After the Survey
After the Survey - *This section is designed to help you write an effective Plan of Correction and how to prepare the documentation needed to be ready for re-visit. You can find out how other licensed Missouri long-term care facilities did on their last inspection and how they wrote their plan at [http://health.mo.gov/safety/showmelongtermcare/](http://health.mo.gov/safety/showmelongtermcare/).*

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*Updated June 2018*
Transmittals for Appendix Q

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  483(b) Requirements: Abuse
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PREAMBLE

Changes made to Appendix Q – Guidelines for Determining Immediate Jeopardy, reflect CMS’ concern that crisis situations in which the health and safety of individuals are at risk, are accurately identified, thoroughly investigated and resolved as quickly as possible. In the interest of consistency, the new Guidelines standardize the definitions of Immediate Jeopardy, abuse and neglect across all certified Medicare/Medicaid entities (excluding CLIA), and describe the process surveyors use in making a determination of Immediate Jeopardy. The Guidelines provide a detailed analysis of the steps surveyors should follow to assist them in accurately identifying those circumstances which constitute Immediate Jeopardy: preparation, investigation, decision-making and implementation. “Triggers” alert surveyors that some circumstances may have the potential to be identified as Immediate Jeopardy situations and therefore require further investigation before any determination is made. A detailed review of three sample cases “walk” surveyors through the steps necessary to carefully analyze and accurately determine whether or not an Immediate Jeopardy situation exists. To provide further guidance to surveyors, Attachment B uses actual examples of situations in which Immediate Jeopardy has been cited.

In the interest of reducing or eliminating abuse and neglect to all beneficiaries, the Guidelines caution surveyors that when abuse or neglect has been identified, the circumstances must be thoroughly evaluated to determine if Immediate Jeopardy exists.

The Guidelines also clarify that actual harm, as well as the potential for harm, to one or to more than one individual may constitute Immediate Jeopardy.

I - Introduction

Immediate Jeopardy is interpreted as a crisis situation in which the health and safety of individual(s) are at risk (see SOM §3010). These guidelines are for use in determining if circumstances pose an Immediate Jeopardy to an individual’s health and safety. These guidelines will assist Federal and State Survey and Certification personnel and Complaint Investigators in recognizing situations that may cause or permit Immediate Jeopardy.

These guidelines apply to all certified Medicare/Medicaid entities (excluding CLIA) and to all types of surveys and investigations: certifications, recertifications, revisits, and complaint investigations. In these guidelines, “entity” applies to all Medicare/Medicaid certified providers, suppliers, and facilities. “Surveyor” represents both surveyors and complaint investigators. “Team” represents either a single surveyor or multiple surveyors. The term “Immediate Jeopardy” replaces the terms “Immediate and Serious Threat” and “Serious and Immediate Threat” for all certified Medicare/Medicaid entities.

NOTE: The primary goals of these Immediate Jeopardy guidelines are to identify and to prevent serious injury, harm, impairment, or death.
II - Definitions

The following definitions apply to all certified Medicare/Medicaid entities:

**Immediate Jeopardy** - “A situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.” (See 42 CFR Part 489.3.)

**Abuse** - “The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.” (See 42 CFR Part 488.301.)

**Neglect** - “Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.” (See 42 CFR Part 488.301.)

III - Principles

The goal of the survey process is to ensure the provision of quality care to all individuals receiving care or services from a certified Medicare/Medicaid entity. The identification and removal of Immediate Jeopardy, either psychological or physical, are essential to prevent serious harm, injury, impairment, or death for individuals.

- Only **ONE INDIVIDUAL** needs to be at risk. Identification of Immediate Jeopardy for one individual will prevent risk to other individuals in similar situations.

- **Serious harm, injury, impairment, or death** does NOT have to occur before considering Immediate Jeopardy. The high potential for these outcomes to occur in the very near future also constitutes Immediate Jeopardy.

- Individuals must not be subjected to abuse by **anyone** including, but not limited to, entity staff, consultants or volunteers, family members or visitors.

- Serious harm can result from both abuse and neglect.

- Psychological harm is as serious as physical harm.

- When a surveyor has established through investigation that a cognitively impaired individual harmed an individual receiving care and services from the entity due to the entity’s failure to provide care and services to avoid physical harm, mental anguish, or mental illness, this should be considered neglect.

- Any time a team cites abuse or neglect, it should consider Immediate.
Upon recognizing a situation that may constitute Immediate Jeopardy, the investigation process must proceed until it confirms or rules out Immediate. The serious harm, injury, impairment or death may have occurred in the past, may be occurring at present, or may be likely to occur in the very near future as a result of the jeopardy situation. After determining that the harm meets the definition of Immediate Jeopardy, consider the following points regarding entity compliance:

- The entity either created a situation or allowed a situation to continue which resulted in serious harm or a potential for serious harm, injury, impairment or death to individuals.
- The entity had an opportunity to implement corrective or preventive measures.

After recognizing Immediate Jeopardy and completing the investigation, the team will then choose the specific Federal regulation(s) to address the deficient practice. Although a specific Federal regulation may not be found for each situation, all Medicare/Medicaid entities have a responsibility to provide quality care. The principles of Immediate Jeopardy apply to all certified entities and need to be followed for all individuals receiving care and services in those entities. The team should determine which Federal regulation(s) to document the deficient practice(s).

**NOTE:** The key factor in the use of Immediate Jeopardy termination authority is, as the name implies, limited to **Immediate Jeopardy**. Immediate Jeopardy procedures must not be used to enforce compliance quickly on more routine deficiencies.

### IV - Immediate Jeopardy Triggers

This guide lists issues with associated triggers. The issues include general statements of practices such as “Failure to protect from abuse.” The guide includes situations that most likely create jeopardy to an individual’s psychological and/or physical health and safety.

Triggers that will assist the surveyor in considering Immediate Jeopardy accompany each issue. Triggers describe situations that will cause the surveyor to consider if further investigation is needed to determine the presence of Immediate Jeopardy. The listed triggers do not automatically equal Immediate Jeopardy. The team must investigate and use professional judgment to determine if the situation has caused or is likely to cause serious harm, injury, impairment or death. These triggers are general examples and are not all-inclusive. Many triggers may apply to more than one issue. A trigger for an issue such as C, “Failure to Protect from Psychological Harm,” could well be an example of A, “Failure to Prevent Abuse,” or B, “Failure to Prevent Neglect.” The team must rely on professional judgment and utilize the resources of the State survey agency, the Regional Office and/or, in the case of Medicaid-only facilities, the State Medicaid Agency to determine the presence of Immediate Jeopardy.
NOTE: Harm does NOT have to occur before considering Immediate Jeopardy. Consider both potential and actual harm when reviewing the triggers in the table.
<table>
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| A Failure to protect from abuse.  | 1. Serious injuries such as head trauma or fractures;  
                                  | 2. Non-consensual sexual interactions; e.g., sexual harassment, sexual coercion or sexual assault;  
                                  | 3. Unexplained serious injuries that have not been investigated;  
                                  | 4. Staff striking or roughly handling an individual;  
                                  | 5. Staff yelling, swearing, gesturing or calling an individual derogatory names;  
                                  | 6. Bruises around the breast or genital area; or Suspicious injuries; e.g., black eyes, rope marks, cigarette burns, unexplained bruising. |
| B Failure to Prevent Neglect      | 1. Lack of timely assessment of individuals after injury;  
                                  | 2. Lack of supervision for individual with known special needs;  
                                  | 3. Failure to carry out doctor’s orders;  
                                  | 4. Repeated occurrences such as falls which place the individual at risk of harm without intervention;  
                                  | 5. Access to chemical and physical hazards by individuals who are at risk;  
                                  | 6. Access to hot water of sufficient temperature to cause tissue injury;  
                                  | 7. Non-functioning call system without compensatory measures;  
                                  | 8. Unsupervised smoking by an individual with a known safety risk;  
                                  | 9. Lack of supervision of cognitively impaired individuals with known elopement risk;  
                                  | 10. Failure to adequately monitor individuals with known severe self-injurious behavior;  
                                  | 11. Failure to adequately monitor and intervene for serious medical/surgical conditions;  
                                  | 12. Use of chemical/physical restraints without adequate monitoring;  
                                  | 13. Lack of security to prevent abduction of infants;  
                                  | 14. Improper feeding/positioning of individual with known aspiration risk; or  
                                  | 15. Inadequate supervision to prevent physical altercations. |
| C Failure to protect from psychological harm | 1. Application of chemical/physical restraints without clinical indications;  
                                  | 2. Presence of behaviors by staff such as threatening or demeaning, resulting in displays of fear, unwillingness to communicate, and recent or sudden changes in behavior by individuals; or  
<pre><code>                              | 3. Lack of intervention to prevent individuals from creating an environment of fear. |
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<td>D Failure to protect from undue adverse medication consequences and/or failure to provide medications as prescribed.</td>
<td>1. Administration of medication to an individual with a known history of allergic reaction to that medication; 2. Lack of monitoring and identification of potential serious drug interaction, side effects, and adverse reactions; 3. Administration of contraindicated medications; 4. Pattern of repeated medication errors without intervention; 5. Lack of diabetic monitoring resulting or likely to result in serious hypoglycemic or hyperglycemic reaction; or 6. Lack of timely and appropriate monitoring required for drug titration.</td>
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<td>E Failure to provide adequate nutrition and hydration to support and maintain health.</td>
<td>1. Food supply inadequate to meet the nutritional needs of the individual; 2. Failure to provide adequate nutrition and hydration resulting in malnutrition; e.g., severe weight loss, abnormal laboratory values; 3. Withholding nutrition and hydration without advance directive; or 4. Lack of potable water supply.</td>
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<td>F Failure to protect from widespread nosocomial infections; e.g., failure to practice standard precautions, failure to maintain sterile techniques during invasive procedures and/or failure to identify and treat nosocomial infections</td>
<td>1. Pervasive improper handling of body fluids or substances from an individual with an infectious disease; 2. High number of infections or contagious diseases without appropriate reporting, intervention and care; 3. Pattern of ineffective infection control precautions; or 4. High number of nosocomial infections caused by cross contamination from staff and/or equipment/supplies.</td>
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<td>G Failure to correctly identify individuals.</td>
<td>1. Blood products given to wrong individual; 2. Surgical procedure/treatment performed on wrong individual or wrong body part; 3. Administration of medication or treatments to wrong individual; or 4. Discharge of an infant to the wrong individual.</td>
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<td>H Failure to safely administer blood products and safely monitor organ transplantation.</td>
<td>1. Wrong blood type transfused; 2. Improper storage of blood products; 3. High number of serious blood reactions; 4. Incorrect cross match and utilization of blood products or transplantation organs; or 5. Lack of monitoring for reactions during transfusions.</td>
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<td>I Failure to provide safety from fire, smoke and environment hazards and/or failure to educate staff in handling emergency situations.</td>
<td>1. Nonfunctioning or lack of emergency equipment and/or power source; 2. Smoking in high risk areas; 3. Incidents such as electrical shock, fires; 4. Ungrounded/unsafe electrical equipment; 5. Widespread lack of knowledge of emergency procedures by staff; 6. Widespread infestation by insects/rodents; 7. Lack of functioning ventilation, heating or cooling system placing individuals at risk; 8. Use of non-approved space heaters, such as kerosene, electrical, in resident or patient areas; 9. Improper handling/disposal of hazardous materials, chemicals and waste; 10. Locking exit doors in a manner that does not comply with NFPA 101; 11. Obstructed hallways and exits preventing egress; 12. Lack of maintenance of fire or life safety systems; or 13. Unsafe dietary practices resulting in high potential for food borne illnesses.</td>
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### Triggers

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<td>J Failure to provide initial medical screening, stabilization of emergency medical conditions and safe transfer for individuals and women in active labor seeking emergency treatment (Emergency Medical Treatment and Active Labor Act).</td>
<td>1. Individuals turned away from ER without medical screening exam; 2. Women with contractions not medically screened for status of labor; 3. Absence of ER and OB medical screening records; 4. Failure to stabilize emergency medical condition; or 5. Failure to appropriately transfer an individual with an unstabilized emergency medical condition.</td>
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Guidelines for Determining Immediate Jeopardy

V - Procedures

A - Preparation

The team should be familiar with the contents of Appendix Q. The guidelines should be foremost in the team’s mind to decrease the potential for missing Immediate Jeopardy. The team should also be familiar with the recommended Key Components of an entity’s systemic approach to prevent abuse and neglect. The seven Key Components include: screening, training, prevention, identification, investigation, protection, and reporting/response. (Refer to Attachment C.) Both Appendix Q and the Key Components apply to all certified Medicare/Medicaid entities.

B - Investigation

The investigation must be conducted in an impartial, objective manner to obtain accurate data sufficient to support a reasonable conclusion.

1. Observation is a key component of any investigation. All observations need to be thoroughly documented. Be specific in noting time, location and exact observations.

2. The interview notes must be clear and detailed. The documentation should include the full name of the person interviewed. The time and date of the interview should be documented. Any witnesses present should be indicated.

3. Record review is used to support observations and interviews. Obtain copies of relevant documentation supporting the Immediate Jeopardy as you investigate (e.g., nurses’ notes, and investigation reports).

4. If the case involves a potential criminal action, the surveyor should be aware that any physical evidence must be preserved for law enforcement agencies.

5. Team Actions

   a. Notify the team leader immediately when an Immediate Jeopardy situation is suspected. The team leader will then coordinate the investigative efforts.

   b. Contact the State survey agency (SA) per the SA protocol.

   c. Gather information to address who, what, when, where and why, such as:
WHO: Who was involved in the Immediate Jeopardy situation: staff, individuals receiving care and services, and others?

Does the individual(s) at risk have special needs? Has this happened to other individuals? If yes, how many? Are there others to whom this is likely to occur? If so, how many and who? Which entity staff knew or should have known about the situation?

WHAT: What harm has occurred, is occurring, or most likely will occur?

How serious is the potential/actual harm? How did the situation occur? What was the sequence of events? What attempts did the entity make to assess, plan, correct, and re-evaluate regarding the potential/actual harm? What did the entity do to prevent any further occurrences of the same nature?

WHEN: When did the situation first occur?

How long has the situation existed? Has a similar occurrence happened before? Has the entity had an opportunity to correct the situation? Did the entity thoroughly investigate the event? Did you agree with the facility’s conclusion after their investigation? Did the entity implement corrective measures to prevent any further similar situations? Did they follow up and evaluate the effectiveness of their measures?

WHERE: Where did the potential/actual harm occur? Is this an isolated incident or an entity wide problem?

WHY: Why did the potential/actual harm occur?

Was the Immediate Jeopardy preventable? Is there a system in place to prevent further occurrences? Is this a repeat deficient practice? Is there a pattern of similar deficient practices?

The team then needs to proceed to **validate** the gathered information with facility staff.

Following are two examples of teams gathering information during the investigation to answer the questions: who, what, when, where and why. Refer to **C – Decision Making** for the completion of the examples.

**Example Case #1:** The resident was admitted following a hospitalization for psychiatric care. The resident had a history of exiting behavior, impulsiveness and impaired cognition and judgment. Diagnoses included dementia with psychosis and delusion, psychomotor agitation, acute behavioral disturbances, and possible right cerebral vascular accident (CVA). Documented behavior of standing by the facility door waiting for someone to open the door and then sneaking out very fast was included in the chart.
**TRIGGER:** Lack of supervision of cognitively impaired individuals with known elopement risk.

**Investigation:**

**WHO:** Who is the resident? Is the resident cognitively impaired with poor decision-making skills? Is the resident’s diagnosis pertinent in this case? Is the resident physically impaired? What is the resident’s ambulatory status? Was the resident identified by the facility as a wanderer oblivious to physical and safety needs? Does the resident have a history of leaving the facility without informing the staff? Does the resident’s care plan address wandering and risk for elopement? Does the resident wear a safety alarm device? Is there a history of elopement from this facility? How many residents were/are at risk for elopement?

**WHAT:** What happened? What was the resident’s physical, mental, and emotional status prior to elopement? Was the resident injured? Did the facility seek outside medical treatment for the resident? If so, what did the reports from the ER physician’s exam include regarding the resident’s condition when examined?

**WHEN:** When was the resident last seen? When did the resident leave the facility? When did the facility take action? When was the resident found? Who found the resident? Was the potential for injury present? Was the outdoor temperature excessively hot or cold? Was it raining, snowing, or storming, etc.? If excessively cold temperatures were present, what was the wind chill factor? How was the resident dressed? What areas of the skin were exposed and for how long?

**WHERE:** Where did the resident reside? Was the resident on a special unit with extra elopement precautions? Where did this happen? How did the resident exit the facility? Describe the exact location of exit. Where is the facility located (urban or rural)? What hazards were present in the vicinity of the facility (railroad, high motor vehicle traffic, construction zones, farm fields, lakes, ponds, etc.)?

**WHY:** Why did this happen? Was the care plan followed? Were door alarms working properly? Were exit doors visible at all times? If so, by whom? What was the facility’s plan to supervise the resident? Was it followed? If so, why did it fail? What was the physician’s version of the cause for harm? Were crucial medications involving therapeutic blood/serum levels involved in the elopement (i.e., insulin, psychotropic, antihypertensives, etc.)? What other contributing factors, such as diagnosis, should be considered?

**Example Case #2:** Confused, debilitated 75 year old female admitted as an inpatient to the hospital has orders to discontinue all nutrition and hydration support.

**TRIGGER:** Withholding nutrition and hydration without sufficient documentation of advance directives could be an Immediate Jeopardy situation.
Investigation:

**WHO:** Who wrote the order? Is this the patient’s primary care physician? Who has the authority to make the medical care decisions? Does the patient have a living will? Does the patient have a durable power of attorney? Who has spoken with the person designated to make health care decisions for the patient; e.g., social worker, primary care physician, specialist, hospice nurse, or chaplain?

**WHAT:** What is the patient’s diagnosis? Is documentation of a terminal disease process by the attending physician contained in the progress notes? What does the progress note contain about risks and benefits of discontinuation of hydration and nutrition? What alternative treatment options have been considered and discussed with the person responsible for making health care decisions for this patient? What events precipitated the decision to discontinue hydration and nutrition? What care and services have been planned during the absence of nutrition and hydration? What steps have been taken to ascertain the patient’s wishes? What is State law regarding advance directives and end of life issues?

**WHEN:** When did the hospital obtain evidence of the patient’s wishes regarding end of life treatment? When did the physician discuss end of life issues, diagnosis, prognosis and the patient’s wishes with the person designated by the patient or by law to make health care decisions?

**WHERE:** If the patient has an advance directive, how easy/difficult is it to find in the chart to verify the patient’s wishes? If the advance directive is not in the chart, does the chart indicate where the advance directive is kept? If the patient does not have an advance directive, where is the documentation in the chart to support the patient’s wishes to discontinue nutrition and hydration at the end of life? Where is the documentation to support that the person making the health care decisions is fully informed of the risks and benefits and is making the decisions the patient would have made? If the patient does not have an advance directive, does the patient’s chart reflect compliance with the State law and the legal representative’s decision-making authority concerning withdrawal of hydration and nutrition? Has the person with decision-making authority been fully informed of all options, including home care, hospice and long term care placement?

**WHY:** If the physician wrote an order to discontinue nutrition and hydration, does the progress note contain documentation of the rationale? Is there clear documentation to support the decision?

**C - Decision-Making**

The information gathered is used to evaluate the provision of related care and services, occurrence frequency, and the likelihood of repetition. The team needs to have gathered
and validated sufficient information to address the three components of Immediate Jeopardy (listed below) to begin the decision process.

**Components of Immediate Jeopardy**

1. **Harm**
   
   a. **Actual** - Was there an outcome of harm? Does the harm meet the definition of Immediate Jeopardy, e.g., has the provider’s noncompliance caused serious injury, harm, impairment, or death to an individual?
   
   b. **Potential** - Is there a likelihood of potential harm? Does the potential harm meet the definition of Immediate Jeopardy; e.g., is the provider’s noncompliance likely to cause serious injury, harm, impairment, or death to an individual?

2. **Immediacy** - Is the harm or potential harm likely to occur in the very near future to this individual or others in the entity, if immediate action is not taken? (Refer to the SOM §3010(B)(6) for timelines during normal termination.)

3. **Culpability**
   
   a. Did the entity know about the situation? If so when did the entity first become aware?
   
   b. Should the entity have known about the situation?
   
   c. Did the entity thoroughly investigate the circumstances?
   
   d. Did the entity implement corrective measures?
   
   e. Has the entity re-evaluated the measures to ensure the situation was corrected?

**Note:** The team must consider the entity’s response to any harm or potential harm that meets the definition of Immediate Jeopardy. The stated lack of knowledge by the entity about a particular situation does not excuse an entity from knowing and preventing Immediate Jeopardy. The team should use knowledge and experience to determine if the circumstances could have been predicted. The Immediate Jeopardy investigation should proceed until the team has gathered enough information to evaluate any prior indications or warnings regarding the jeopardy situation and the entity’s response. The crisis situations in which an entity did not have any prior indications or warnings, and could not have predicted a potential serious harm, are very rare.
Team Actions:

- Meet as a team;
- Follow Appendix Q;
- Share collected data;
- Identify the three components of Immediate Jeopardy;
- Decide if you have enough information to make a decision. If not, continue the investigation;
- Identify any inconsistencies or contradictions between interviews, observations and record reviews;
- Clarify any inconsistencies or contradictions;
- Determine the specific Federal regulation for the situation; and
- Consult with the SA, as necessary.

The following are examples of decision-making as the team analyzes the information obtained during the investigation. Example #1 and 2 are continuations from B-Investigation.

Example Case #1 (Continued):  (Refer to B - Investigation) During the survey, the resident was observed to enter the code and exit the unit without assistance 5 times in 30 minutes and was brought back by nursing staff from the unit, nursing staff from other units and administrative staff. The front door to the facility had a broken alarm and did not latch properly and was easily accessible after exiting the locked unit. The facility was aware of the broken alarm and latch. The chart contained documentation that the facility was aware of the resident’s ability to operate the door keypads for at least 60 days. The facility was located in an urban area on a busy street. A row of trees prevented anyone in the facility from viewing a resident exiting the property and crossing the street.

The record included documentation of the resident exiting the building successfully without notice. The documentation included only a brief description of the incident. After a search, the resident was located in an area emergency room being treated for a minor laceration of the lip. Police notified the facility that bystanders who had called 911 had found the resident lying down with blood on her face. The chart included subsequent reports of repeated frequent attempts to elope 25-40 times per shift, and the statement, “Patient requires 1:1, care not safe on this unit secondary to continuous exit seeking.” A review of the facility investigations revealed that the facility had not completed any investigations for this resident.
Decision Making:

- Has actual harm occurred? Yes.
- Does the actual harm that occurred meet the definition of Immediate Jeopardy? No.
- Is there a likelihood of potential serious harm? Yes.
- Does the potential harm meet the definition of Immediate Jeopardy? Yes.
- Is the harm likely to recur in the very near future, if immediate action is not taken? Yes.
- Did the facility have knowledge of the situation? Yes. If so when did they first become aware? Before admission when notified of history.
- Did they thoroughly investigate the circumstances? No.
- Did they implement corrective measures? No.
- Does this meet the definition of Immediate Jeopardy? Yes.
- Which is the most appropriate tag to define the failed practice?

Outcome:

- The team identifies the most appropriate regulation that applies to the situation.
- The team proceeds with documentation of the Immediate Jeopardy deficient practice.
- The SA proceeds with the termination procedures per the SOM.
- Except in the case of Medicaid-only facilities, the RO proceeds with termination actions.

Example Case #2 (Continued): (Refer to B - Investigation) During the investigation, the surveyor finds that the chart does not include a copy of the patient’s advance directive. The progress note does not contain any documentation of the patient ever stating a wish to have nutrition and hydration withdrawn at the end of life. The patient has a diagnosis of advance dementia with a documented history of refusal to eat in a long-term care facility. The patient had been admitted because of continued weight loss and dehydration related to the refusal to eat or drink. The patient has a daughter who actively
participates in her mother’s care, is identified as the legal representative, and is identified in the social service notes as the closest living family member. The primary care physician documented a discussion with the daughter concerning the patient’s poor prognosis for meaningful recovery. While death is not imminent as a result of the dementia, death is the expected result at some unknown time in the future. The chart does not include any documentation that the daughter expressed a wish to have nutrition and hydration support withdrawn. The social worker was unable to confirm that the daughter had expressed a wish to have all support withdrawn. The social worker is uncertain why the nutrition and hydration were discontinued. When contacted, the daughter is unaware that support has been withdrawn and is very upset. The surveyor copies the order sheet, the progress notes and the social service notes. The surveyor clearly documents the interviews with the social worker and the daughter. There is a discrepancy between the written order for withdrawal of support and the daughter’s and the social worker’s knowledge of the situation. The surveyor decides to present the information to the team prior to contacting the physician.

**Decision Making:**

- Has actual harm occurred? No.

- Is there a likelihood of potential serious harm? Yes.

- Does the potential serious harm meet the definition of Immediate Jeopardy, e.g., serious injury, harm, impairment, or death? Yes.

- Is the potential serious harm likely to occur in the very near future, if immediate action is not taken? Yes.

- Did the facility have knowledge of the situation? Yes.

- If so, when did they first become aware? After the doctor’s order was written?

- Did they thoroughly investigate the circumstances? No.

- Did they implement corrective measures? No.

- Does this meet the definition of Immediate Jeopardy? Yes.

- Which is the most appropriate tag to define the failed practice?

**Outcome:**

- The team identifies the most appropriate regulation that applies to the situation.
• The team proceeds with documentation of the Immediate Jeopardy deficient practice.

• The SA proceeds with the termination procedures per the SOM.

• The RO proceeds with termination actions.

**Example Case #3:** An outside intruder entered a resident’s room by cutting through the screen. A resident with a diagnosis of advanced dementia was raped. The resident did not notify staff at the time of the incident. The intruder was not observed entering the facility by any facility staff. However, nightshift staff immediately called the police after noticing a stranger in the courtyard at the back of the facility. The police came and were unable to locate anyone. The police checked the grounds without incident and then encouraged the staff to check the locks on the doors and windows and obtain services to monitor the premises for increased security. The police indicated that no prior intruders had been reported in the neighborhood.

The facility immediately contacted a local security service and hired a security guard to monitor the outside grounds. The security guard arrived within 45 minutes and began patrolling the grounds. The facility staff checked all the doors and windows to ensure security. They checked on all of the residents and did not observe any problems. During morning rounds, the resident reported that someone had hurt her during the night. The staff noted that the screen had been damaged and immediately contacted the police and the SA. The police came and had the resident transported to the nearest emergency room for a rape assessment. The emergency room confirmed that the resident had been raped.

**Decision-Making:**

• Has actual harm occurred? Yes.

• Does the harm meet the definition of Immediate Jeopardy, e.g., serious injury, harm, impairment, or death to an individual? Yes.

• Is the harm likely to recur in the very near future, if immediate action is not taken? Yes.

• Did the entity have knowledge of the situation? Yes.

• If so when did they first become aware? In the morning when the resident reported she had been hurt.

• Did they thoroughly investigate the circumstances? Yes.

• Did they implement corrective measures? Yes.
• Does this meet the definition of Immediate Jeopardy? No. The facility reacted appropriately and followed the recommendations of the law enforcement experts to protect all residents. The harm to the resident had already occurred before the facility had any indications or warnings, and could not have been predicted or prevented.

Outcome:

• The team gathered sufficient data to reach the conclusion that the facility had no predictable way of knowing that residents were at risk for harm from an intruder.

• The team also gathered sufficient data to reach a decision that the facility reacted immediately to protect residents when they had knowledge of a potential risk.

• The team concludes that there was no failed practice.

• The team concludes their investigation of this complaint.

VI - Implementation

A - Team Actions

If the team reaches a consensus concerning the presence of Immediate Jeopardy, the team leader then contacts the SA per the protocol established by the SA. The SA review should be expedited. If the team is unable to follow the SA protocol for administrative consultation, actions to proceed with implementation of Immediate Jeopardy must continue. Decide if any other agencies need to be notified, e.g., Law Enforcement Agency, Nurses Aide Registration Board.

NOTE: Any criminal act needs to be reported to the local law enforcement agency. The entity should be encouraged to make the report, if needed. The surveyor should only assume this responsibility if the entity refuses.

B - SA Actions

Upon review of the findings, if the SA concurs with the team’s consensus of Immediate Jeopardy, the SA will inform the RO for all Medicare and dually certified entities. For Medicaid-only facilities, the SA will notify the State Medicaid Agency. For Immediate Jeopardy in Medicaid-only facilities, contact the RO per the protocol established between the SA and the RO.

C - Team Action

Once the team has decided that Immediate Jeopardy exists, the team should notify the administration of the Immediate Jeopardy. A verbal notice should be given with the
specific details, including the individuals at risk, before the survey team leaves the premises of the entity. **The entity should begin immediate removal of the risk to individuals, and immediately implement corrective measures to prevent repeat Jeopardy situations.** The team should encourage the entity to provide evidence of their implementation of corrective measures.

The notice describing the Immediate Jeopardy must be delivered to the entity no later than 2 days (refer to specific SOM reference) of the end of the survey. If official notification of all deficiencies, i.e., Form CMS-2567, was not given on the second day, a completed Form CMS-2567 must be sent to the entity on the tenth working day.

**VII - Documentation**

**A - Skilled Nursing Facilities/Nursing Facilities (SNF/NF)**

**1 - Confirmation of Removal of Immediate Jeopardy**

Only onsite confirmation of implementation of the facility’s corrective actions justifies a determination that the Immediate Jeopardy has been removed.

**2 - Immediate Jeopardy Removed, Deficient Practice Corrected**

If the facility is able to remove the Immediate Jeopardy before the survey team leaves the facility and to correct associated deficient practices, cite the Immediate Jeopardy at the Immediate Jeopardy severity and scope (J, K or L). Document evidence of the facility’s actions, including dates that indicate that the facility has removed the Immediate Jeopardy and corrected the deficient practice. The date of full correction will be shown on the Form CMS-2567B, a copy of which can be found at [http://cms.hhs.gov/forms/cms2567b.pdf](http://cms.hhs.gov/forms/cms2567b.pdf)

**3 - Immediate Jeopardy Removed, Deficient Practice Present**

If the facility is able to employ immediate corrective measures that remove the Immediate Jeopardy, but an associated deficient practice still exists at a lesser severity and scope, cite the Immediate Jeopardy at the Immediate Jeopardy severity and scope. Include the documentation to support the remaining deficient practice. Document the level of harm and the identified residents in the Statement of Deficiencies. Attach the corrective measures submitted by the facility as an immediate plan of correction.

**4 - Immediate Jeopardy Not Removed**

If the facility is unable or unwilling to remove the Immediate Jeopardy before the end of the survey, inform the administration that the RO will be notified of the
Immediate Jeopardy and termination procedures will be initiated. Use the appropriate SOM reference to define the end of the survey.

B - All Entities Not Noted Above

Immediate Jeopardy is always cited at the Condition level on the Form CMS-2567, a copy of which can be found at [http://www.cms.hhs.gov/forms/cms2567.pdf](http://www.cms.hhs.gov/forms/cms2567.pdf).

1 - Confirmation of Removal of Immediate Jeopardy

Only onsite confirmation of implementation of the facility’s corrective action justifies a determination that the Immediate Jeopardy has been removed.

2 - Immediate Jeopardy Removed, Deficient Practice Corrected

If the entity is able to remove the Immediate Jeopardy and correct associated deficient practices before the team exits, cite the Immediate Jeopardy at the Condition level on the Form CMS-2567. Corrective actions taken by the provider/supplier will be included in the Form CMS-2567 documentation. The date of full correction will be shown on the Form CMS-2567B.

3 - Immediate Jeopardy Removed, Deficient Practice Present at Condition Level

If the entity is able to employ immediate corrective measures that remove the Immediate Jeopardy, but an associated deficient practice still remains at the condition level for the same Condition of Participation, cite the Condition of Participation as not met and proceed with 90-day termination procedures. Include documentation of both the Immediate Jeopardy with subsequent removal, and the remaining deficient practice in this citation.

4 - Immediate Jeopardy Removed, Deficient Practice Present at Standard or Elemental Level

If the entity is able to employ immediate corrective measures, which remove the Immediate Jeopardy but an associated deficient practice still remains at the standard or elemental level, cite the Immediate Jeopardy at the Condition of Participation level on Form CMS-2567. Cite the remaining deficiency at the most appropriate standard or elemental tag. The date of removal of the Immediate Jeopardy will be shown on the Form CMS-2567B.

5 - Immediate Jeopardy Not Removed

If the entity is unable or unwilling to remove the Immediate Jeopardy before the team’s exit, inform the administration that the RO will be notified of the Immediate Jeopardy situation and termination procedures will be initiated. In the case of a
Medicaid-only facility, the State Medicaid Agency will be notified of the Immediate Jeopardy.

VIII - Enforcement
(Rev. 102, Issued: 02-14-14, Effective: 02-14-14, Implementation: 02-14-14)

A - Termination for Title XIX-Only NFs, ICFs/IID

Refer to SOM §3005 E for specific instructions.

IX - References

- SOM Appendices (Excluding Appendix C, CLIA)
- Principles of Documentation
- SOM §3005 E
- SOM §§3010-3012
- SOM §§7307-7309
Attachment A  
(Rev. 102, Issued: 02-14-14, Effective: 02-14-14, Implementation: 02-14-14)

The jeopardy situations that follow are actual citations that have been upheld.

IMMEDIATE JEOPARDY NOT REMOVED BEFORE EXIT

ICF/IID Failed Practice

Condition of Participation - The facility failed to assure medical services were provided to a client with an emergency medical condition.

Summary - At 4:30 a.m. on x/x/x, the nursing staff was notified that Client #1 had not slept during their shift and had three to four liquid stools that night. Nursing staff assessed the client, found his bed smeared with feces (color and consistency not described), his color slightly pale, abdomen slightly distended, and dried blood around his mouth. Assessed vital signs were blood pressure 100/60, heart rate 70 beats per minute, temperature 100.5 degrees Fahrenheit. His treatment consisted of Tylenol (given orally) at 5:10 a.m.

At approximately 5:45 a.m., Client #1 became unsteady while exiting the bathroom and was lowered to the floor with staff assistance. At 6:00 a.m., the client was described as, “skin cold, clammy - color pale.” His blood pressure had dropped to 88/50, heart rate 85 beats per minute, oxygen saturation 93%. The client was placed on oxygen at 5 liters per minute and preparations were initiated to transfer the client to the infirmary.

At 6:25 a.m., Client #1 was still on the floor outside of the bathroom and the records indicated he was unresponsive. His blood pressure was 80/50, and his heart rate dropped to 67 beats per minute. The client tried to remove the nasal cannula that supplied him with oxygen and “insisted on sitting up.” After sitting up, his skin was documented as decreased in color and “sallow.” He had coffee ground drooling coming from both corners of his mouth.

At 6:40 a.m., the community emergency response number (911) was called. At 6:45 a.m., Client #1 was documented as being unresponsive with absent blood pressure, pulse, and respirations. Cardiopulmonary Resuscitation (CPR) was initiated. At 6:49 a.m., the community 911-response team arrived and took over CPR. The client expired at 7:00 a.m..

The Superintendent stated that staff were expected to use their own judgment as to when to access 911 emergency services. Review of facility Procedure #X revealed a lack of clear guidelines to facility staff on when to call for community 911 emergency response.

Issue - Failure to protect from neglect.
**Trigger** - Failure to adequately monitor and intervene for serious medical/surgical conditions.

**Decision Making:**

- Has actual harm occurred? Yes
- Does the harm meet the definition of Immediate Jeopardy, e.g., serious injury, harm, impairment, or death to an individual? Yes
- Is the harm likely to recur in the very near future, if no immediate action is taken? Yes
- Did the entity have knowledge of the situation? Yes If so, when did the entity first become aware? On the night shift.
- Did they thoroughly investigate the circumstances? No
- Did they implement corrective measures? No
- Does this meet the definition of Immediate Jeopardy? Yes
- Which is the most appropriate tag to define the failed practice? Cite the most appropriate tag at the Condition of Participation level for Immediate Jeopardy.

**Outcome** - The team cited the Condition of Participation, Health Care Services (Tag W318). The facility implemented a corrective action plan after receiving written notice. Onsite revisit confirmed correction.
Attachment B

Documentation for Immediate Jeopardy should follow the Principles of Documentation. The following are examples of Forms CMS-2567 documenting Immediate Jeopardy.

Example for LTC: Failure to Prevent Abuse

F223

483(b) Requirements: Abuse

Scope and Severity B Level is J - The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion.

This requirement is not met as evidenced by the following:

Based on interview, and record reviews, it was determined the facility failed to assure that the female residents on the North Wing had an environment that was free from sexual abuse. The findings constituted an Immediate Jeopardy situation. Facility staff had knowledge of the inappropriate sexual behaviors of two male residents (Residents #12 and 27). The facility had not consistently identified the victims, had not conducted investigations, and had not implemented effective preventive measures to protect the female residents on North Wing from actual and potential sexual abuse. There were multiple incidents of actual harm with three identified sample residents (Residents #3, 14, and 25). There were three incidents of potential harm for three unidentified residents.

Findings include:

1. A review of Resident #12's record revealed a nurse’s note dated xx/xx/xx, at 1:30 a.m., the resident was found sitting next to Resident #3 in the common area. Resident #12 had “one hand on [Resident #3's] buttock and one hand on the breast. [Resident #3] was attempting to push Resident #12's hand away.” At 4:00 a.m., the same day, Resident #12 was found in the hallway with hands on an unidentified, nude female resident.

2. Resident #12 record revealed that on xx/xx/xx, at 11:30 p.m., the resident was found in an unidentified female resident’s bed with both side rails up. Resident #12 had one hand directly on the female’s labia. The female resident was unable to respond. The nurses notes dated xx/xx/xx, stated, “Resident #12 was sexually inappropriate with a female resident who could not give consent.”

3. On xx/xx/xx, at 7:15 p.m., a nurses note in Resident #12's record stated that the resident was found standing in the hall, behind Resident #14, who was sitting in a
wheelchair. Resident #12's hands were on Resident #14's breast. Resident #14 stated, “I am going to call the police.”

4. Interview with the Administrator and DON on xx/xx/xx, confirmed that none of the incidents involving Resident #12 had been reported to the State per the State’s complaint protocol.

5. On xx/xx/xx at 3:30 a.m., Resident #27's record revealed the resident was found in the room of Resident #25 (a severely cognitively impaired resident, who was unable to communicate) standing by the bed, with pajama bottoms down and hands in Resident #25's genital area. An incident report, dated xx/xx/xx revealed Resident #25 “looked frightened, with widened eyes, unable to defend self or call for help.”

6. Nurses notes dated xx/xx/xx, at 10:30 p.m., revealed Resident #27 was found in an unidentified resident’s room, with the covers pulled back, and hands in the resident’s genital area.

7. There were no incident reports for xx/xx/xx or xx/xx/xx for Resident #27. Interview with the charge nurse on xx/xx/xx, revealed that she had no knowledge of the incidents, whether an investigation of the incidents had been conducted, or if efforts had been made to protect female residents.

Example for All Other Entities with Conditions of Participation or Conditions of Coverage: Failure to provide safety from fire, smoke and environmental hazards and/or failure to educate staff in handling emergency situations

I 117

485.723 Condition: Physical Environment

The building housing the organization is constructed, equipped, and maintained to protect the health and safety of patients, personnel, and the public and provides a functional, sanitary, and comfortable environment.

This Condition is not met as evidenced by the following:

Based on observation, interview and review of policies and procedures, the agency failed to assure patients were protected from fire hazards, failed to provide adequate egress for emergencies (refer to I-118) and failed to provide adequate protection from hazardous chemicals (refer to I-158). These deficiencies resulted in potential harm for 20 of 20 sample patients (#1-20) and the 90 additional patients receiving care at the agency. An Immediate Jeopardy to the patients and the public was created by these deficiencies.
I-118

485.723(a) Standard  Safety of Patients

The organization satisfies the following requirements:

1. It complies with all applicable State and local building, fire, and safety codes.

2. Permanently attached automatic fire-extinguishing systems of adequate capacity are installed in all areas of the organization considered to have special fire hazards. Fire extinguishers are conveniently located on each floor of the premises. Fire regulations are prominently posted.

3. Doorways, passageways, and stairwells negotiated by patients are:
   a. Of adequate width to allow for easy movement of all patients (including those on stretchers or in wheelchairs);
   b. Free from obstruction at all times;
   c. In the case of stairwells, equipped with firmly attached handrails on at least one side;
   d. Lights are placed at exits and in corridors used by patients and are to be supported by an emergency power source;
   e. A fire alarm system with local alarm capability and, where applicable, an emergency power source is functional;
   f. At least two persons are on duty on the premises of the organization whenever a patient is being treated; and
   g. No occupancies or activities undesirable or injurious to the health and safety of patients are located in the building.

This Standard is not met as evidenced by the following:

Based on an observation and interview, the agency failed to provide unobstructed hallways and exits for 1 of 2 exit doors and hallways; failed to provide adequate maintenance of exit lighting for 1 of 2 exits and 2 of 4 emergency lights; and failed to provide a fire alarm system; resulting in the potential harm for all the agency’s current patients including 20 of 20 sample patients (#1-20). This resulted in an Immediate Jeopardy.
Findings Include:

1. Observation of the passageway on xx/xx/xx at 3 p.m. and on xx/xx/xx at 10 a.m., revealed that the east hallway was partially obstructed with several items of furniture and other obstacles. During interview, at 11 a.m. on xx/xx/xx, the administrator stated that the building manager was temporarily storing these items in the hallway. The administrator was unable to provide a date when the items might be relocated.

2. Observation at 12 noon on xx/xx/xx, revealed that the exercise pool for the agency was located in the basement in a windowless room. The room had two exit doors, located at opposite ends of the pool with narrow walkways on each side of the pool. One of the emergency exit signs above the door was not illuminated. The other exit door, with the illuminated emergency light, was locked. Four small battery powered flashlights had been placed throughout the room. Two of the four lights failed to illuminate when activated. The two remaining lights, when activated, failed to provide adequate lighting to allow visibility for egress.

3. Review of the agency’s policies and procedures indicated that, in case of fire, employees were to pull the manual alarm. Interview with staff during the survey revealed that seven of the seven staff members on duty were unable to identify where the pull alarm was located. Observation on xx/xx/xx at 10 a.m. failed to provide any evidence of a fire alarm. During interview with the administrator on xx/xx/xx at 12 noon, the absence of a fire alarm was confirmed.

I 158

485.723(b) Standard: Maintenance of Equipment/Buildings/Grounds

The organization establishes a written preventive maintenance program to ensure that:

1. The equipment is operative and is properly calibrated; and

2. The interior and exterior of the building are clean and orderly and maintained free of any defects that are a potential hazard to patients, personnel, and the public.

This Standard is not met as evidenced by the following:

Based on observation and review of the policies and procedures, the agency failed to provide preventative maintenance of the clothes dryer resulting in a potential fire hazard, and failed to properly store pool supplies resulting in a potential chemical hazard for 20 of 20 sample residents (#1-20) and all of the current patients. This resulted in Immediate Jeopardy.
Findings Include:

1. Observation of the laundry room on xx/xx/xx at 12:50 a.m., revealed a large amount of dryer lint on top of the dryer and the water heater, behind the washer, dryers, and water heater, and covering the ceiling and the ceiling roof vent. The washing machine repairman, during interview on xx/xx/xx at 1 p.m., related the extent of the lint accumulation to a plugged dryer exhaust vent and stated that this was an “extreme fire hazard.” The administrator was notified of the potential fire hazard on xx/xx/xx at 1:30 p.m. The vent had not been cleaned, nor had the lint been removed by xx/xx/xx, even though the administrator had been notified of the potential hazard 2 days prior.

2. Observation of the storage area for pool supplies and equipment on xx/xx/xx at 2 p.m., revealed that the chlorine powder was stored in barrels with damaged lids which did not close properly. The chlorine powder had been spilled on the floor and had been tracked out into the pool area. Neither the storage area nor the pool area contained any hazardous chemical warnings. An interview with the pool maintenance staff on xx/xx/xx at 2:15 p.m., did not provide any evidence that the staff had been educated regarding the precautions for hazardous chemicals. The staff was unable to locate any policies or procedures regarding how employees should respond to a chemical spill.
Attachment C - Overview - Recommended Key Components of Systemic Approach to Prevent Abuse and Neglect
(Rev. 102, Issued: 02-14-14, Effective: 02-14-14, Implementation: 02-14-14)

Examples--Key Components applied to the following provider types:

Key Components Applicable To All Providers

1. Prevent

The facility or system has the capacity to prevent the occurrence of abuse and neglect and reviews specific incidents for “lessons learned” which form a feedback loop for necessary policy changes.

Nursing Homes

Regulation Authority: 483.13(b), 483.13(c), 483.13(c)(3)

Survey Guidance - Surveyors determine if:

The facility must develop and implement written policies and procedures that include the seven key components: screening, training, prevention, identification, investigation, protection and reporting/response; the facility identifies, corrects and intervenes in situations in which abuse or neglect is more likely to occur, and the facility identifies characteristics of physical environment and deployment of staff and residents (e.g., those with aggressive behaviors) likely to precipitate abuse or neglect.

ICFs/IID

Regulation Authority: 483.420(a)(5), 483.420(d)(1), 483.420(d)(1)(I)

Survey Guidance - Surveyors determine if:

The facility has and implements abuse prevention policies and procedures; and the facility organizes itself in such a manner that individuals are free from threat to their health and safety.

2. Screen

The facility or system provides evidence and maintains efforts to determine if persons hired have records of abuse or neglect.

Nursing Homes
Regulation Authority - 483.13(c)(1)(ii) (A)&(B)
Survey Guidance - Surveyors determine if: The facility screens potential employees for a history of abuse, neglect, or mistreating residents as defined by the applicable requirements.

ICFs/IID

Regulation Authority - 483.420(c)(1)(iii)
Survey Guidance - Surveyors determine if: The facility screens potential employees to prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect, or mistreatment.

3. Identify

The facility or system creates and maintains a proactive approach to identify events and occurrences that may constitute or contribute to abuse and neglect.

Nursing Homes

Regulation Authority - 483.13(c)(2)
Survey Guidance - Surveyors determine if: The facility identifies events such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse; and determine the direction of the investigation.

ICFs/IID

Regulation Authority - 483.420(a)(5)
Survey Guidance - Surveyors determine if: The facility identifies patterns or isolated incidents of unexplained functional regression, or other evidence of physical, verbal, sexual or psychological abuse or punishment posing a serious and immediate threat to individuals.

4. Train

The facility or system, during its orientation program, and through an ongoing training program, provides all employees with information regarding abuse and neglect and related reporting requirements, including prevention, intervention and detection.

Nursing Homes
**Regulation Authority - 483.74(e)**

**Survey Guidance - Surveyors determine if:** The facility has procedures to train employees, through orientation and on-going sessions, on issues related to abuse prohibition practices.

**ICFs/IID**

**Regulation Authority - 483.420(d)(1), 483.430(e)(1)**

**Survey Guidance - Surveyors determine if:** Facility ensures that staff can define what constitutes abuse and punishment and actively promotes respect for individuals; and facility assures that staff have received training, both upon hiring and on an ongoing basis, which results in the competencies needed to do their job.

5. **Protect**

   The facility or system must protect individuals from abuse and neglect during investigation of any allegations of abuse or neglect.

   **Nursing Homes**

   **Regulation Authority - 483.13(c)(3)**

   **Survey Guidance - Surveyors determine if:** The facility has procedures to protect residents from harm during an investigation.

   **ICFs/IID**

   **Regulation Authority - 483.430(d)(3)**

   **Survey Guidance - Surveyors determine if:** The facility prevents further potential abuse while the investigation is in progress.

6. **Investigate**

   The facility or system ensures, in a timely and thorough manner, objective investigation of all allegations of abuse, neglect, or mistreatment.

   **Nursing Homes**

   **Regulation Authority - 483.13(c)(2)(3)&(4)**
Survey Guidance - Surveyors determine if: The facility has procedures to investigate different types of abuse; and identify staff member responsible for the initial reporting of results to the proper authorities.

ICFs/IID

**Regulation Authority - 483.420(d)(3)**

Survey Guidance - Surveyors determine if: The facility investigates all injuries of unknown origin and allegations of mistreatment, neglect, or abuse.

7. Report/ Respond

The facility or system must assure that any incidents of substantiated abuse and neglect are reported and analyzed, and the appropriate corrective, remedial or disciplinary action occurs, in accordance with applicable local, State or Federal law.

Nursing Homes

**Regulation Authority - 483.13(c)(1)(iii), 483.13(c)(2), 483.13(c)(4)**

Survey Guidance - Surveyors determine if: The facility has procedures to report all alleged violations and substantiated incidents to the State agency and to all other agencies, as required, and to take all necessary corrective actions, depending on the results of the investigation; report to State nurse aide registry or licensing authorities any knowledge it has of any action by a court of law which would indicate an employee is unfit for service, and analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences.

ICFs/IID

**Regulation Authority - 483.420(1)(6), 483.420(d)(2), 483.420(d)(4)**

Survey Guidance - Surveyors determine if: The results of all investigations are reported to the administrator or designated representative or to other officials in accordance with State law within 5 working days of the incident and, if the alleged violation is verified, appropriate corrective action is taken.
## Transmittals Issued for this Appendix

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<td>02/14/2014</td>
<td>State Operations Manual (SOM) Appendix Q revisions for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)</td>
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Memorandum Summary

- This memo replaces the following Survey & Certification (S&C) Memos: 16-31-NH released July 22, 2016 and revised on July 29, 2016, and S&C: 18-01-NH, released in draft on October 27, 2017. The October 2017 memo solicited comments on a proposed directive requiring, for certain situations, immediate imposition of federal remedies on Medicare and Medicaid participating skilled nursing facilities. After reviewing comments, CMS is issuing a final version of the directive. Substantive revisions to the prior Immediate Imposition of Federal Remedies guidance include:
  - When the current survey identifies Immediate Jeopardy (IJ) that does not result in serious injury, harm, impairment or death, the CMS Regional Offices may determine the most appropriate remedy;
  - We clarified that Past Noncompliance deficiencies (as described in §7510.1 of this chapter) are not included in the criteria for Immediate Imposition of Remedies; and,
  - For Special Focus Facilities (SFFs), S/S level “F” citations under tags F812, F813 or F814 are excluded from immediate imposition of remedies.

- Revisions to Chapter 7 of the State Operations Manual (SOM) (Attachment): The Centers for Medicare & Medicaid Services (CMS) has revised guidance in Chapter 7 of the SOM related to the Immediate Imposition of Federal Remedies as noted in this memo and its attachment. Other sections of Chapter 7 have been revised to ensure conformity and consistency with these revisions.

Background

Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs) and dually participating facilities (SNF/NFs) are required to be in substantial compliance with Medicare and Medicaid requirements at all times and are always responsible for the health and safety of their residents.

The purpose of federal remedies, which are imposed after finding a facility is out of substantial compliance with Medicare and Medicaid requirements, is to encourage quick action on the part of facilities to promptly achieve, sustain, and maintain compliance with all federal requirements.
When a facility fails to maintain compliance with federal Medicare and Medicaid participation requirements, there are specific statutorily mandated remedies under sections 1819 and 1919 of the Social Security Act that CMS is statutorily required to take that address higher scope and severity (S/S) harm level deficiencies, substandard quality of care and cases of extended noncompliance. To support the purpose of federal remedies, we are directing the immediate imposition of federal remedies in certain situations.

In addition to the required remedies that must be imposed when a facility is determined to be out of substantial compliance, CMS will select federal remedies that inspire a facility to act quickly in order to achieve compliance and maintain continued compliance with Medicare and Medicaid requirements. Noncompliance may occur for a variety of reasons; however, whenever a facility is out of substantial compliance, it is a danger to the health and safety of its residents and can result in harm or likely harm to residents.

The CMS Regional Offices (ROs) should consider the extent to which the cited noncompliance is a one-time mistake or accident, the result of larger systemic concerns, or a more intentional action or disregard for resident health and safety in order to select a remedy that protects the health, safety and well-being of patients by encouraging the facility to quickly achieve compliance with Medicare and Medicaid requirements. When facilities are out of substantial compliance for designated time periods, have deficiencies that harm residents in violation of quality of care regulations, have repeated deficiencies that harm residents or put them in immediate jeopardy, and when SFFs are cited for certain deficiencies, States must refer case information to CMS ROs for enforcement action as specified in Chapter 7 of the SOM.

Revisions to Chapter 7 of the State Operations Manual (SOM), Chapter 7 - Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities (Attachment)

- CMS has revised guidance relating to the Immediate Imposition of Federal Remedies in Chapter 7 of the SOM as reflected in the advanced copy attached to this memo. Substantive revisions to the prior Immediate Imposition of Federal Remedies guidance S&C: 16-31-NH include:
  - When the current survey identifies Immediate Jeopardy (IJ) that does not result in serious injury, harm, impairment or death, the CMS RO must immediately impose a remedy. Some of the possible remedies include a civil money penalty (CMP), directed in service training, directed plan of correction. A complete list of enforcement remedies can be found at https://www.gpo.gov/fdsys/pkg/CFR-2014-title42-vol5/pdf/CFR-2014-title42-vol5-sec488-408.pdf;
  - Clarifying that Past Noncompliance deficiencies (as described in §7510.1 of Ch. 7 of the State Operations Manual (i.e. Determining Citations of Past Noncompliance at the Time of the Current Survey) are not included in the criteria for Immediate Imposition of Remedies; and,
  - For SFFs, scope/severity level “F” citations under tags F812, F813 or F814 are excluded from immediate imposition of remedies. The complete list of all F-Tags is located at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/List-of-Revised-FTags.pdf

Other sections of Chapter 7 have been revised to ensure conformity and consistency with these revisions. Specifically, the following sections, which include previous language that has been
Page 3 – State Survey Agency Directors
renumbered, moved and/or consolidated to provide better organized guidance:

- §7205 - Survey Frequency: 15-Month Survey Interval and 12-Month State-wide Average
- §7205.1 – Last Day of Survey
- §7205.1.1 – Setting the Mandatory 3-Month and 6-Month Sanction Time Frames
- §7310 - Immediate Jeopardy (IJ) Does Not Exist
- §7317 – Acceptable Plan of Correction
- §7400.4 - Other Factors That May Be Considered in Selecting Enforcement Remedy Within a Remedy Category
- §7510.1 – Determining Citations of Past Noncompliance at the Time of the Current Survey

The final version of these revisions to Chapter 7, when published in the SOM may differ slightly from this attached interim advanced copy.

Contact: For questions related to this memo, please contact the DNH Triage Team at dnh_triageteam@cms.hhs.gov.

Effective Date: This memorandum will be effective within 30 days of its publication date. Therefore, this guidance should be communicated with all survey and certification staff, their managers, and the State/RO training coordinators within 30 days of this memorandum.

/s/
David R. Wright

Attachment: Advanced Guidance Revisions to SOM Chapter 7

cc: Survey and Certification Regional Office Management
    State Medicaid Agencies
Sanction Time Frames

SUBJECT: Revisions to the State Operations manual (SOM 100-07) Chapter 7

I. SUMMARY OF CHANGES: Revisions to the State Operations manual (SOM 100-07) Chapter 7 – To provide revisions in sections 7205 through 7205.1.1, 7304 through 7304.6, 7306 through 7306.4, 7308 through 7308.3, 7309 through 7309.5, 7310 through 7310.2, 7311 through 7311.3, 7313 through 7313.2, 7317, 7400 through 7400.5.3 and 7510.1.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: Upon Issuance
IMPLEMENTATION DATE: Upon Issuance

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual not updated.) (R = REVISED, N = NEW, D = DELETED) – (Only One Per Row.)

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III. FUNDING: No additional funding will be provided by CMS.

IV. ATTACHMENTS:

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*Unless otherwise specified, the effective date is the date of service.*
This section does not apply to the date of survey for remedy imposition and termination timeframes. The survey and certification provisions set forth in §§1819(g)(2)(A)(iii) and 1919(g)(2)(A)(iii) of the Act and in 42 CFR §488.308 require that each skilled nursing facility and nursing facility be subject to a standard survey no later than 15 months after the last day of the previous standard survey and that the statewide average interval between standard surveys of skilled nursing facilities and nursing facilities not exceed 12 months.

7205.1 - Last Day of Survey

The last day of survey is the last day of onsite observations during a survey, regardless of whether the exit conference was performed on that same day.

For purposes of computing three months or six months from a finding of noncompliance when the health and life safety code portions of the survey are on the same enforcement track, use the last day of onsite observations of the standard health survey on which the noncompliance was identified, regardless of which survey preceded the other. Even when the life safety code was the second of the two surveys to be performed on the same enforcement track, and it was the survey that found the noncompliance, the clock still starts on the last day of the standard health survey and will always be used to begin counting the number of noncompliance days. For purposes of the first notice of noncompliance, use the last day of the survey that found the cited noncompliance.

When two separate enforcement tracks are being used (one track for the health portion and one track for the life safety code portion of the standard survey), the mandatory denial of payment for new admissions and termination time frames would be three months and six months, respectively, for each separate portion.

7205.1.1 - Setting the Mandatory 3-Month and 6-Month Sanction Time Frames

These dates should be set based on full months rather than on a number of days. With few exceptions, these dates should be set by simply going to the same numerical date in the 3rd or 6th month following the survey date. For example, if a survey ended on January 15, the 3-month effective date for the mandatory denial of payment for new admissions remedy is April 15, and the 6-month mandatory termination date is July 15.

Exceptions to this rule involve those cases for which a 3-month or 6-month numerical date is not on the calendar. In these cases, move ahead a day or two to the beginning of the next month. For example, if a survey ended on January 31, the 3-month effective date for the mandatory denial of payment for new admissions remedy would be April 31. However, since there is no April 31, the 3-month effective date is May 1 and the 6-month mandatory termination date is July 31.

7304 - Mandatory Immediate Imposition of Federal Remedies
Noncompliance may occur for a variety of reasons and can result in harm to residents or put residents at risk for harm. When facilities do not maintain substantial compliance, CMS may use various enforcement remedies to address a facility’s responsibility to promptly achieve, sustain and maintain compliance with all federal requirements. To support this purpose, we are directing the immediate imposition of federal remedies in certain situations outlined in §7304.1 below, and we recommend using the type of remedy that best achieves the purpose based on the circumstances of each case.

This guidance does not apply to past noncompliance deficiencies as described in §7510.1 of this chapter. The determination to impose a federal remedy for past noncompliance is not mandatory and is at the discretion of the CMS Regional Office (RO).

7304.1 - Criteria for Mandatory Immediate Imposition of Federal Remedies Prior to the Facility's Correction of Deficiencies
(Rev.)

CMS will impose federal remedies and the survey will be identified as a “No Opportunity to Correct” if the situation meets any one or more of the following criteria:

- Immediate Jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Any deficiency from the current survey at levels “G, H or I” that falls into any of the regulatory sections that constitute Substandard Quality of Care (SQC); OR
- Any deficiency at “G” or above on the current survey AND if there were any deficiencies at “G” or above on the previous standard health or LSC survey or if there was any deficiency at “G” or above on any type of survey between the current survey and the last standard health or LSC survey. These surveys (standard health or LSC, complaint, revisit) must be separated by a certification of compliance, i.e., they must be from different noncompliance cycles. For instance, level G or above deficiencies from multiple surveys within the same noncompliance cycle must not be combined to make this a “double G or higher” determination; OR
- A facility classified as a Special Focus Facility (SFF) AND has a deficiency citation at level “F,” (excluding any level “F” citations under tags F812, F813 or F814) or higher for the current health survey or “G” or higher for the current Life Safety Code (LSC) survey.

The remedies to be imposed by statute do not change, (e.g., 3-month automatic Denial of Payment for new admissions (DPNA), 23-day termination when IJ is present and 6-month termination). In addition to these statutory remedies, the CMS RO must also immediately impose one or more additional remedies for any situation that meets the criteria identified above. The State Survey and/or Medicaid Agencies shall not permit changes to this policy.

Use of Federal Remedies in Immediate Jeopardy (IJ) Citations - When IJ is identified on the current survey that resulted in serious injury, harm, impairment or death, a CMP must be imposed.

For IJ citations where there is no resultant serious injury, harm, impairment or death but the likelihood is present, the CMS RO must impose a remedy or remedies that will best achieve the
purpose of attaining and sustaining compliance. CMPs may be imposed, but they are not required.

NOTE: “Current” survey is whatever Health and/or LSC survey is currently being performed, e.g., standard, revisit, or complaint. “Standard” survey (which does not include complaint or revisit surveys) is a periodic, resident-centered inspection that gathers information about the quality of service furnished in a facility to determine compliance with the Requirements of Participation.

Process for State Enforcement Recommendations - While States are not required to recommend the types of remedies to be imposed, they are encouraged to do so since States may be more familiar with a facility’s history and the specific circumstances in the case at hand. The CMS RO will consider these recommendations but ultimately makes the enforcement determination. To ensure effective communication and exchange of information, CMS encourages that all documentation is included in the ASPEN - Enforcement Manager (AEM) system or any subsequent system.

Regardless of a State’s recommendation, the CMS RO must take the necessary actions to impose a remedy or multiple remedies, based on the seriousness of the deficiencies following the criteria set forth in 42 C.F.R. §488.404. Also refer to §§7400.5.1 and 7400.5.2 of this chapter. In addition to any statutorily imposed remedy, additional remedies should be selected that will bring about compliance quickly and encourage facilities to achieve and maintain compliance. When making remedy choices, the CMS RO should consider the extent to which the noncompliance is the result of a one-time mistake, larger systemic concerns, or an intentional action of disregard for resident health and safety.

The State Survey Agency is authorized to both recommend and impose one or more Category 1 remedies, in accordance with §7314 of this Chapter. CATEGORY 1 remedies include:

- Directed plan of correction,
- State monitoring, and
- Directed in-service training.

Types of Remedies - The choice of remedy is made that best achieves the purpose of attaining and sustaining compliance based on the circumstances of each case and recommendations from the State. Federal remedies are summarized below. Refer to §§7500 - 7556 of this chapter for more detail on these remedies.

Civil Money Penalties (CMPs) - Federal CMPs may only be imposed by the CMS RO. If a CMP is imposed, it must be done in accordance with instructions in the CMP Analytic Tool and §§7510 through 7536 of this chapter.

Directed In-Service Training – Refer to §7502 of this chapter. Consider this remedy in cases where the facility has deficiencies where there are knowledge gaps in standards of practice, staff competencies or the minimum requirements of participation and where education is likely to correct the noncompliance. Depending on the topic(s) that need to be addressed and the level of training needed, facilities should consider using programs developed by well-established centers of geriatric health services such as schools of medicine or nursing, centers for the aging, and area health education centers which have established programs in geriatrics and geriatric...
psychiatry. If it is willing and able, a State may provide special consultative services for obtaining this type of training. The State or regional office may also compile a list of resources that can provide directed in-service training and could make this list available to facilities and interested organizations. Facilities may also utilize the ombudsman program to provide training about residents’ rights and quality of life issues.

Directed Plan of Correction Refer to §7500 of this chapter. This remedy provides for directed action(s) from either the State or CMS RO that the facility must take to address the noncompliance or a directed process for the facility to more fully address the root cause(s) of the noncompliance. Achieving compliance is ultimately the facility’s responsibility, whether or not a directed plan of correction is followed.

Temporary Management - Refer to 42 CFR §§488.408 and 488.410. This is the temporary appointment by CMS or the State of a substitute facility manager or administrator with authority to hire, terminate or reassign staff, obligate facility funds, alter facility procedures, and manage the facility to correct deficiencies identified in the facility’s operation. A temporary manager may be imposed anytime a facility is not in substantial compliance but may also be imposed when a facility’s deficiencies constitute I.I or widespread actual harm and a decision is made to impose an alternative remedy in lieu of termination. It is the temporary manager’s responsibility to oversee correction of the deficiencies and assure the health and safety of the facility’s residents while the corrections are being made. The temporary manager’s term can extend beyond the time which deficiencies are corrected by agreement of the facility and the temporary manager. A temporary manager remedy may also be imposed to oversee orderly closure of a facility. The State will select the temporary manager when the State Medicaid Agency is imposing the remedy and will recommend a temporary manager to the regional office when CMS is imposing the remedy. Each State should compile a list of individuals who are eligible to serve as temporary managers. These individuals do not have to be located in the State where the facility is located.

Denial of Payment for all New Medicare and Medicaid Admissions (DPNA) – See §7506 of this chapter. This remedy may be imposed alone or in combination with other remedies to encourage quick compliance. Regardless of any other remedies that may be imposed, a mandatory denial of payment for new admissions must be imposed when the facility is not in substantial compliance three months after the last day of the survey identifying deficiencies, or when a facility has been found to have furnished substandard quality of care on the last three consecutive standard surveys (see 42 CFR 488.414).

Denial of all Payment for all Medicare and Medicaid Residents (DPAA) (Discretionary). See §7508 of this chapter. Only CMS has the authority to deny all payment for Medicare and/or Medicaid residents. This is in addition to the authority to deny payment for all new admissions (discretionary) noted above. This is a severe remedy. Factors to be considered in selecting this remedy include but are not limited to:

1. Seriousness of current survey findings;
2. Noncompliance history of the facility; and
3. Use of other remedies that have failed to achieve or sustain compliance.

State Monitoring - Refer to §7504 of this chapter. A State monitor oversees the correction of cited deficiencies in the facility as a safeguard against further harm to residents when harm or a situation with a potential for harm has occurred. Consider imposing this remedy when, for example, there are concerns that the situation in the facility has the potential to worsen or the
facility seems unable or unwilling to take corrective action. A State monitor must be used when a facility has been cited with substandard quality of care (SQC) deficiencies on the last three consecutive standard health surveys.

Termination of Provider Agreement - See §7556 of this chapter. While this remedy may be imposed at any time the circumstances warrant regardless of whether IJ is present; regardless of any other remedies that may be imposed, termination of a facility’s provider agreement must be imposed when the facility is not in substantial compliance six months after the last day of the survey identifying deficiencies or within no more than 23 days if IJ is identified and not removed.

7304.2 - Effective Dates for Immediate Imposition of Federal Remedies (Rev.)

Once a remedy is imposed, it becomes effective as of the date specified in the notice letter for the remedy being imposed. All remedies remain in effect and continue until the facility has demonstrated and is determined to be in substantial compliance. Substantial compliance must be verified in accordance with §7317 of this chapter. Substantial compliance may be determined to occur anytime between the latest correction date on the approved Plan of Correction (PoC) up until the date of the revisit. The date of substantial compliance is determined by the date on which the evidence provided by the facility supports correction of deficiencies as determined by the Survey Agency.

For Immediate Jeopardy (IJ) Situations: A facility’s removal of the conditions that caused the IJ may, at CMS’s discretion, result in the rescission of the 23-day termination. A per day CMP must be lowered when the survey agency has verified that the IJ has been removed but deficiencies at a lower level continue. Refer to the CMP Analytic Tool instructions for determining the dates of a per day CMP. However, CMS shall not rescind any other remedies imposed until the facility achieves substantial compliance or is terminated. Remedies imposed must remain in effect, irrespective of when the IJ is removed, unless otherwise rescinded or revised as a result of legal proceedings. Remedies will be immediately imposed and effectuated whether the IJ was:

- removed during the survey, or,
- removed in a subsequent IJ removal revisit before the 23rd day.

7304.3 - Responsibilities of the State Survey Agency and the CMS Regional Office (RO) when there is an Immediate Imposition of Federal Remedies (Rev.)

When federal remedies are to be immediately imposed as outlined in §7304:

- Within five (5) business days after the last day of the current survey when any of the criteria in §7304.1 is met the survey agency must notify the CMS RO their review and action; and,
- The CMS RO will review these cases within five (5) business days of receipt from the survey agency and decide if an immediate imposition of remedies is appropriate.

Timeliness is important to ensure that remedies are imposed, and notices are sent to the facility before the effective dates of the remedies to be imposed and meet the timelines for notices as outlined in §7305 of this chapter.
The survey agency (State or Federal) must enter all of these cases as a NO opportunity to correct into the Automated System Processing Environment (ASPEN)/ASPEN Enforcement Manager (AEM) system within five (5) business days of sending the initial notice to the facility. The State Survey Agency and the CMS RO must have systems in place to routinely check and monitor the ASPEN-AEM database to identify cases that may require enforcement action or additional follow-up, as needed.

7308 - Enforcement Actions When Immediate Jeopardy (IJ) Exists (Rev.)

If at any time during the survey one or more team members identify a possible IJ, the team must meet immediately to confer. If the team agrees that deficiencies constitute IJ, the team leader must contact, while on-site, its management to discuss the findings. If it is determined that IJ exits the team must notify the facility administration, while on-site, of the IJ findings.

When the State Survey Agency identifies IJ, it must notify the CMS Regional Office (RO), or the State Medicaid Agency, or both, as appropriate, so that either agency terminates the provider agreement within 23 calendar days of the last date of the survey, and/or appoints a temporary manager who must remove the IJ within 23 calendar days of the last date of the survey which identified the IJ. When the CMS RO imposes termination of a Medicaid provider agreement, it notifies the State Medicaid Agency to terminate the agreement. However, action can be taken more quickly than 23 days as long as the required notice is given. In either case, the IJ must be removed no later than 23 days from the last day of the survey or the provider agreement will be terminated.

In addition, when IJ is identified on the current survey, (whatever Health and/or LSC survey is currently being performed, e.g., standard, revisit, or complaint), that resulted in serious injury, harm, impairment or death a CMP must be imposed.

For IJ citations where there is no resultant serious injury, harm, impairment or death but the likelihood is present, a remedy must be imposed; however, the CMS RO may select any remedy that best achieves the purpose of achieving and sustaining compliance and address various levels of noncompliance. See Section 7400 which describes available remedies.

When IJ is identified, the facility must submit an allegation that the IJ has been removed. This allegation must include a plan of sufficient detail to demonstrate how and when the IJ has been removed.

A plan of correction for the deficiencies should be deferred until a revisit is conducted to verify the removal of the IJ. Documentation resulting from the revisit must be completed indicating whether the IJ was removed and deficiencies corrected (Form CMS-2567B), or that the IJ was removed but compliance had not been achieved (Form CMS-2567). When a new Form CMS-2567 is necessary, it should be written with evidence that supports the remaining noncompliance.

NOTE: In order for a 23-day termination to be stopped, the IJ must be removed, even if the underlying deficiencies have not been fully corrected. Waiting for acceptable plans of correction can result in undue delay in determining removal of IJ. Therefore, plan of corrections should be deferred until the IJ is removed.
If the facility alleges that the IJ is removed and a revisit verifies that it has been removed but the facility is still not in substantial compliance, use the non-IJ process, which requires a plan of correction for all citations. Waiting for the complete statement of deficiencies (Form CMS-2567) and the facility’s plan of correction for the non-IJ deficiencies can result in undue delay in determining removal of IJ. Therefore, a Statement of Deficiencies (Form CMS-2567) and a facility’s plan of correction for the non-IJ deficiencies may be deferred until the survey agency verifies the IJ is removed.

In addition, whenever a facility has deficiencies that constitute both IJ and substandard quality of care (SQC) (as defined in 42 CFR §488.301), the survey agency must notify the attending physician of each resident found to have received SQC as well as the State board responsible for licensing the facility’s administrator. Notify physicians and the administrator licensing board in accordance with §7320.

7309 - Key Dates When Immediate Jeopardy (IJ) Exists
(Rev.)

NOTE: These timelines apply whether the survey was conducted by a State Survey Agency, CMS Regional Office (RO) or a CMS contractor.

7309.1 - 2nd Calendar Day
(Rev.)

No later than two (2) calendar days (one of which must be a working day) following the last date of the survey which identified the IJ the survey entity must notify in writing;

- The CMS RO and the State Medicaid Agency of its findings by e-mail or facsimile (FAX): and,
- The facility of the IJ findings and that the survey entity is recommending to the CMS RO and the State Medicaid Agency that the provider agreement be terminated and that a Civil Money Penalty (CMP) or other remedies may be imposed. A temporary manager may be imposed in lieu of or in addition to termination (see §488.410)

This notice may also serve as the formal notice from the State Survey Agency for imposition of any category 1 remedy or denial of payment for new admissions remedy when authorized by the CMS RO and/or the State Medicaid Agency. This notice must also include the facility’s right to informal dispute resolution (IDR) or an independent informal dispute resolution (IIDR) and to a formal appeal of the noncompliance.

Note: this written notice is separate from the survey entity’s responsibility to inform the facility onsite during the survey of the IJ findings and their responsibility to provide a written allegation of removal of the IJ with sufficient detailed information to demonstrate how and when the IJ was removed.

7309.2 - 5th - 21st Calendar Day
(Rev.)
Except when formal notice of remedies is provided by the State Survey Agency, as authorized by CMS and/or the State Medicaid Agency, the CMS RO and/or the State Medicaid Agency issues a formal notification of remedies to the facility. In addition, the notice should include the facility’s right to a formal appeal of the noncompliance which led to the temporary management remedy, termination, or any other enforcement actions (except State monitoring). For the temporary management remedy, the notice will advise the facility of the conditions of temporary management and that failure to relinquish control to the temporary manager will result in termination. The general public is also given notice of the impending termination.

7309.3 - No Later Than 10th Business Day
(Rev.)

If the survey entity verifies that the IJ has been removed, then it must send the Statement of Deficiencies (Form CMS-2567) to the facility.

NOTE: The facility must submit a written allegation of removal of the IJ with sufficient detailed information to demonstrate how and when the IJ was removed. If a PoC is to be submitted, it must be received no later than 10 calendar days after the facility receives their Statement of Deficiencies (Form CMS-2567).

7309.4 - By 23rd Calendar Day
(Rev.)

Termination takes effect unless the IJ has been removed.

7310 - Immediate Jeopardy (IJ) Does Not Exist
(Rev.)

These procedures incorporate §§1819(h)(2)(A)(ii), 1919(h)(1)(B), and 1919(h)(3)(B)(ii) of the Act, as well as implementing regulations in 42 CFR 488.412.

The broad array of remedies varies in form and severity in recognition of the fact that there can be variations in impact posed by each violation of participation requirements. Therefore, while provider agreement terminations are authorized in non-immediate jeopardy cases, it is not generally necessary or desirable to choose that remedy when substantial compliance may be achieved rapidly through imposition of one or more alternative remedies.

When the surveying entity finds that a facility’s deficiencies do not pose IJ to resident health or safety, but the facility is not in substantial compliance, the surveying entity may recommend that the enforcing entity either terminate the facility’s provider agreement, or impose alternative remedies, or do both. The State may also provide formal notice of imposition and rescission of category 1 remedies and/or denial of payment for new admissions, as authorized by CMS and/or the State Medicaid Agency. The action may be taken immediately, or the facility may be given an opportunity to correct, as described in §7304.

When the CMS Regional Office finds through a validation survey or review of the State’s findings that any of the facility’s deficiencies do not pose IJ to resident health or safety but the facility is not in substantial compliance, the CMS Regional Office must, as appropriate, take action itself to
terminate the facility’s provider agreement (or stop Federal financial participation), or impose alternative remedies instead of terminating the provider agreement, or both; or direct the State Medicaid Agency to terminate the facility’s Medicaid provider agreement. The authority for CMS to take enforcement action for any nursing facility, when CMS finds the nursing facility to be out of compliance, is at §1919(h)(3)(A) and (B).

7313 - Procedures for Recommending Enforcement Remedies When Immediate Jeopardy (IJ) Does Not Exist (Rev.)

Once noncompliance is identified, the surveying entity must first determine whether to immediately impose remedies in accordance with the criteria in §7304.1 or give the facility an opportunity to correct its deficiencies before remedies are imposed.

7313.1 - Facilities Given an Opportunity to Correct Deficiencies prior to the Immediate Imposition of Federal Remedies (Rev.)

A facility may be permitted to correct its deficiencies and delay the imposition of remedies only when the criteria outlined in §7304.1 of this chapter are not met. Facilities must submit an acceptable plan of correction for its deficiencies (other than Scope/Severity level A).

7317 - Acceptable Plan of Correction (Rev.)

Except in cases of past noncompliance, facilities having deficiencies (other than those at scope and severity level A) must submit an acceptable plan of correction. An acceptable plan of correction must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility in writing. If the plan of correction is acceptable, the State will notify the facility by phone, e-mail, etc. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely.

The plan of correction serves as the facility’s allegation of compliance and, without it, CMS and/or the State have no basis on which to verify compliance. A plan of correction must be submitted within 10 calendar days from the date the facility receives its Form CMS-2567. If an acceptable
plan of correction is not received within this timeframe, the State notifies the facility that it is recommending to the RO and/or the State Medicaid Agency that remedies be imposed effective when notice requirements are met. The requirement for a plan of correction is in 42 CFR 488.402(d). Further, 42 CFR 488.456(b)(ii) requires CMS or the State to terminate the provider agreement of a facility that does not submit an acceptable plan of correction.

A facility is not required to provide a plan of correction for a deficiency cited as past noncompliance because that deficiency is corrected at the time it is cited; however, the survey team must document the facility’s corrective actions on Form CMS-2567.

7400 - Enforcement Remedies for Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs) and Dually Participating Facilities (SNFs/NFs) (Rev.)

Sections 1819(h) and 1919(h) of the Act, as well as 42 CFR §§488.404, 488.406, and 488.408, provide that CMS or the State may impose one or more remedies in addition to, or instead of, termination of the provider agreement when the State or CMS finds that a facility is out of compliance with federal requirements. Enforcement protocols/procedures are based on the premise that all requirements must be met and take on greater or lesser significance depending on the specific circumstances and resident outcomes in each facility.

7400.1 - Available Federal Enforcement Remedies (Rev.)

In accordance with 42 CFR §488.406, the following remedies are available:

- Termination of the provider agreement;
- Temporary management;
- Denial of payment for all Medicare and/or Medicaid residents by CMS;
- Denial of payment for all new Medicare and/or Medicaid admissions;
- Civil money penalties;
- State monitoring;
- Transfer of residents;
- Transfer of residents with closure of facility;
- Directed plan of correction;
- Directed in-service training; and
- Alternative or additional State remedies approved by CMS.

7400.2 - Enforcement Remedies for the State Medicaid Agency (Rev.)

Regardless of what other remedies the State Medicaid Agency may want to establish in addition to the remedy of termination of the provider agreement, it must establish, at a minimum, the following statutorily-specified remedies or an approved alternative to these specified remedies:

- Temporary management;
- Denial of payment for all new admissions;
- Civil money penalties;
- Transfer of residents;
- Transfer of residents with closure of facility; and
- State monitoring.

The State Medicaid Agency may establish additional or alternative remedies if the State has been authorized by CMS to do so under its State plan. Guidance on the review and approval (or disapproval) of State Plan amendment requests for alternative or additional remedies can be found in §7805.

Whenever a State Medicaid Agency’s remedy is unique to its State plan and has been approved by CMS, then that remedy may also be imposed by the Regional Office against the Medicare provider agreement of a dually participating facility in that State. For example, where CMS has approved a State’s ban on admissions remedy as an alternative remedy under the State plan, CMS may impose this remedy but only against Medicare and Medicaid residents; only the State can ban the admission of private pay residents.

7400.3 - Selection of Remedies
(Rev.)

To select the appropriate remedy(ies) for a facility’s noncompliance, the seriousness, scope and severity of the deficiencies must first be assessed. The purpose of federal remedies is to address a facility responsibility to promptly achieve, sustain and maintain compliance with all federal requirements. In addition to the required enforcement action(s), remedies should be selected that will bring about compliance quickly. While a facility is always responsible for all violations of the Medicare and Medicaid requirements, when making remedy choices, the CMS RO should consider the extent to which the noncompliance is the result of a one-time mistake, larger systemic concerns, or an intentional action of disregard for resident health and safety.

7400.3.1 - Matrix for Scope & Severity
(Rev.)

| Immediate jeopardy to resident health or safety | J █ ▒ ▒ | K ▒ ▒ | L ▒ ▒ |
| Actual harm that is not immediate | G ▒ ▒ | H ▒ ▒ | I ▒ ▒ |
| No actual harm with potential for more than minimal harm that is not immediate jeopardy | D ▒ ▒ | E ▒ ▒ | F ▒ ▒ |
| No actual harm with potential for minimal harm | A ▒ No PoC | B ▒ | C ▒ |

Substandard Quality of Care (SQC) is defined in 42 C.F.R. §488.301 as one or more deficiencies which constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm, related to certain participation requirements.

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. Substantial compliance constitutes compliance with participation requirements (42 C.F.R. §488.301).

7400.4 - Other Factors That May Be Considered in Selecting Enforcement Remedy Within a Remedy Category
(Rev.)
Additional factors that may be considered to assist in determining which and/or how many remedies to impose within the available remedy categories for levels of noncompliance, include but are not limited to:

- The relationship of one deficiency to other deficiencies;
- The facility’s prior history of noncompliance in general, and specifically with reference to the cited deficiencies; and
- The likelihood that the selected remedy(ies) will achieve correction and continued compliance.

EXAMPLE: If failure to spend money is the root cause of the facility’s noncompliance, then any civil money penalty that is imposed should at least exceed the amount saved by the facility by not maintaining compliance.

7510.1 – Determining Citations of Past Noncompliance at the Time of the Current Survey
(Rev.)

Past noncompliance may be identified during any survey. For the purpose of making determinations of current noncompliance or past noncompliance, the survey team is expected to follow the investigative protocols and surveyor guidance. To cite past noncompliance with a specific survey data tag (F-tag or K-tag), all of the following three criteria must be met:

1. The facility was not in compliance with the specific regulatory requirement(s) (as referenced by the specific F-tag or K-tag) at the time the situation occurred;
2. The noncompliance occurred after the exit date of the last standard (recertification) survey and before the survey (standard, complaint, or revisit) currently being conducted; and
3. 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), as referenced by the specific F-tag or K-tag.

A nursing home does not provide a plan of correction for a deficiency cited as past noncompliance because the deficiency is already corrected; however, the survey team documents the facility’s corrective actions on the CMS-2567.

Regulations at 42 CFR 488.430(b) provide that a civil money penalty (CMP) may be imposed for past noncompliance since the last standard survey. CMS strongly urges States to recommend the imposition of a CMP for past noncompliance cited at the level of immediate jeopardy.

When a CMP is recommended, the State Survey Agency notifies the CMS Regional Office (RO) and/or State Medicaid Agency within 20 days from the last day of the survey that determined past noncompliance of its recommendation to impose a CMP. The CMS RO and/or State Medicaid Agency responds to the recommendation within 10 days, and if accepted, sends out the formal notice in accordance with the notice requirements in §7305 and §7520.
Class I, I/II, II, II/III, or III is noted in the Requirements column of the Inspection Results, usually at the end of the regulatory text

Class I

A violation which presents either an imminent danger to the health, safety or welfare of any resident or a substantial probability that death or serious physical harm would result. This is the most severe classification of State deficiencies. If an inspection results in any Class I violations, inspectors will revisit the facility within 20 days.

Class II

A violation which has a direct or immediate relationship to the health, safety or welfare of any resident, but which does not create any imminent danger. This is the intermediate classification of State deficiencies. If an inspection results in any Class II violations, but no Class I violation, inspectors will revisit the facility between 40 and 90 days.

Class III

A violation which has an indirect or a potential impact on the health, safety or welfare of any resident. This is the least severe classification of State deficiencies. If an inspection results in less than twenty Class III violations and no Class II or Class I violations, the facility is considered to be in substantial compliance and no revisits are required. These violations are not required to be corrected; therefore a correction date may not be displayed on the website. If an inspection results in twenty or more Class III violations and no Class II or Class I violations, inspectors will revisit the facility within 120 days.

Class I/II

This violation may be cited as a Class I or a Class II. It will be cited at the lower classification, Class II, unless there is sufficient evidence to support the more severe classification of Class I.

Class II/III

This violation may be cited as a Class II or a Class III. It will be cited at the lower classification, Class III, unless there is sufficient evidence to support the more severe classification of Class II.
Missouri nursing homes have an opportunity, under state law, to refute citations issued by the state Department of Health & Senior Services. DHSS inspectors are required to survey every licensed long-term care facility in the state at least twice per fiscal year.

Long-term-care facility managers may exercise their right to refute the findings of state surveys through Primaris.

Since our organization was contracted by the state to perform review services in the summer of 2011, Primaris’ team of skilled reviewers have conducted informal reviews with the highest regard for objectivity, professionalism and fairness to all parties involved.

NEED IDR ASSISTANCE? PRIMARIS CAN HELP

INFORMAL DISPUTE RESOLUTION IS A SIMPLE PROCESS, AND IT ALL STARTS WITH COMPLETING OUR ONE-PAGE INTAKE FORM. YOU CAN FIND THE FORM ONLINE AT WWW.PRIMARIS.ORG OR CONTACT OUR IDR DEPARTMENT AT 800-735-6776, EXT. 213.
informal dispute resolution: myths vs facts

**myth**
It takes too many resources (both time and money).

**fact**
There is no fee charged by Primaris or DHSS. The facility would only pay legal fees if they chose to have legal representation. The majority of IDR reviews do not involve legal counsel. Telephonic reviews and desk reviews are available which reduce the time away from the office. You can spend as much or as little time as you feel is appropriate in preparing your exhibits.

**myth**
My facility will be penalized or retaliated against for requesting IDR.

**fact**
Not true. DHSS is extremely sensitive to concerns regarding survey objectivity and/or retaliation. Regulation provides this one opportunity to have disputed citations reviewed by a third party (Primaris).

**myth**
The conference will be biased and an uncomfortable process.

**fact**
Reviewers are trained and experienced in keeping the conference objective and professional to avoid any adversity in the process. In fact, one of the most common statements we receive from our post-review surveys is regarding how professional and non-confrontational the conferences are.

**myth**
The chances of getting a citation reduced or deleted are very slim.

**fact**
Not true. In fact, Primaris recommends revisions to 1 in 3 citations. This includes removing a deficiency entirely or reducing the scope and severity.

**myth**
The process is too complicated.

**fact**
It's as simple as completing our one-page Intake form. The form and instructions are available at www.primaris.org or you can call Lisa Steward at 573-817-8300 ext. 186.

**myth**
It won't make a difference.

**fact**
There are many potential positive outcomes. A good outcome can positively influence Five Star Ratings, the representation of your facility in the SOD – which is a public record document, and you may incur much less exposure to liability for certain claims when tags are reduced/removed.

MO-14-10-NH August 2014

Instructions for Completing IDR Intake Form

NOTE: For additional information about the IDR process and helpful tips for preparing exhibits see our website @ http://primaris.org/informal-dispute-resolution

1. Enter today’s date
2. Enter facility name (as listed with DHSS)
3. Enter contact person’s name
4. Enter contact person’s phone number and email address
5. Enter Administrator’s name (if different than “contact person”)
6. Enter SNF, ICF, ALF, or RCF. Mark appropriate box indicating if facility is “Certified” or “Licensed Only”
7. Enter facility’s license number
8. Enter Administrator’s phone number and email
9. Enter Region #
10. Enter facility phone number
11. Enter facility fax number
12. Enter any dates that are preferred by the facility for purposes of scheduling the IDR conference. We will try to accommodate all requests to the best of our ability.
13. Enter facility address
14. Enter SOD date (exit date)
15. Enter any dates that the facility is not available for purposes of scheduling the IDR conference
16. Please mark the YES or NO box indicating whether or not you will have legal representation for the IDR process.
17. Enter attorney’s name (if applicable)
18. Enter attorney’s phone # and email address (if applicable)
19. Mark the type of review you are requesting (either telephonic, face-to-face, or desk)
20. Enter attorney’s street address (if applicable)
21. Enter attorney’s city and state (if applicable)
22. Enter attorney’s zip code (if applicable)
23. Enter Federal/ State Tags being disputed
24. Using the codes listed in the box located on the right, please indicate the applicable code for the reason(s) you are disputing the indicated tag.
25. DO NOT ENTER ANYTHING IN THIS BOX UNLESS YOU HAVE SPECIFICALLY BEEN SENT A LETTER STATING ELIGIBILITY FOR THE INDEPENDENT INFORMAL DISPUTE RESOLUTION PROCESS (IIDR). We recommend that before marking this box you call Carmen or Lisa in the Primaris IDR Department at 573-817-8300 ext. 124 (Carmen) or ext. 186 (Lisa).
26. Please sign
27. Please date
1. Today's Date:  
2. Facility Name:  
3. Contact Person:  

4. Contact Person's Phone & Email  
5. Administrator's Name:  
6. Facility Level: 
   Certified Facility:     Yes          No  
   Licensed Only:          Yes          No  

7. Facility License Number:  
8. Administrator's Phone & Email:  
9. Region: 
   Primaris will automatically schedule the conference but it’s helpful to
   know, in advance, if there are preferred dates by the facility. The
   conference will be scheduled to be held within 10 days of receiving this
   INTAKE.  

10. Facility Phone Number           11. Facility Fax Number:    12. Date(s) preferred by facility (if any):  

13. Facility Address (Street/City/State/Zip):  
14. Date of SOD: 
15. Date(s) facility is UNAVAILABLE (if any):  

*NOTE:  Helpful tips and hints for preparing your exhibits and frequently asked Q & As can be found on our website @  
http://primaris.org/informal-dispute-resolution  
Enter the date that you received your letter and official SOD from DHSS_____________________

16. Will the facility have legal counsel involved in the IDR Process: 
   Yes ☐     No ☐  

17. Attorney’s Name:  
18. Attorney’s Phone # and Email:  
19. Review Type Requested: 
   Telephonic_____ Face-to-Face_____ Desk Review_____  
20. Attorney’s Street Address:  
21. Attorney’s City, State:  
22. Attorney’s Zip:  

Please Enter Specific Information Regarding the Disputed Tag(s) Below. All associated state tags will automatically be reviewed unless specifically requested otherwise. Please fax your request and completed Intake form to Lisa Steward at 573-777-1016. If additional space is needed, please attach a separate sheet.

<table>
<thead>
<tr>
<th>Disputed Tag/Code</th>
<th>Reason for Dispute (See Codes)</th>
<th>Comments</th>
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<tbody>
<tr>
<td>23. Fed Tag ______ State Tag_______</td>
<td>24</td>
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25. **If Requesting an Independent Informal Dispute Resolution (IIDR) please check: Yes ☐**

Complete the following information and fax along with a copy of the CMP Notification Letter to 573-777-1016:

| Signature of Requestor /Date of Request: | 26. Signature : | 27. Date: |

*If at any time during the process it is determined that legal counsel will attend the conference, WE MUST KNOW THIS IN ADVANCE!*
HOW TO WRITE A PLAN OF CORRECTION

1. The first statement on the plan of correction should be a disclaimer such as:

"Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law”.

2. For each deficiency cited you must include in the POC the following information:

   a. How will you correct the deficiency for the residents who were cited? Explain what you did to correct the issues that were identified for each of these residents.

   b. What did you do to try to identify any other residents who may be affected by the same deficient practice? What did you do to identify other residents who have the potential to have the same issue? Audits, reviews, interviews, etc. If this is an environmental tag what did you do to identify any other issues in the facility related to this tag.

   c. What system will you put in place to correct the deficient practice and make sure that the problem remains fixed. This will include in-servicing, a change in the system approach, a change in the review process, etc. You must make some sort of change because whatever the facility was previously doing did not work.

   d. How will you monitor the system to make sure that the changes that have been made stay in place? You must include how you will monitor with your QA procedure. What type of monitoring, who will do the monitoring and how often will it be done.

   e. By what date will you complete this process. The Section for Long Term Care Regulations expects that no plan of correction date exceed 45 days from date of exit.

3. Be careful not to put something in your POC that may be difficult or impossible for the facility to comply or keep in place.
After the survey the facility should immediately start working on their plan of correction. The facility should have some idea what deficiencies the state has identified and why. A plan needs to be put into place for in-servicing, reviewing/updating chart information, completing assessments, auditing processes etc. Everything that is done after the survey should be documented and maintained for the “re-visit”.

Once the 2567 (statement of deficiencies) is received and your plan of correction has been completed a “Credible Allegations” book should be put together. In this book there should be a divider for each deficiency. A copy of that specific deficiency and your plan of correction should be placed behind each divider. Everything that is done to clear that deficiency should be copied and added to the binder. This will include audits, reviews, in-services, updates of any information that may have been changed such as the care plan, assessments, physician orders, etc. The idea of the book is to provide the surveyor with all the information necessary to clear the tag without ever leaving the office. Most surveyors will still be on the floor and looking at the items, but they should not have to ask for any information. Everything they need to validate your plan of correction should be in the book. If an in-service is completed and it covers more than one deficiency, make a copy of that in-service for each deficiency covered. A copy of the facility employee roster should be obtained with any information other than name and job title erased. This can then be used as your in-service sign-in sheet which will ensure that all the employees for that respective deficiency has been in-serviced. For each deficiency, highlight the area that speaks of the specific deficiency and place a copy behind each divider. (Example: you in-service nursing staff on hand-washing for the infection control tag (F-880) and peri-care for the ADL tag (F-677) during the same in-service. You will make two copies of the in-service. You will highlight the first copy where you covered hand-washing and place that copy under F-880. Then highlight the 2nd copy where you covered peri-care and place that copy under F-677. Be sure to copy the signature sheet also.

If your plan of correction stated you would do daily audits, there should be an audit for each day of the week in the book. If you are doing weekly audits, there needs to be one for each week, etc. You should also create a list of items needed to make sure your book is complete and check them off as you receive and place in your book. Each day there should be a status update on each tag and any audits collected from the day before.

All Notebooks should be kept in a single place which is the Administrator’s Office. Management staff should know where this information is kept, in case the re-visit occurs when you’re not present.
GETTING READY FOR RE-VISIT

1. Be sure that everything is completed in your Credible Allegations Book by the deadline you set as your date of compliance.

2. Follow up on any issues that may have developed while working your plan of correction.

3. Monitor to assure no “new problems” arise that could result in a new deficiency. Do not let your current systems go down while working on your POC.

4. Be sure all staff are aware of the re-visit and are always prepared.

5. Continue your room rounds by department heads and your resident monitoring systems.

6. Review your POC, in its entirety, a minimum of weekly to make sure that you have not failed to review/correct an item. Status updates on corrective action(s) and completed audits should be reviewed daily and inserted in your “Credible Allegations Book.

7. Be sure to review you plan of correction at your monthly QA meeting.