduct interviews and observations for the onsite selected residents you chose for your initial pool.

Option C:

- **Screen all residents, identify your initial pool, then return to conduct interviews and observations for all initial pool residents**
  - Go room to room. Screen and consider MDS indicators and matrix information for all residents in your area to help you decide which to choose as onsite selected residents in your initial pool. You likely will encounter the offsite selected and complaint/FRI residents in your area at this time and can briefly screen them (knowing they will be in your initial pool), but do not complete interviews and observations for these or any other residents during the first walk through.
  - When you have completed screening all residents, choose your eight initial pool residents. These will include your offsite selected residents, complaint/FRI residents, and onsite selected residents.
  - Go back to the rooms to conduct observations and interviews for all of your initial pool residents.

For **New Admissions** or **Vulnerable** residents

- When you identify these residents in your area, include them in your initial pool and conduct the observation, interview and limited record review unless your area has such a high number of new admissions (e.g., rehab unit) or vulnerable (e.g., Alzheimer's unit) residents that you must prioritize.

For residents with **Identified Concerns**:

- For residents who are not in any other subgroup (i.e., offsite selected, new admission, vulnerable, complaint or FRI), you are only required to briefly observe the resident for significant concerns (e.g., staff are ignoring a resident yelling out in pain; resident has facial bruising).

Assess the interview status of residents in your initial pool

- Mark one of the following in the **Interview status** field, regardless of the resident's BIMS score.
- Interviewable –Conduct a full resident interview.
- Non-interviewable – The resident is a candidate for a resident representative interview (RRI)/family interview.
- Refused - If the resident refuses, do not attempt to interview the resident again.
- Unavailable for Interview - If the resident is busy when you attempt an interview, make a few more attempts or try to schedule an appointment before marking this option, but still complete the resident observation (as you are observing the resident during each encounter) and limited record review.
- Out of Facility – If the resident is out of the facility for the duration of the initial pool process (dialysis), mark this option but still complete the limited record review.

Investigation, Other Survey Activities, and Potential Citations

- After sample selection, the team spends the rest of the survey investigating all concerns that required further investigation for every resident in the sample. Facility task and closed record investigations are also conducted (although dining is observed the first day). When investigations are complete, the team makes citation, severity, and scope decisions for every tag identified by each surveyor.

- **Conduct the full resident observation (RO)** for all residents in the initial pool.
- **Conduct resident representative interviews (RRI)/family interviews**.
- **Conduct a limited record review (RR) after** your interviews and observations are completed. Surveyors should continue to complete observations of the residents while working on resident record reviews by completing the RRs on the floor and not in the conference room.
- The majority of your time should be spent conducting interviews and observations, and limited time spent on record review.

- For any resident marked as non-interviewable, refused, or unavailable, review the record for the following information: **pressure ulcers, dialysis, infections, nutrition** (system can help calculate % weight loss)**, falls** in the last 120 days**, ADL decline** in the last 120 days**, low risk bladder and bowel (B&B), unplanned hospitalizations, elopement** and **change of condition** in the last 120 days**.**
- For any resident in the initial pool who is currently receiving **insulin, an anticoagulant, an antipsychotic with a diagnosis of Alzheimer's** or **dementia**, or has an appropriate diagnosis but is not receiving **PASARR Level II** services, review the record to confirm the information**.**
- For newly admitted residents in the initial pool who did not have an MDS, complete a review of the record to identify current **high risk meds** and **hospice**.

- At least one resident who **Smokes**, one resident who is receiving **Dialysis**, one resident on **Hospice,** one resident on a **Ventilator**, and one resident who is on **Transmission-Based Precautions** should be included in the initial pool for the team if available.

New Complaint

- If a **complaint is called into the State Agency and added to the survey during the initial pool process**, the team should discuss whether to include the complaint resident in the initial pool as long as the team hasn't included five complaint or FRI residents already.

Team and Sample Size

- The *Sample Size Grid and Recommended Team Size* shows the expected sample size and recommended survey team size according to facility census number. States have some flexibility around the recommended **survey team size**, but must adhere to the expected **total number of residents in the initial pool**.

IJ or Harm Deficiencies

- **If you identify a significant concern (IJ or harm)** during your observations, interviews or limited record review, select Harm or IJ in the **Include in sample due to** (under the interview status) to ensure the resident is included in the sample.
- Immediate jeopardy is defined as a situation in which the facility's failure to meet one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

- If one or more team members identifies possible immediate jeopardy, the team should meet immediately to confer.
- The guiding principles to determine immediate jeopardy and serious threat make it clear that the threat can be related to mental, as well as physical well-being, and that the situation in question need not be a widespread problem.
- If the team concurs, the team coordinator must consult immediately with his/her supervisor.

- If the supervisor concurs that the situation constitutes immediate jeopardy, the team coordinator informs the facility Administrator or designee that the immediate jeopardy termination procedures are being invoked. The team coordinator should explain the nature of the immediate jeopardy to the Administrator or designee. The survey team should complete the entire survey.

Dining Observation:

- Each surveyor will **observe the first scheduled FULL meal** using the Dining facility task pathway in the software.
- If feasible, observe the meal for your initial pool residents who have weight loss, food, or hydration concerns.

- **Step 14: Share data at the end of each day**
- **Step 15: End of Day 1 team meeting**

Substandard Quality of Care

- **If SQC is suspected** - expand the sample as necessary to determine scope and whether there is sufficient evidence to rule out SQC. If the evidence is not adequate and the number of observations only allowed for isolated scope when there is a severity level 3, or pattern for scope when there is a severity level 2, then expand the sample to include additional reviews of that requirement.

- **Step 16: Share Completed Initial Pool Data**
- **Step 17: Select the Sample**

- The residents included in the sample will have an in-depth investigation completed for any area of concern marked for further investigation.
- There may be some residents who had concerns from the initial pool who are not included in the sample. The team should ensure that their concerns will be covered by other sampled residents.
- The sample should include only active residents. Closed records are not included in the total sample number.

- Do not identify residents or family members/representatives who provided information through interviews (e.g., about injuries due to broken equipment, prolonged use of restraints, and opened mail) without their permission. If expanding the sample determines that SQC does not exist, no extended survey will be conducted.

The system selected residents include:

- Any offsite selected resident who had at least one care area marked as further investigation.
- Any resident that a surveyor marked as Include in Sample (i.e., harm or IJ), which is displayed under the Sample Reason column.
- Any identified abuse concern from the initial pool process or the facility has a history of abuse citations or allegations since the last survey (abuse is now a care area, not a triggered task). If abuse is being investigated based exclusively on a facility history of abuse (refer to Offsite Prep screen), ask the facility for all allegations of abuse since the last survey so you can select at least one resident to review (different from residents reviewed in the past).

If the sample size is not met,

- **Consider the criteria below to include more residents in the sample**:
  - Residents with the most concerns
  - Residents with concerns related to QOL and resident rights
  - Residents who were selected for the Unnecessary Medication review but are not a part of the sample. They will have a Yes indicated in the Unnecessary Medication column but won't have any surveyor assigned to the resident. To include the resident, in the Sample column, select the resident's name.
  - Prior survey and complaint results
  - Unrepresented area(s) of the building

- **Finalize the selection of residents for the three closed record reviews** (death, hospitalization and community discharge)

V. INVESTIGATION

- **Step 18: Conduct investigations for sampled residents**
- There are **two ways to conduct your investigation**:

Investigation By Resident – you can access all of the care areas being investigated for that resident.

Investigation By Care Area – you can access all of your residents being investigated for that care area.

- Observe and interview staff to determine whether they consistently implement the care plan over time and across various shifts.
- During observations of the interventions, note and follow up on deviations from the care plan as well as potential negative outcomes.
- Observe care (e.g., AM care, wound care, restorative, incontinence care, transfers) if warranted for the investigation.
- If concerns are identified with areas such as pressure ulcers and incontinence, complete continuous observations to adequately determine whether appropriate care and services are provided in accordance with the care plan.
- If a non-interviewable resident has a representative or family who visits often, make an effort to interview the representative/family just like you would interview the resident, as part of your investigation.

Facility Wide Assessment

- The facility must conduct a **facility wide assessment** to determine what resources are needed to competently care for residents each day and during emergencies. If systemic concerns are identified in resident-specific areas (e.g., hospice, dialysis, ventilators, activities, nutrition, behavioral/emotional, dementia) or if there is a systemic concern with a lack of adequate resources (e.g., specialized rehabilitation, pharmacy), review the facility assessment.

VI. ONGOING AND OTHER SURVEY ACTIVITIES

- **Step 19: Complete closed record reviews**
- **Step 20: Complete facility task assignments**
- **Dining**
- **Infection Control**
- **SNF Beneficiary Protection Notification Review**
- **Kitchen**

- **Med Admin**
- We highly recommend that nurses and pharmacists conduct this task.
- If the opportunity presents itself, observe meds for a sampled resident whose med regimen is being reviewed. Otherwise, observe meds for any resident to whom the nurse is ready to administer meds.
- Observe different routes, units and shifts.
- Observe 25 medication opportunities, including whether the administered med is expired.

- **Med Storage**
- Any surveyor can complete the med storage task.
- Review half of the med storage rooms, covering different units.
- Review half of the med carts on units where the storage room was not observed.

Sufficient and Competent Nurse Staffing

- Throughout the survey, all surveyors are considering whether concerns with staffing can be linked to resident complaints, or quality of life and care concerns.
- The surveyor assigned primary responsibility for the task should coordinate the review of the availability of licensed nursing staff to provide and monitor the delivery of care.

Triggered Tasks

- Only completed if the survey team has concerns:
- **Personal Funds** Complete this review when there are identified concerns with sampled residents not having access to funds or not receiving a quarterly statement.
- **Environment** Complete an environmental review only if there are concerns identified with sampled residents. Review the specific concerns the team has with the environment. Note: it may not be necessary complete a review of the entire environment. Do not complete a review of oxygen storage, the generator, or disaster and emergency preparedness as these areas are reviewed by life safety.
- **Resident Assessment** Complete this review if there were concerns with 1) a delay with the completion and/or submission of MDS assessments; and/or 2) MDS discrepancies for care areas that weren't marked for further investigation.

Step 21: End of the day meeting

- Each team member **shares their data with the TC**
- **Meet for 30 to 45 minutes at the end of each day** Are there newly identified harm or IJ concerns (system populates only if severity 3 or 4 is marked)?
- Have at least three resident representative interviews been completed?
- If **the team determines IJ or SQC** at any point during the survey, the extended survey should be completed. If the team plans to complete the extended during the survey, go to Investigations | Facility Tasks from the Navigation menu and assign the surveyor(s) who will investigate the extended.

Step 22: Complete QAA/QAPI

This facility task should take place at the **end of the survey**.

- Prior to interviewing the facility staff about the QAA program, **review** the Facility Rates for MDS Indicators, prior survey history, FRIs, and complaints.
- Review the **QAPI plan**.
- During team meetings, ensure you have a list of concerns the facility should be aware of (e.g., harm or IJ, pattern or widespread issues, or concerns identified by two or more surveyors).

VII. POTENTIAL CITATIONS

- **Step 23: Deficiency determination as a team**
  - There will be a consolidated list of potential citations
  - The TC should then share the consolidated list of potential citations with the team
  - The **team makes a compliance and scope and severity** determination for individual potential deficiencies.

Scope and Severity

- To **cite a tag**, select the tag, place a checkmark next to each resident who should be included in the citation, mark Cite and include the final severity and scope.
- When determining scope and severity refer to the scope and severity grid and the psychosocial outcome severity guide.

- After determining the severity level of a deficient practice, determine scope. When determining scope, evaluate the cause of the deficiency. If the facility lacks a system/policy (or has an inadequate system) to meet the requirements and this failure has the potential to affect a large number of residents in the facility, then the deficient practice is likely to be widespread. If an adequate system/policy is in place but is being inadequately implemented in certain instances, or if there is an inadequate system with the potential to impact only a subset of the facility's population, then the deficient practice is likely to be pattern. If the deficiency affects or has the potential to affect one or a very limited number of residents, then the scope is isolated.

- If the evidence gathered during the survey for particular requirement includes examples of various severity or scope levels, surveyors should generally classify the deficiency at the highest level of severity, even if most of the evidence corresponds to a lower severity level. For example, if there is a deficiency in which one resident suffered a severity 3 while there were widespread findings of the same deficiency at severity 2, then the deficiency would be generally classified as severity 3, isolated.

Step 24: Exit Conference with Facility

- Conduct an exit conference with the facility administration/leadership to inform the facility of the survey team's observations and preliminary findings.
- Invite the ombudsman and an officer of the organized residents group, if one exists, to the exit conference. Also, invite one or two residents to attend. The team may provide an abbreviated exit conference specifically for residents after completion of the normal facility exit conference. If two exit conferences are held, notify the ombudsman and invite the ombudsman to attend either or both conferences

Past Noncompliance

- Past noncompliance may be identified during any survey of a nursing home. When a citation of past noncompliance is written, a nursing home does not provide a plan of correction as the deficiency is already corrected; however, the survey team documents the facility's corrective actions on Form CMS-2567. To cite past noncompliance with a specific survey data tag (F-tag or K-tag), all of the following three criteria must be met:
- The facility was not in compliance with the specific regulatory requirement(s) at the time the situation occurred;
- The noncompliance occurred after the exit date of the last standard survey and before the survey currently being conducted; and
- There is sufficient evidence that the facility corrected the noncompliance and is in substantial compliance at the time of the current survey for the specific regulatory requirement(s).

- Do not discuss survey results in a manner that reveals the identity of an individual resident. Provide information in a manner that is understandable to those present, e.g., say the deficiency "relates to development of pressure ulcers," not "Tag F686."
- Describe the team's preliminary deficiency findings to the facility and let them know they will receive a report of the survey which will contain any deficiencies that have been cited (Form CMS-2567).

- If an extended survey is required and the survey team cannot complete all or part of the extended survey prior to the exit conference, inform the Administrator that the deficiencies, as discussed in the conference, may be amended upon completion of the extended survey.
- During the exit conference, provide the facility with the opportunity to discuss and supply additional information that they believe is pertinent to the identified findings. Because of the ongoing dialogue between surveyors and facility staff during the survey, there should be few instances where the facility is not aware of surveyor concerns or has not had an opportunity to present additional information prior to the exit conference.
- If your state provides the sample list during the exit, click the Reports icon; select the “Sample List Provided to Facility” report; click **Run Reports** and then send the report in a secure method electronically OR print the report. States may also elect to send the Sample List with the CMS-2567.

Enforcement Delays: S&C 18-04-NH

- 18-month moratorium on certain enforcement remedies
  - Moratorium on imposition of CMPs, discretionary DPNAs, and discretionary terminations for affected Phase 2 F-tags
  - Does not affect mandatory remedies
    - 90-day DPNAs
    - 180-day terminations
    - 23-day terminations for unabated IJs
  - Does NOT apply to Phase 1 F-tags

Enforcement Delays: S&C 18-04-NH

- A survey with both Phase 1 and Phase 2 F-tags cited may still be subject to CMPs and discretionary DPNAs/terminations for the Phase 1 F-tags only
- If the same conduct leads to both Phase 1 and Phase 2 tags, CMPs and other remedies are still on the table for the Phase 1 tags
- Other remedies available for Phase 2 F-tags
  - Directed Plan of Correction
  - Directed In-Service Training

Enforcement Delays: S&C 18-04-NH

- Affected Phase 2 F-tags
  - F655 (baseline care plan)
  - F740 (behavioral health services)
  - F741 (sufficient staffing—behavioral health)
  - F758 (psychotropic medications—PRN limitations)
  - F838 (facility assessment)
  - F881 (antibiotic stewardship)
  - F865 (QAPI plan development)
  - F926 (smoking policies)
- Moratorium does NOT apply to F608 (reporting of a reasonable suspicion of a crime)

Enforcement Delays: S&C 18-04-NH

- One-year freeze of 5-Star Ratings
  - Applies for **health inspections** conducted on or after Nov. 28, 2017
  - Ratings may still change to reflect survey cycles still open or under appeal/IDR prior to the freeze
  - Other data (staffing, quality measures) will not be affected by the freeze
  - After the freeze is lifted, survey findings <u>will</u> be incorporated into 5-star rating

Latest CMP Guidance

- S&C 17-37-NH, July 2017
- Revisions to CMP Tool: When noncompliance exists, enforcement remedies, such as civil money penalties (CMPs), are intended to promote a swift return to substantial compliance for a sustained period of time, preventing future noncompliance.
- To increase national consistency in imposing CMPs, the Centers for Medicare & Medicaid Services (CMS) is revising the CMP analytic tool in the following areas which are further explained within this policy memorandum:
  - Past Noncompliance;
  - Per Instance CMP is the Default for Noncompliance Existed Before the Survey;
  - Per Day CMP is the Default for Noncompliance Existing During the Survey and Beyond;
  - Revisit Timing; and
  - Review of High CMPs.
- This policy memo replaces S&C Memo 15-16-NH: The prior versions of the CMP Tool are obsolete, as of the effective date of this memo, July 17, 2017

Responding to a Survey: Exit Conference

- According to CMS, the exit conference is a courtesy to allow facilities to plan ahead, but not required
- An Exit Conference is not always guaranteed, as is noted in section 2724 of the SOM.
- Provides an opportunity to exchange information
- Findings are preliminary—they may change pursuant to the State and CMS supervisory review processes.
- Surveyors may identify F-tags if asked, but will not provide scope and severity information
  - IJ will be identified, but not whether J/K/L
  - May provide information on general seriousness

Know when to ask--

- Per CMS, for SNF/NF surveys, if the provider asks for the specific regulatory basis or the specific tag code, the surveyors should generally provide this information (except as noted below), but must always caution the facility that such coding classifications are preliminary and are provided only to help the provider gain more insight into the issues through the interpretive guidance.
- If the facility does not specifically ask for the regulatory basis or tag, the survey team may use its own judgment in determining whether this additional information would provide additional insight for the facility.

- At the exit conference, the team may still be deliberating.
- The team may believe that additional consultation should occur with other State personnel (e.g., a pharmacist) before a specific tag number is assigned to the deficiency finding. In these cases, the survey team should describe the general area of non-compliance without identifying a specific tag code.
- This is a judgment to be made by the survey team onsite, so in preparation for the exit conference the team should deliberate as to the degree of detail that will be appropriate.

- Under no circumstances, however, would the surveyors provide the Scope and Severity of a given deficiency finding (unless it is an immediate jeopardy), pending supervisory review.
- Survey teams may describe the general seriousness (e.g., harm) or urgency that, in the preliminary view of the survey team, a particular deficiency may pose to the well-being of residents.
- If a provider asks whether the noncompliance is isolated, pattern, or widespread, the surveyor should respond with the facts (i.e., noncompliance was found affecting X number of residents).

Responding to a Survey: After the Survey Ends

- Look for your Notice of Deficiencies—even on weekends; track the agency's obligation to deliver the statement of deficiencies within 10 days of the end of the survey. Is the end of the survey extended past the exit conference due to the exchange of additional information?
  - DATE STAMP
- Notice of Deficiencies
  - Substandard Quality of Care identified?
  - NATCEP terminated? Does your facility need to appeal the loss of the training program? Qualify to seek a waiver?
  - Recommended federal remedies
  - State CMPs
    - due dates
    - dates for appeal/waiver of appeal

Responding to a Survey: After the Survey Ends

- Calendar your deadlines
  - Plan of correction due (based on receipt of Notice)
  - Informal Dispute Resolution due (based on receipt of Notice)
  - 45^{th}/90^{th}/180^{th} day (based on exit date)
- Statement of Deficiencies (2567)
  - Any repeat deficiencies identified?
  - F/with SSQ or G or above?

Responding to a Survey: Plan of Correction

- Plan of correction
  - Effectiveness
  - Sustainability
  - Accountability
- Five elements
  - How will you correct the deficiency for the specific residents identified?
  - How will you identify other residents with the potential to be affected?
  - What measures will you put into place to ensure the deficiency does not recur?
  - How will you monitor your corrective efforts?
  - When will corrective action be complete?

Responding to a Survey: Plans of Correction

- Deficient plans of correction
  - Deficiencies are being cited for failures to comply with prior Plans of Correction so deficiencies are not fixed.
  - Plans of correction are being rejected for failure to be complete and responsive
  - Can occur multiple times, even for lower deficiencies.
  - Can result in a Directed Plan of Correction
  - Can result in an additional CMP
  - Can result in sufficient delay that a DPNA results

Responding to a Survey: Plan of Correction

- Identify clear targets and end dates for intensive monitoring efforts
- Who is responsible for ensuring corrections occur?
  - "All medication orders will be reviewed" (All of them? Forever?)
  - "Ten charts will be audited weekly" (Whose charts? For how long?)
- Set realistic goals—you will be held to them
- Don't be antagonistic
- Identify a realistic compliance da

Responding to a Survey:
Date of Substantial Compliance

- KEY DATE: What is the date OHCQ and CMS agree is the date when substantial compliance was demonstrated. Can be earlier than the revisit date.
  - See CMS State Operations Manual, chart at Section 7317.2
  - Examples of acceptable evidence may include, but are not limited to:
    - An invoice or receipt verifying purchases, repairs, etc.
    - Sign-in sheets verifying attendance of staff at in-services training.
    - Interviews with more than 1 training participant about training.
    - Contact with resident council, e.g., when dignity issues are involved.
- This is a significant issue when an IJ is cited, determined to be abated, but substantial compliance is not found to exist until a revisit occurs.
- May need an IDR to challenge the date substantial compliance is considered demonstrated.

When an IJ is identified

- Bear in mind that CMPs are presently considered mandatory.
- If per diem, lower CMPs will continue to be imposed after abatement, up until substantial compliance

Responding to a Survey: Informal Dispute Resolution

- When is it appropriate to think about IDR?
  - After a self-report
  - When deficiencies are identified during survey or exit conference
  - Immediately on receipt of the survey report
- Who should be involved?
  - Facility leadership
  - Consider: is outside expertise needed?
  - Consult staff with relevant factual information
- Important: the POC process is separate—don't neglect it

Responding to a Survey: Informal Dispute Resolution

- Develop a clear, focused IDR
- Based on the survey report and well-supported with documentation
- Possible topics for IDR:
  - Refuting deficiency?
  - Refuting scope and severity?
  - Refuting date when the deficiency arose?
  - Refuting the date when an IJ was abated?
  - Refuting the date when substantial compliance was achieved?
  - Refusing the absence of a past noncompliance finding?

Responding to a Survey: After the IDR/POC

- Has your plan of correction been accepted?
- Are you implementing your plan of correction as promised?
- Will resurvey be required? If so, are you prepared?
  - Keep tracking deadlines!
  - Implications of repeat deficiencies on resurvey
  - Look out for DPNA notice—15 days before 90th day
- Keep an eye out for imposition of federal remedies from CMS

Responding to a Survey: Penalties from CMS

- CMS will impose federal remedies separate from state Notice of Deficiencies
  - DATE STAMP
- CMP increased substantially on February 3, 2017
- Key Questions
  - Per diem or per instance CMPs?
  - Duration of CMPs?
    - IJ vs. non-IJ CMPs
    - Start date of deficiency (per diem)
- Other remedies imposed? Starts NEW calendar
  - If no IDR or state IDR process complete: 10 days to submit IIDR
  - 60 days to EITHER waive appeal for 35% discount or file DAB appeal

Responding to a Survey: Independent Informal Dispute Resolution

- When is IIDR available?
  - Applicable when federal remedies are imposed
  - If the state IDR process is still pending, IIDR is *not* available
  - If the state IDR process is complete, remaining deficiencies may be IIDRed
- IDR vs. IIDR
  - Two separate processes
  - Largely the same issues raised
  - IDR: usually the state (some states contract out)
  - IIDR: independent contractor (some states use other states)
  - CMS Regional Office has the final say on <u>both</u>

Responding to a Survey: Financial Hardship/Payment Plan

- Plan in advance
- 15 day deadline
- Who owes the CMP? Are there special arrangements such as the use of an IGT/UPL program that makes another entity the provider?
- Be prepared to promptly provide the information requested, including from related organizations as required
- Be prepared to include other helpful information demonstrating why funds are not readily available to pay the CMP in relation to capital and operating funds, improvements to the facility, resident care needs, and impact
- Be mindful of the additional requirement for a declination of a loan to obtain a payment plan for longer than one year
- Be mindful of the federal interest rate that would be applied

Issues in Life Safety Code Surveys: Waivers

- Does the facility need a categorical waiver?
  - CMS identified certain federal LSC requirements for which a categorical waiver is available to a provider without the need to apply specifically to CMS, nor does the facility need to wait to be cited for a deficiency to seek a waiver.
  - CMS determined that the 2000 edition of the NPFA LSC may result in unreasonable hardship for providers or suppliers for which an adequate alternative level of protection can be demonstrated.
- Waiver requirements
  - Documentation on hand
  - Notify surveyor and provide documentation

Issues in Life Safety Code Surveys: Waivers

- Do not assume that historical LSC waivers that are not “categorical waivers” are automatic
- Take each one seriously, demonstrating why they should be continued and do not adversely affect residents
- Closer review of fire safety waivers
  - Use of Fire Safety Evaluation System method to demonstrate substantial compliance

Ending the Survey Cycle

- When are you done?
  - Single survey track: achieve substantial compliance
  - Combined survey track: achieve substantial compliance in both surveys
- Ask questions!
  - Complaint survey during cycle: ask whether part of same survey cycle or different cycle
- Date of substantial compliance
  - May be before revisit if evidence of compliance provided
  - Key for IJ in particular

Focus on Past Noncompliance

- What is past noncompliance?
  - Facility not in compliance at the time the survey occurred
  - Incident occurred after the exit date of the last standard survey and before the current survey began
  - Noncompliance corrected and facility in substantial compliance at time of current survey
- Importance of past noncompliance
  - Closes survey cycle
  - No plan of correction required
  - Limits time frame of potential CMPs
  - Lowers impact on 5-star ranking

Past Noncompliance vs. CMP reductions for Self Correction: 42 CFR, Section 488.438(c)(2)

- CMS can determine to reduce the amount of the penalty by 50 percent, provided that all of the following apply -
  - (i) The facility self-reported the noncompliance to CMS or the State before it was identified by CMS or the State and before it was reported to CMS or the State by means of a complaint lodged by a person other than an official representative of the nursing home;

- (ii) Correction of the self-reported noncompliance occurred on whichever of the following occurs first:
  - (A) 15 calendar days from the date of the circumstance or incident that later resulted in a finding of noncompliance; or
  - (B) 10 calendar days from the date the civil money penalty was imposed;
- (iii) The facility waives its right to a hearing under § 488.436;
- (iv) The noncompliance that was self-reported and corrected did not constitute a pattern of harm, widespread harm, immediate jeopardy, or result in the death of a resident;

  - (v) The civil money penalty was not imposed for a repeated deficiency, as defined in paragraph (d)(3) of this section, that was the basis of a civil money penalty that previously received a reduction under this section; and
  - (vi) The facility has met mandatory reporting requirements for the incident or circumstance upon which the civil money penalty is based, as required by Federal and State law.
- Under no circumstances will a facility receive both the 50 percent civil money penalty reduction for self-reporting and correcting under this section and the 35 percent civil money penalty reduction for waiving its right to a hearing under § 488.436.

Implications of the Survey Cycle

- Potential for massive financial consequences
  - Per diem CMPs for extremely long periods of time at high rates
  - Substantial increases in actual harm and immediate jeopardy-level citations
  - Citation history affects CMP level
- All eyes on quality
  - Nursing Home Compare
  - CMS bundled payment programs: tied to star rankings
  - Value-based purchasing programs
  - Hospital discharge planning: proposed rule requires quality information be provided
- Potential for scrutiny by MFCU, OIG

Questions?