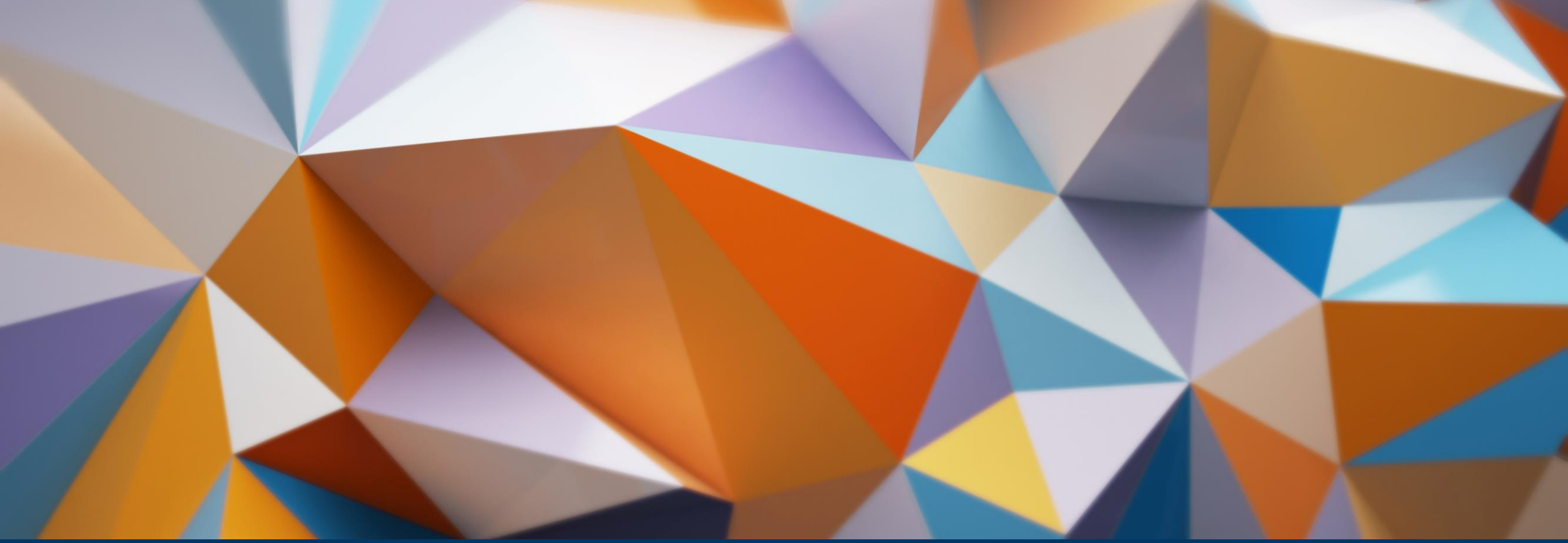
CMS Updates to Chapter 5 and Chapter 7 QSO-26-03-NH

Health Regulation Division



Chapter 5 - Complaint Procedures

Karen Aldinger | RN Regional Operations Manager

Complaint Procedures

- Chapter 5 updated to ensure national consistency.
- Complaint procedures for fires resulting in serious injury or death were updated to align with current processes.
- Examples of complaint intakes that can be reviewed off-site were clarified.

IJ Triage Language Updated

- All intakes alleging abuse of a resident/patient/client that involve serious injury, harm, impairment, or death of a resident/patient/client or likelihood for such, and it is uncertain that they are adequately protected.
- For nursing homes, all intakes where a resident was discharged to an unsafe setting, or in a manner that place the resident at risk for serious harm (e.g., the resident still has medical needs, but they cannot be supported in the setting they were discharged to).

Same Language Nursing Homes IJ triage

- In addition, for nursing homes, facility-reported incidents are assigned this priority if immediate jeopardy may have occurred, regardless of whether an immediate risk may continue to exist.

Administrative Review/Offsite Investigations

- If an offsite investigation is done, may confirm at next on-site survey.
- Offsite investigations are rare and are not permitted unless approved in advance by CMS. For example, a complaint is received relate to arbitration agreements, prohibition on third party guarantee of payment, or prohibition on charges for services covered under Medicaid, CMs may approve an offsite review of those or other documents to assess compliance and cite noncompliance and require corrections, as necessary.

Remove Substantiated/Unsubstantiated

- The role of the surveyor is to determine if the facility is in compliance with the Federal requirements for Medicare/Medicaid-certified providers or suppliers.
- The role of the surveyor is not to validate whether the events contained in the allegation had occurred.

Chapter 7

Karen Aldinger | RN Regional Operations Manager

Chapter 7 Updates

- Nurse Staffing Waivers and Resident Room Variances
- Onsite vs. Off-site revisits
- Immediate Jeopardy (IJ) examples updated
- Acceptable Plan of Correction
- Enforcement Guidance
- Informal Dispute Resolution (IDR)

Definitions and Acronyms

Karen Aldinger | RN Regional Operations Manager

Survey Definition

- Abbreviated Standard Survey means a survey other than a standard survey that gathers information primarily through resident-centered techniques on facility compliance with the requirements for participation. An abbreviated standard survey may be premised on complaints received; a change in ownership, management, or director of nursing; or other indicators of specific concern. (42 CFR 488.301) NOTE: Abbreviated standard surveys **may also be referred to as complaint investigations.**

- Standard survey (**Also known as a recertification survey**) means 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. (42 CFR 488.301).

Immediate Family Defined

Immediate family as defined in 42 CFR 488.301 means a husband or wife; natural or adoptive parent, child or sibling; stepparent, stepchild, stepbrother, or stepsister; father in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild. NOTE: see guidance at tag F563 in Appendix PP under Resident Rights §483.10(f)(4)(ii)-(v) – “For purposes of this regulation, immediate family is not restricted to individuals united by blood, adoptive, or marital ties, or a State’s common law equivalent. It is important to understand that there are many types of families, each of which being equally viable as a supportive, caring unit. For example, it might also include a foster family where one or more adult serves as a temporary guardian for one or more children to whom they may or may not be biologically related. Residents have the right to define their family.”

Resident Representative Defined

Resident Representative or Representative - means any of the following:

1) An individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;

2) A person authorized by State or Federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications; or

3) Legal representative, as used in section 712 of the Older Americans Act; or

4) The court-appointed guardian or conservator of a resident.

5) Nothing in this rule is intended to expand the scope of authority of any resident representative beyond that authority specifically authorized by the resident, State or Federal law, or a court of competent jurisdiction.

Waivers

Karen Aldinger, RN | Regional Operations Manager

Nurse Staffing Waivers Updated in Chapter 7

- Requirements moved from Appendix PP to Chapter 7 with clarifications:
- Licensed nurse 24 hours a day.
- RN 8 consecutive hours, 7 days a week and RN more than 40 hours a week.
- Must meet certain criteria.
- Request for waiver may be submitted at any time; however, a survey must happen to determine if the facility meets the requirements to qualify for a waiver.
- If no current waiver - Facility is cited for noncompliance and then SA determines if meets the qualifications for a waiver (must not be higher than level 1).

F727 Appendix PP

Required nursing care and facility waivers:

- NF must use the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week.
- SNF must use the services of a RN at least for 8 consecutive hours a day, 7 days a week and:
  - Must designate a RN to serve as the DON on a full-time basis
  - The DON may serve as CN only when average daily occupancy of 60 or fewer residents.

Except when waived under F731

Dually Certified Facilities (SNF/NF)

- If a facility is a dually-certified SNF/NF, the only waiver available is the waiver of the requirement for an RN for at least 8 consecutive hours a day, 7 days a week. This is because as a SNF, a waiver of the requirement to have licensed nurses 24 hours a day is not available.
- Requirements identified in F731 must be met under both NF and SNF sections to qualify for a waiver.

SNF Waiver for an RN 8 consecutive hours/day, 7 days a week (1/3)

A waiver may be obtained for a SNF RN 8 HR/Day, 7 days/week if:

- Located in rural area and supply of skilled nursing facility services in the area is not sufficient to meet the needs of individuals residing in the area.
- Must have a full time RN who is regularly on duty 40 hours a week.
- Only has patients whose MD has indicated through MD orders or admission notes that they do not require the services of an RN or MD for a 48-hour period, or
- Has made arrangements for an RN or MD to spend time at the facility as determined necessary by the MD to provide necessary skilled nursing services on days when the regular full-time RN is not on duty.

SNF Waiver for an RN 8 consecutive hours/day, 7 days a week (2/3)

- Facility demonstrates made diligent efforts to recruit appropriate personnel.
- SA determines the waiver will not endanger the health or safety of the residents in the facility.
- May require facility use other qualified, licensed personnel.
- If granted waiver prior year, must provide evidence residents/representatives notified. If not provided, may still be granted if meet all other requirements and provides evidence notified now.

SNF Waiver for an RN 8 consecutive hours/day, 7 days a week (3/3)

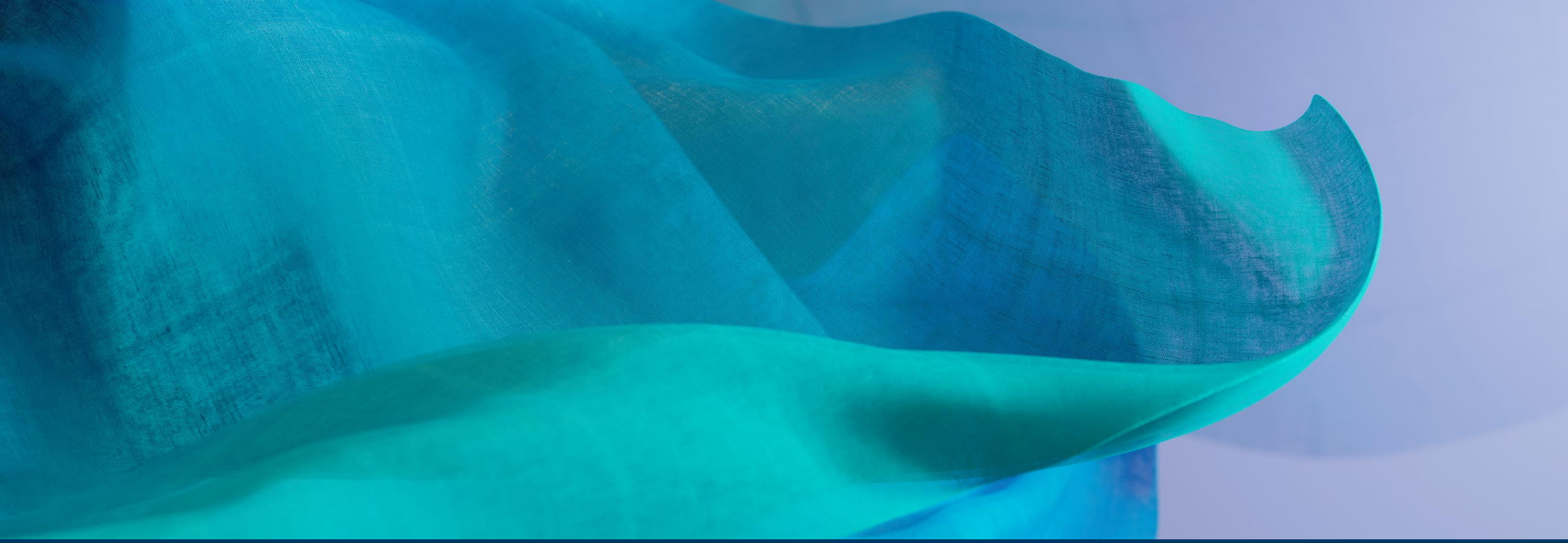
- SA forwards all of the information to the CMS location for review.
- CMS location grants the waiver.
- CMS Location provides notice of the waiter to LTC Ombudsman.
- Subject to annual renewal.

Survey Must Include CMS671 and CMS2567

State Agency (SA) and CMS must accurately document any waiver granted on form CMS671 and entered into IQIES.

- Date survey completed to verify resident safety if the waiver is granted
- Date the waiver was granted
- Specific waiver granted; and
- Number of hours waived each week.

When a waiver request is denied or terminated, the SA or CMS must include the reason for denial or termination on form CMS2567.



Waiver Room Size or Beds Per Room

Karen Aldinger, RN | Regional Operations Manager

Waiver Patient Room Size or Beds per Room

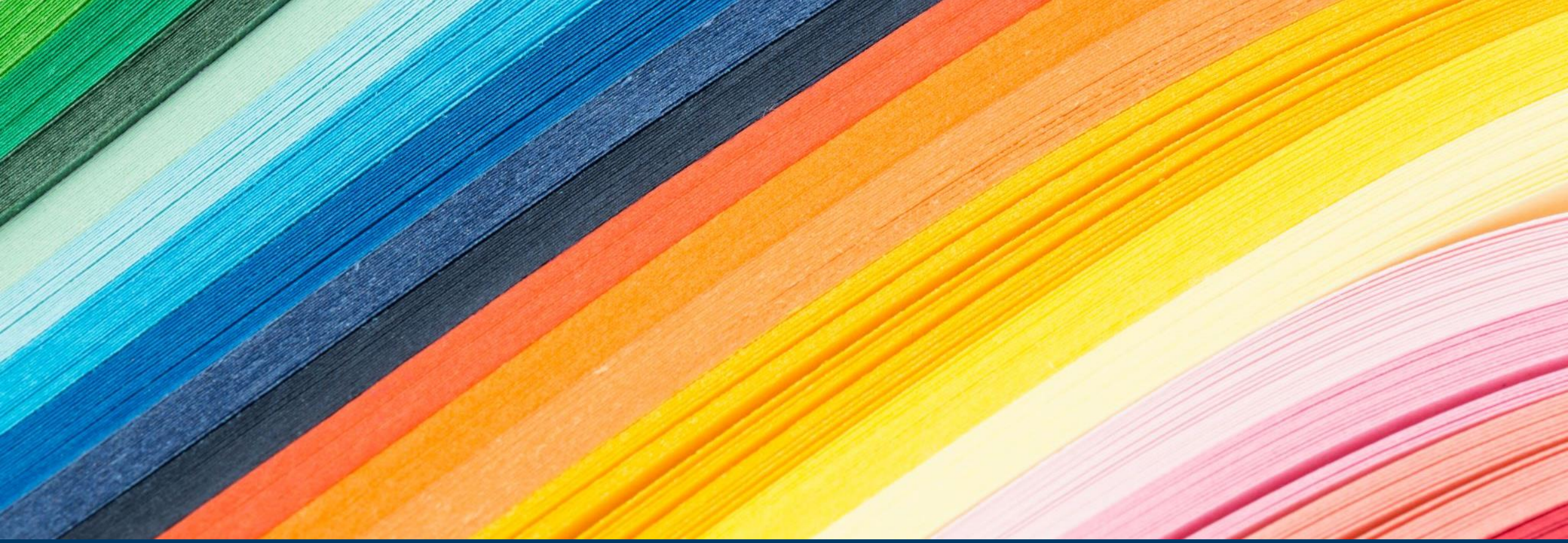
Resident rooms may have no more than four beds per room. However, for facilities that receive approval of construction or reconstruction plans by State and local authorities or are newly certified after November 28, 2016, bedrooms must accommodate no more than two residents. All resident rooms must afford a minimum of 80 square feet per bed in multi-patient rooms. Single rooms must measure at least 100 square feet. In 42 CFR 483.90(e)(3) variations may be permitted in individual cases where the facility demonstrates in writing that the variations are in accordance with the special needs of the residents and will not adversely affect their health and safety.

Waiver of Room Size/Beds (1/2)

- If a facility has never been granted a waiver under this section, or was granted a waiver in the past, but did not have a waiver after the last standard survey: the facility is cited for noncompliance with the applicable requirements, and the state agency will then determine if the facility meets the requirements to qualify for a waiver.
- If a facility was granted a waiver on the last standard survey: the surveyor will determine if the facility continues to meet the requirements to qualify for a waiver.
  - If the facility continues to meet the requirements, the facility is not cited, and another waiver may be granted.
  - If the facility no longer meets the requirements for a waiver, the facility is cited, and a waiver is not granted. The facility must correct the noncompliance to meet the requirements at §483.90 (e)(1)(i) or (ii).

Waiver of Room Size/Beds (2/2)

The CMS Location has jurisdiction to approve such waivers or variances and are subject to annual review by CMS. The State has jurisdiction to approve them in Medicaid-only NF cases. In either case, the approved waiver for the requirements at §483.90(e)(1)(i) and (ii) must be accurately documented in the CMS survey and certification system, such as ACO/ARO, or subsequent approved CMS system. When CMS or the state agency denies the request or terminates a variation / waiver under §483.90(e)(1)(i) or (ii), the state agency or the CMS Location must include the reason for the denial or termination in the Statement of Deficiencies form CMS-2567.



Survey Changes

Shannon Gilb | Regional Operations Manager

Resident Privacy

- Survey team must allow for greatest confidentiality for residents.
  - Use identifier on the CMS2567
- When observing residents respect privacy
  - If genital, rectal area, or breast must be observed in order to document and confirm suspicions of a care problem, a member of the nursing staff must be present.
  - Resident must give clear consent. If unable, ask health care proxy.
  - May be made without consent if resident is unable and proxy cannot be reached and there is a strong possibility that the resident is receiving less than adequate care, that can only be confirmed by observation.

Confidentiality of Survey Materials

- Surveyor notes and documentation collected during survey contain pre-decisional information and are not to be disclosed to the facility at time of survey.
- Survey team to maintain open and ongoing dialogue with the facility. This gives the opportunity to provide additional information in considering any alternative explanations before making deficiency determinations.
- Daily exit conference is not held and not every negative observation is reported daily.
- If negative observation relates to a routine that needs to be monitored over time to determine whether a deficiency exits the team should wait until a trend has been established before notifying facility.

Past Non-Compliance

Criteria to be met:

- The facility was not in compliance with the specific regulatory requirement at the time the situation occurred.
- The noncompliance occurred after the exit date of the last standard (recertification) survey and before the current survey
- There is sufficient evidence that the facility corrected the noncompliance and is in substantial compliance at the time of the current survey.

Exit Conference (1/2)

- Courtesy to the facility to provide preliminary findings so the facility can take swift corrective action.
- Findings are preliminary and subject to supervisory review.
- Conducted with facility personnel. Ask administrator to invite Medical Director. Invite the Ombudsman, officer of resident group.
- May provide an abbreviated exit conference specifically for residents.
- Give clear information so facility can develop an appropriate plan of correction.

Exit Conference (2/2)

- Generally, not to give citation tag number. May if asked but caution preliminary and may need additional review before determination made.
- Not to provide scope and severity unless it is an immediate jeopardy.
- May describe general seriousness such as harm or urgency.
- Not to provide consultation, only provide facts,
- Not do discuss in manner that reveals identify of a resident.

When Immediate Jeopardy Exists

- IJ means 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.
- IJ Template
  - Noncompliance: an entity has failed to meet one or more federal health, safety, and/or quality regulations; AND
  - Serious Adverse Outcome or Likely Serious Adverse Outcome: As a result of the identified noncompliance, serious injury, serious harm, serious impairment or death has occurred, is occurring, or is likely to occur to one or more identified recipients at risk; AND
  - Need for Immediate Action: The noncompliance causes a serious adverse outcome or likely serious adverse outcome and creates a need for immediate corrective action by the entity to prevent serious injury, serious harm, serious impairment or death from occurring or recurring.

When IJ is Removed

When an IJ has been identified and removed during the current survey or the revisit, the SA must ensure the core components of the IJ, and the actions taken by the entity to remove the IJ are documented on the Form CMS2567. Documentation must identify:

- The date the IJ began
- The date the entity was notified
- The specific requirement that has been violated, including a description of the noncompliance and the serious adverse outcome that occurred, or was likely to occur;
- Identification of recipients that were affected or were identified at risk of serious injury, harm, impairment, or death within the deficient practice statement;
- Date when the IJ was removed, as confirmed by an onsite verification by surveyor(s); and
- A statement of the seriousness of the remaining noncompliance, if any (i.e., Condition/ Standard/Element-level, or scope/severity).”

Lowering Severity when IJ Removed

When the facility has taken action to remove the IJ, such that no further serious injury, serious harm, serious impairment, or death is occurring to the resident(s) involved and is not likely to occur to any other resident(s), any remaining noncompliance for that tag should be lowered to severity level 2 (no actual harm with potential for more than minimal harm that is not immediate jeopardy). If there are multiple occurrences of noncompliance at the same tag involving different residents with one cited at IJ and the other cited at harm, once IJ is removed, the remaining noncompliance is lowered to harm.

Revisits

- The purpose of the post-survey revisit (follow-up) is to re-evaluate the specific findings of care and services that were cited as noncompliant during the original standard, abbreviated standard, extended or partial extended survey(s).
- For this purpose, the state agency is directed to:
  - Prior to the revisit, review appropriate documents, including the plan of correction, to focus the revisit review.
  - Conduct as many survey tasks as needed to determine compliance, always include QAPI/QAA review.
  - Focus on selecting residents who are most likely to have those conditions/needs/problems cited in the original survey.

Extended Survey (1/2)

An extended survey is conducted when SQC has been verified. The purpose is to explore the extent to which structure and process factors may have contributed to systemic problems causing SQC. This is accomplished by further evaluating the facility's compliance with all provisions.

An extended survey includes all the following:

- Review of a larger sample of resident assessments than the samples used in a standard survey;
- Review of the staffing and in-service training; • If appropriate, examination of the contracts with consultants;
- A review of the policies and procedures related to the requirements for which deficiencies exist; and
- Investigation of any Requirement for Participation at the discretion of the SA.

Extended Survey(2/2)

The State Agency is advised to conduct an extended survey:

- Prior to the exit conference, in which case the facility will be provided with findings from the standard and extended survey; or,
- After the standard survey, but no later than 14 calendar days after the completion of the standard survey. Advise the facility's Administrator that there will be an extended or partial extended survey conducted and that an exit conference will be held at the completion of the survey.

Partial Extended

Partial Extended Survey: Must be conducted after SQC is found during an abbreviated standard survey or during a revisit, when SQC was not previously identified.

7207.2 - All Surveys Must Be Unannounced

Survey teams are expected to remain in the facility after entrance for a **minimum of five consecutive hours**. This applies to all standard health surveys and helps to ensure that the surveys remain unannounced. For example, a survey team should not enter a facility, conduct a brief entrance conference, then leave the facility only to return the next day. Additionally, a survey should not enter a facility on a Friday and not return until the following Monday. Surveys must be conducted on consecutive days.

7207.2.2 - Variance in Timing (Time of Day, Day of Week, Time of Month)

- At least **10 percent of standard health surveys** must be conducted as off-hour surveys. These off-hour surveys are aimed at providing better insight into how a facility is staffed and operates outside of business hours, as well as reducing the predictability of when a survey will occur. Off-hour surveys begin **either** on the weekend **or** before 6:00 a.m. **or** after 5:00 p.m. on weekdays.

- Additionally, a minimum of **50 percent of the 10 percent of off-hour standard health surveys must begin on a weekend day** (Saturday or Sunday). Facilities for weekend surveys must be selected using the list provided by CMS. **State Agencies may do more than a minimum of 50 percent.**

Nursing Home Official Signing the POC (Plan of Correction)

- When a POC is submitted, it must be signed by a facility representative, who should be the Administrator. Other facility representatives may include the Director of Nursing, or a corporate representative.
- The facility representative signing the POC should have management authority and responsibility.
- Regardless of using a hard copy or electronic copy signature format, a nursing home official with authority and responsibility for operations of the facility should be the one who is submitting their signature on the facility's allegation of compliance.

Enforcement Guidance

Joanne Simon | Federal Enforcement Supervisor
Shellae Dietrich | Federal LCR Manager

7301.1 - Immediate Jeopardy Exists

- Immediate Jeopardy receives an automatic Civil Money penalty.
  - State Agency only recommends to CMS.
  - CMS imposed the Civil money penalty.
- **Per day CMPs** (for serious issues like immediate jeopardy): → **$3,050 to $10,000 per day.**
- **Per instance CMPs** (for specific violations): → **$1,000 to $10,000 per violation.**
- They can apply **both types at the same time** for the same survey. There are limits:
  - **Daily cap applies**: Total CMPs for *one day* cannot exceed the regulatory maximum.
  - **But across multiple days**, the total CMP amount **can exceed that maximum**.
  - Each day must still meet at least the **minimum penalty requirement**.

The specific procedures for CMPs can be found in §7510-§7536.

7301.2 - Immediate Jeopardy Does Not Exist

When **Immediate Jeopardy does NOT exist**, civil money penalties (CMPs) may still be imposed:

- **Per day** → **$50–$3,000** , or
- **Per instance of noncompliance** →**$1,000–$10,000** , or both
- Combined CMPs **cannot exceed the daily maximum limit**
- Multiple penalties in a survey are allowed, but:
  - **Daily totals must stay within min/max limits**
  - **Total across multiple days can exceed the daily max**

7510 Civil Money Penalties

- The CMS Location may impose a per day CMP between $50 and $3,000 per day or a “per instance” civil money penalty between $1,000 and $10,000 for each instance of noncompliance, or both per day and per instance CMPs may be imposed for the same survey not to exceed the maximum daily amount when combined, as adjusted under 45 CFR 102.3. The specific procedures for civil money penalties can be found in §7510-§7536.
- In cases when multiple per instance civil money penalties are imposed for a survey, the total dollar amount of all civil money penalties for noncompliance on any single day may not exceed the statutory and regulatory maximum amount and may not be less than the statutory and regulatory minimum amount for each day. When multiple per instance civil money penalties are imposed for different days of noncompliance, the total aggregate amount of all civil money penalties imposed for the survey may exceed the statutory and regulatory maximum (the statutory maximum only applies to the civil money penalty amount for any single day).

Mandatory Criteria for Immediate Imposition of Federal Remedies

Mandatory Criteria for Immediate Imposition of Federal Remedies	Immediate Jeopardy is identified on the current survey	*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*	Deficiencies of actual harm are identified on the current survey AND deficiencies of immediate jeopardy OR actual harm were identified on any type of survey between the current survey and the last standard survey	Facilities classified as a SFF AND has a deficiency citation of "F" level or higher for the current health survey or G or higher for the current LSC survey
Types of Remedy(ies) that, at a minimum, should be considered for immediate imposition by CMS <u>in addition to</u> the CMPs when immediate jeopardy is cited, mandatory 3-month DPNA	1. Termination 2. CMPs[1] <u>must</u> be imposed immediately 3. DDPNA[2] 4. Temp. Mgmt. 5. State Monitoring 6. Directed Plan of Correction 7. Directed In-service 8. Denial of Payment for	1. Termination 2. CMPs 3. DDPNA 4. Directed Plan of Correction 5. Directed In-service Training 6. Denial of Payment for All Individuals	1. Termination 2. CMPs 3. DDPNA 4. Temp. Mgmt. 5. State Monitoring 6. Directed Plan of Correction 7. Directed In-service 8. Denial of Payment for All Individuals	1. Termination 2. CMPs 3. DDPNA 4. Temp. Mgmt. 5. State Monitoring 6. Directed Plan of Correction 7. Directed In-service 8. Denial of Payment for All Individuals

[1] Federal CMPs are imposed in accordance with the instructions in the CMP Analytic Tool
[2] DDPNA = Discretionary Denial of Payment for New Admissions

The specific procedures for imposition of federal remedies can be found at 7304.1

7316.1 - Required Actions When There Is an Opportunity to Correct

- If denial of payment for new admissions has not already been imposed and the facility is still out of compliance at the 3rd month after the last day of the survey, the CMS Location and/or State Medicaid Agency must impose a mandatory denial of payment for all new admissions to be effective 3 months after the last day of the survey. (See §7506.) Formal notice of this remedy may have already been provided in the State's initial letter to the facility (see §7305).
- The SA must adhere to enforcement processing timeframes so that mandatory DPNA is imposed when a nursing home is not in substantial compliance three months after the date of the original survey. The imposition notice is sent by the SA (as authorized by CMS) to the provider by the 70th day. This excludes cases involving Medicaid-only nursing homes.

7316.2 - Required Actions When There Is No Opportunity to Correct

- If denial of payment for new admissions has not already been imposed and the facility is still out of compliance at the 3rd month after the last day of the survey, the CMS Location and/or State Medicaid Agency must impose a mandatory denial of payment for new admissions to be effective 3 months after the last day of the survey. The SA must adhere to enforcement processing timeframes so that mandatory DPNA is imposed when a nursing home is not in substantial compliance three months after the date of the original survey.

- The SA must transfer the enforcement case to CMS by the 70th day or the imposition notice is sent by the SA (as authorized by CMS) to the provider by the 70th day. However, there may be other instances in which cases should be immediately transferred to the CMS Location (i.e., enhanced enforcement). Contact your location for additional information. This excludes cases involving Medicaid-only nursing homes.

7317.1 - Verifying Facility Compliance (1/2)

- While the plan of correction (PoC) serves as the facility's allegation of compliance in non-immediate jeopardy cases, substantial compliance cannot be certified and any remedies imposed cannot be lifted until facility compliance has been verified.
- The date of substantial compliance is determined first by evaluating whether the credible written evidence provided by the facility supports the date it alleges that all deficiencies have been corrected and that it is capable of remaining in substantial compliance as determined by the survey agency.
- While the date of substantial compliance may not always be the date specified by the facility in the approved POC (includes life safety citations), it also is not necessarily the date of the revisit (onsite or paper-review). In some cases, a revisit may determine that a facility was able to correct all deficiencies and return to substantial compliance with the requirements before the alleged correction date on the approved POC.

7317.1 Verifying Facility Compliance (2/2)

- In these cases, the facilities may provide credible evidence that they achieved substantial compliance on a date prior to the alleged correction date on the POC, and/or the date of the most recent revisit, regardless of the number of revisits that have already occurred.
- The facility is responsible for ensuring credible evidence provided to surveyors (for either onsite revisit, or offsite review) clearly establishes the date the facility returned to substantial compliance. Any evidence presented by the facility should establish the timing or dates of actions taken by the facility and how those actions corrected the noncompliance and will prevent recurrence of such noncompliance.
- If the facility does not provide documentation, or evidence that supports an earlier date, surveyors will consider the alleged date of compliance in the POC, or a later date supported by evidence found during a revisit, in determining the date of substantial compliance.

7317.2 - Revisits

- Onsite versus Offsite Revisits
- Mandatory onsite revisits. An onsite revisit is only required when a facility's beginning survey finds deficiencies that constitute substandard quality of care, harm, or immediate jeopardy.
- Discretionary onsite revisits: States may use their discretion to conduct an onsite revisit at any time. This may be done to assess the nature of the corrections and the extent to which they address and correct the deficiencies. For deficiencies involving Quality of Care, Quality of Life, Abuse or Neglect, or repeat deficiencies, which may be indicative of systemic problems, it may be necessary to observe staff practices and interview residents before determining a facility has returned to substantial compliance.
- Offsite revisits: When onsite revisits are not required, or when CMS or States have determined an onsite revisit is not warranted, credible evidence is used to conduct an offsite revisit (see section below on credible evidence).

Number of onsite revisits: Complaint investigations

- Number of onsite revisits. Two onsite revisits are permitted, at the State's discretion, without prior approval from the CMS Location; a third onsite revisit may be approved only at the discretion of the CMS Location. The CMS Locations are limited to approving only this one additional onsite revisit.
- Complaint investigation visits, which occur before the alleged compliance date from the original survey Plan of Correction (PoC), regardless of whether deficiencies are cited or not, are not included in the onsite revisit count. However, when the complaint investigation is conducted at the same time as the onsite revisit, the revisit is included in the onsite revisit count. This also applies to Federal complaint guidelines.

7317.2 – Revisits

- New Noncompliance identified before or during on-site revisit surveys. In some cases, surveyors identify new noncompliance before facilities have been certified as having returned to substantial compliance. This can occur when complaints are investigated before the alleged date of compliance or on the revisit. New noncompliance can also be identified during the course of conducting the on-site revisit. New noncompliance may have an impact on accruing remedies such as civil money penalties, or mandatory remedies such as Denial of Payment for New Admission, and mandatory termination.

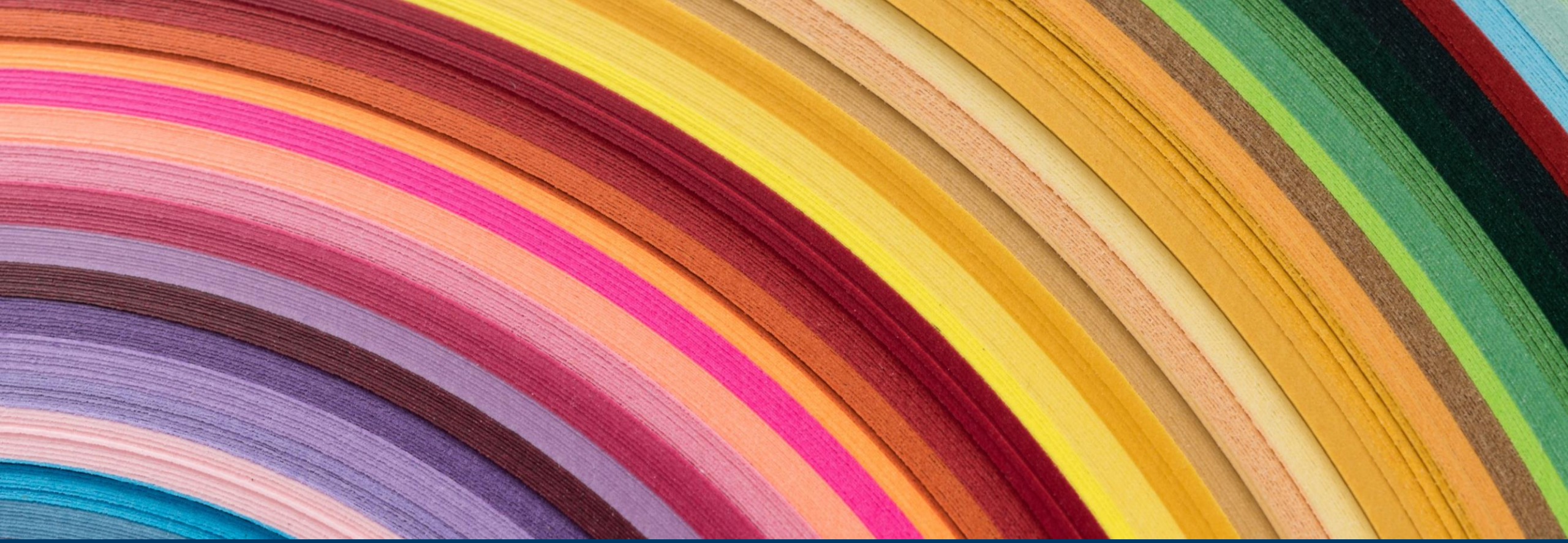
- In situations where it is determined that the provider clearly establishes through credible evidence that they have returned to substantial compliance, **AND** the newly identified noncompliance occurred on a date after the original noncompliance was corrected (i.e., alleged date of compliance), **AND** the noncompliance is different (regardless if it is the same F-tag) from findings on the original survey, the SA and/or the CMS Location should return the provider to substantial compliance for the original survey. This would end the enforcement cycle for the original survey and start a new enforcement cycle for the newly identified noncompliance.

Key Points to be Considered for Revisits (1/2)

- New noncompliance must always be documented on a Form the CMS-2567.
- It is the provider's responsibility to establish the date on which it returned to substantial compliance (note: try not to put the date out too far). Surveyors should always attempt to establish the earliest date of noncompliance when conducting their investigations. If the survey team cannot determine a date before the alleged date of compliance on the approved POC, that is the date that will be used.
- Determination of a period of substantial compliance can only be made after any new allegations have been appropriately investigated.

Key Points to be Considered for Revisits (2/2)

- For purposes of this guidance, SAs/CMS Locations would generally consider noncompliance to be different if they were cited at different F-tags or regulatory groupings. However, in some cases, citations at the same F-tag can also be different and would require a different POC. This can occur at F-tags that cover broad areas of noncompliance, such as Quality-of-Care citations at F684, or Accidents/Supervision at F689, Infection Prevention and Control at F880, among others.
- If newly identified noncompliance which occurs on or after the alleged date of compliance is the same or similar to the noncompliance cited on the original survey, and the facility has not been returned to substantial compliance, it is reasonable to assume the provider did not correct the original deficient practice, regardless of an allegation that the provider returned to substantial compliance. In these cases, the original enforcement cycle will not end, and it will continue until the state agency confirms the facility is in substantial compliance by the original or amended alleged date of compliance.
- If newly identified noncompliance which occurs before the alleged date of compliance is the same or similar to the noncompliance cited on the original survey, the survey team should cite the new noncompliance. The original enforcement cycle would continue until the facility submits a plan of correction for all identified noncompliance and the facility can provide evidence that the noncompliance has been corrected.



IDR/IIDR

Ben Hanson | Reconsiderations Supervisor

IDR procedures

- Aligns IDR procedures with the Independent IDR (IIDR) process. Guidance on uploading deficiencies pending IDR or IIDR
  - IDRs to be completed within 60 days
  - IDR response letters shall contain the result for each deficiency challenged and a brief summary of the rationale for that result.
- Information on the Independent IDR process including where, when and how the process may be accomplished, e.g., **virtually**, in writing, or in a face-to-face meeting, and


Thank
You!!!