AMERICAN COLLEGE OF HEALTHCARE ADMINISTRATORS (ACHCA) - NY CHAPTER

MARCH 10, 2025

2:15 PM –3:45 PM

SURVEY – OY VEY: MITIGATING THE "OY VEYs in LONG-TERM CARE SURVEYS"

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"SURVEY PREPAREDNESS AND READINESS: EVERYDAY!!!

Survey Results – Your REPORT CARD: CMS VIEWS IT AS A REFLECTION ON YOU AND THE ENTIRE FACILITY

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AGENDA

2:15 PM – 3:00 PM: PREPARATION AND ACTUAL SURVEY:

- ❑Survey Readiness
- ❑Long-Term Care Survey Process and Survey Management

3:00 PM – 3:45 PM: POST-SURVEY: THE AFTERMATH

- ❑Assignment of Citations, CMP's and other Enforcement Remedies
- ❑POC
- ❑IDR/IIDR
- ❑Formal Appeals Process with the DAB

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RESOURCES

- ❑ SOM Appendix PP - Guidance to Surveyors for Long Term Care Facilities *(Rev. 225; Issued: 08-08-24)*

CMS QSO-25-12-NH 3/10/25: Implementation of Revised Surveyor Guidance: Moved from 3/24/25 to 4/28/25.

- ❑ Long Term Care Survey Process (LTCSP) Procedure Guide
- ❑ State Operations Manual Appendix Q – Core Guidelines for Determining Immediate Jeopardy
- ❑ SOM Appendix Z- Emergency Preparedness for All Providers – Interpretive Guidance
- ❑ SOM Chapter 7 - Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities
- ❑Survey Resources

https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursinghomes

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SURVEY READINESS

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SURVEY READINESS

- **P**olicies & Procedures: In accordance with Regulations & Consistent with Current Standards of Practice; and Life Safety Code Requirements
- **T**raining and Education: Ensure that Staff is educated and trained on implementation of policies
- **S**ystems: (Resident Care Systems) To effectively implement compliance with regs & facility P&P's
- **D**ocumentation: **MDS & Care Plans**; Review Medical Records

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- **R** (Reduce) – **R**ounds: Observe Staff's Interaction with Residents; Interview residents, families, staff
- **S** (Stress)– **S**urvey Binder: Organize binder – you only have one time to make a 1st impression
- **P** (Plan) - **P**ractice, Practice, Practice : Skills Competencies; e.g., Med Pass, Tx, Don/Doff PPE, etc.

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BE PREPARED!*

1) Be survey ready every day of the year
   a) Provide continuous training with staff
   b) Develop and foster an effective QA/QAPI program
   c) Promote an active Resident Council
   d) Have an effective Customer Service Program
   e) Grow a robust Grievance Program
   f) Make daily and weekly rounds a routine
2) Maintain a complete and up to date SURVEY BOOK.
3) Make sure that all staff knows their job functions before surveyors enter the building.
4) Have a plan for weekends, holidays, & off hours survey entrances.
5) Train staff on what to expect during the survey.
6) Train staff on policies and procedures so they are able to respond to surveyors' questions.
7) Review the list of Questions State Surveyors Might Ask CNA

*SOURCE: WISCONSIN DHS, Division of Quality Assurance Bureau of NH Resident Care

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SURVEY BINDER

- ❑MINDSET: Think about your survey all year and not wait until your survey window.
- ❑BEST PRACTICE: Maintain a **Survey Binder** which should contain what surveyors ask for upon entering facility.
- ❑The Survey Binder should be **available, organized, and kept current at least weekly.** Make sure that other management staff know where you keep the Survey Book as surveyors could show up when you are not available.
- ❑Life Safety Code (LSC) surveyors have a different list of needed documentation and that is referenced in Documentation for Life Safety Code Surveys
- ❑Entrance Conference Form & other forms found at: *https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursing-homes*

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PAGES 1 AND 2

ENTRANCE CONFERENCE WORKSHEET

INFORMATION NEEDED FROM THE FACILITY IMMEDIATELY UPON ENTRANCE
❑ 1. Census number
❑ 2. Complete matrix for new admissions in the last 30 days who are still residing in the facility.
❑ 3. An alphabetical list of all residents (note any resident out of the facility).
❑ 4. A list of residents who smoke, designated smoking times, and locations.
ENTRANCE CONFERENCE
❑ 5. Conduct a brief Entrance Conference with the Administrator. Ask the Administrator to make the Medical Director aware that the survey team is conducting a survey. Offer an opportunity to the Medical Director to provide feedback to the survey team during the survey period if needed.
❑ 6. Information regarding full time DON coverage (verbal confirmation is acceptable).
❑ 7. Information about the facility's emergency water source (verbal confirmation is acceptable).
❑ 8. Signs announcing the survey that are posted in high-visibility areas.
❑ 9. A copy of an updated facility floor plan, if changes have been made, including COVID-19 observation and COVID-19 units.
❑ 10. Name of Resident Council President.
❑ 11. Provide the facility with a copy of the CASPER 3.
❑ 12. Does the facility offer arbitration agreements? If so, please provide a sample copy.
❑ 13. Has the facility asked any residents or their representatives to enter into a binding arbitration agreement?
❑ 14. Name of the staff responsible for the binding arbitration agreements.

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INFORMATION NEEDED FROM FACILITY WITHIN ONE HOUR OF ENTRANCE
❑ 15. Schedule of mealtimes, locations of dining rooms, copies of all current menus including therapeutic menus that will be served for the duration of the survey and the policy for food brought in from visitors.
❑ 16. Schedule of Medication Administration times.
❑ 17. Number and location of med storage rooms and med carts.
❑ 18. The actual working schedules for all staff, separated by departments, for the survey time period.
❑ 19. List of key personnel, location, and phone numbers including the Medical Director and contract staff (e.g., rehab services).
❑ 20. If the facility employs paid feeding assistants, provide the following information: a) Whether the paid feeding assistant training was provided through a State-approved training program by qualified professionals as defined by State law, with a minimum of 8 hours of training; b) A list of staff (including agency staff) who have successfully completed training for paid feeding assistants, and who are currently assisting selected residents with eating meals and/or snacks; c) A list of residents who are eligible for assistance and who are currently receiving assistance from paid feeding assistants.
❑ 21. Name of the facility's infection preventionist (IP). Documentation of the IP's primary professional training and evidence of completion of specialized training in infection prevention and control.

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INFORMATION NEEDED FROM FACILITY WITHIN FOUR HOURS OF ENTRANCE
❑ 22. Complete the matrix for all other residents. The TC confirms the matrix was completed accurately.
❑ 23. Admission packet.
❑ 24. Dialysis Contract(s), Agreement(s), Arrangement(s), and Policy and Procedures, if applicable.
❑ 25. List of qualified staff providing hemodialysis or assistance for peritoneal dialysis treatments, if applicable.
❑ 26. Agreement(s) or Policies and Procedures for transport to and from dialysis treatments, if applicable.
❑ 27. Does the facility have an onsite separately certified ESRD unit?
❑ 28. Hospice Agreement, and Policies and Procedures for each hospice used (name of facility designee(s) who coordinate(s) services with hospice providers).
❑ 29. Infection Prevention and Control Program Standards, Policies and Procedures, including: • the surveillance plan; • Antibiotic Stewardship program; and • Influenza, Pneumococcal, and COVID-19 Immunization Policy & Procedures.
❑ 30. QAA committee information (name of contact, names of members and frequency of meetings).
❑ 31. QAPI Plan.
❑ 32. Abuse Prohibition Policy and Procedures.
❑ 33. Description of any experimental research occurring in the facility.
❑ 34. Facility assessment.
❑ 35. Nurse staffing waivers.
❑ 36. List of rooms meeting any one of the following conditions that require a variance: • Less than the required square footage • More than four residents

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INFORMATION NEEDED BY THE END OF THE FIRST DAY OF SURVEY
❑ 37. Provide each surveyor with access to all resident electronic health records – do not exclude any information that should be a part of the resident's medical record. Provide specific information on how surveyors can access the EHRs outside of the conference room. Please complete the attached form on page 4 which is titled "Electronic Health Record Information."
❑ 38. Provide a list of residents, who are currently residing in the facility, that have entered into a binding arbitration agreement on or after 9/16/2019.
❑ 39. Provide a list of residents who resolved disputes through arbitration on or after 9/16/2019.
INFORMATION NEEDED FROM FACILITY WITHIN 24 HOURS OF ENTRANCE
❑ 40. Completed Medicare/Medicaid Application (CMS-671).
❑ 41. Please complete the attached form on page 3 which is titled "Beneficiary Notice - Residents Discharged Within the Last Six Months".

LAST UPDATE: 10/2023

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PAGE 3

Beneficiary Notice - Residents Discharged Within the Last Six Months

Please complete and return this worksheet to the survey team within 24 hours. Please provide a list of residents who were discharged from a Medicare covered Part A stay with benefit days remaining in the past 6 months. Please indicate if the resident was discharged home or remained in the facility. (Note: Exclude beneficiaries who received Medicare Part B benefits only, were covered under Medicare Advantage insurance, expired, or were transferred to an acute care facility or another SNF during the sample date range).

Resident Name	Discharge Date	Discharged to:	
		Home/Lesser Care	Remained in facility
1.			
2.			
3.			
4.			

REMINDERS: Include Medicare Part A stays only. Use the most updated Beneficiary Notices & follow instructions for completion

- ✓ NOMNC : Form CMS 10123 (Exp. 11/30/2027) – New Form Mandatory effective 1/1/2025
- ✓ SNF-ABN: Form CMS-10055 (2024) – Mandatory 10/31/2024

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PAGE 4

ENTRANCE CONFERENCE WORKSHEET
ELECTRONIC HEALTH RECORD (EHR) INFORMATION

Please provide the following information to the survey team before the end of the first day of survey.

Provide specific instructions on where and how surveyors can access the following information in the EHR (or in the hard copy if using split EHR and hard copy system) for the initial pool record review process. Surveyors require the same access staff members have to residents' EHRs in a read-only format.	
Example: Medications	EHR: Orders – Reports – Administration Record – eMAR – Confirm date range – Run Report
Example: Hospitalization	EHR: Census (will show in/out of facility) MDS (will show discharge MDS) Prog Note – View All - Custom – Created Date Range - Enter time period leading up to hospitalization – Save (will show where and why resident was sent)
1. Pressure ulcers	
2. Dialysis	
3. Infections	
4. Nutrition	
5. Falls	
6. ADL status	
7. Bowel and bladder	
8. Hospitalization	
9. Elopement	
10. Change of condition	
11. Medications	
12. Diagnoses	
13. PASARR	
14. Advance directives	
15. Hospice	
16. COVID-19 test results	

Please provide name and contact information for IT and back-up IT for questions:

IT Name and Contact Info: _____

Back-up IT Name and Contact Info: _____

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SURVEY BINDER

SURVEY FORMS – Follow Entrance Conference Worksheet

- ❑Beneficiary Notice - Residents Discharged Within the Last Six Months - **MDS COORDINATOR/SOCIAL SERVICES**
- ❑Electronic Health Record Information – **PCC; SIGMA CARE; MATRIX; VISUAL**
- ❑CMS-671 Long-Term Care Facility Application for Medicare & Medicaid; Staffing - **ADMINISTRATION**
- ❑CMS-802 Matrix for Providers - **UNIT MANAGERS/ CHARGE NURSES**
- ❑ Staffing – **STAFFING COORDINATOR, DON, DEPT. HEADS**
- ❑**Facility Generated Forms: UNIT MANAGERS/DEPT. HEADS; HR**

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SURVEYOR'S TOOLS/FORMS

INITIAL POOL PROCESS:

- ❑***RESIDENT INTERVIEW QUESTIONS – SS AND ACTIVITIES DEPARTMENT, UM'S***
- ❑***RESIDENT OBSERVATION (by CARE AREA) – ALL DEPARTMENT HEADS***
- ❑***LIMITED RECORD REVIEW – IDCP TEAM***
- ❑***RESIDENT REPRESENTATIVE INTERVIEW – SS AND ACTIVITIES DEPARTMENT***

***USE THESE FORMS AND TOOLS TO PRACTICE!!!**

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SURVEYOR'S TOOLS/FORMS

- ❑*CMS-20052: Beneficiary Protection Notification Review – MDS COORDINATOR, SS & BILLING*
- ❑*CMS-20053: Dining Observation – DIETITIAN, UM'S*
- ❑*CMS-20054: Infection Prevention, Control & Immunization – IP, DON*
- ❑*CMS-20055: Kitchen Observation – DIETITIAN, FSD*
- ❑*CMS-20056: Medication Administration – PHARMACY CONSULTANT, UM'S, SUPERVISORS*
- ❑*CMS-20057: Resident Council - ACTIVITIES*
- ❑*CMS-20058: QAA and QAPI – DIRECTOR OF QAPI*
- ❑*CMS-20062: Sufficient/Competent Staffing – DON, STAFFING EDUCATOR, DEPARTMENT HEADS*
- ❑*CMS-20089: Medication Storage – PHARMACY CONSULTANT, UM'S, SUPERVISORS*

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LTC SURVEY PROCESS

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LONG-TERM CARE SURVEY PROCESS (LTCSP) GUIDE : *What the Surveyors Follow*

- A **resident-centered**, **outcome-oriented** inspection that relies on **case-mix stratified sample of residents** to gather information about the **facility's compliance** with participation requirements
- **Organized into 7 Parts**
  1. Off-Site Preparation
  2. Facility Entrance
  3. **Initial Pool Process**
  4. **Sample Selection**
  5. **Investigations**
  6. On-going and Other Survey Activities
  7. EXIT CONFERENCE: Potential Citations

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OFF-SITE PREPARATION: SURVEYORS

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OFF-SITE PREPARATION: Review of Data

IT-Related TASKS: Create a "survey shell" & Review of Data

- ❑The administrator's name and previous survey date
- ❑**CASPER 3 report for pattern of repeat deficiencies**
- ❑**Results of last standard survey**
- ❑**Complaints (COMP) and Facility Reported Incidents (FRI)** since the last Standard survey to gain a general understanding of repeated issues or concerns that have been reported since last standard survey, including active/outstanding complaints. ***Include information on the specific allegations for each resident AND Facility Reported Incidents (FRI) since last standard survey, including any that require investigation during the survey***

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OFF-SITE PREPARATION: Data Review & Ombudsman Notification

- ❑**Review the CASPER PBJ Staffing Data Report for identified concerns regarding staffing.**
- ❑**H/O of abuse/allegations or citations since the last survey**
- ❑Facility Federal Variances/waivers
- ❑**Active enforcement cases that should not be investigated (e.g., pending complaints already investigated that have a CMP)**
- ❑Ombudsman notification to notify of proposed day of entrance into facility
- ❑Review CDC, state/local public health information, if available, to be aware of the COVID-19 status of the facility including the level of community transmission.

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OFF-SITE PREPARATION: FACILITY UNIT ASSIGNMENTS

- ❑Team Coordinator (TC) indicates the unit assignment for each surveyor.
  - Assign all units equally across the team members using the last year's floor plan
  - Do not assign same surveyor to the Rehab and Alzheimer's Unit
  - Keep surveyors on one unit as much as possible.
  - Assign Complaint/FRI residents to the surveyor who has the resident on their unit.
  - Assign units by discipline, if possible (e.g. Social Worker to the Dementia Care Unit)

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OFF-SITE PREPARATION: MANDATORY FACILITY TASK ASSIGNMENTS

Team Coordinator (TC) assigns mandatory facility tasks:

1. **Beneficiary Notification Review**
2. **Dining Observation***
3. **Infection Control***
4. Kitchen/Food Service Observation
5. Medication Administration
6. Medication Storage and Labeling
7. QAPI/QAA Review
8. Resident Council Meeting
9. **Sufficient and Competent Nurse Staffing***

Assign all surveyors but communicate that one surveyor has primary responsibility.

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OFF-SITE PREPARATION: MANDATORY FACILITY TASK ASSIGNMENTS

Team Coordinator (TC) prints documents

1. **Facility Matrix with Instructions (1 copy of instructions, multiple copies of the blank matrix)**
2. **Entrance Conference worksheet (1 copy)**
3. **Beneficiary Notices worksheet (3 copies) – The worksheet is titled, "Beneficiary Notification Review" in the Reports window**

Team Coordinator (TC) shares off-site prep data with team members

Team members independently review the Offsite Prep information prior to the survey.

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TIPS FOR SUCCESS

- ❑Ensure that all MDS assessments are promptly completed, transmitted & accepted in CMS Server (iQIES)
- ❑Review CASPER 3 Reports: Focus on Resident Roster – Triggered Quality Measures
- ❑Review Results of Last Standard Survey and Complaints since last Standard Survey – includes active/outstanding complaints. = Review proper implementation of POC to avoid repeat deficiencies
- ❑Review FRIs (Facility Reported Incidences) since last Standard Survey & History of abuse/allegations or citations since the last survey = Make sure that all pertinent records and documents are in place
- ❑ Ensure that all NHSN REPORTING & PBJ hours are accurately completed and PROMPTLY SUBMITTED

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FACILITY ENTRANCE

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FACILITY ENTRANCE

Surveyors enter the facility and go to their assigned area

1) TC: Upon entering the facility, discuss with the Administrator information needed from the facility immediately, which are listed on the Entrance Conference screen prior to conducting the brief Entrance Conference. Ask facility about any policies for entering/exiting special units, if applicable.
2) Team Coordinator **(TC) conducts a Brief Entrance Conference.** Cover the remaining items on the entrance conference screen and ensure the administrator/facility representative understands what is needed.*

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FACILITY ENTRANCE: Entrance Conference Worksheet

- Ask the Administrator to **make the Medical Director aware that the survey team is conducting a survey.** Invite the Medical Director to provide feedback to the survey team during the survey period if needed.
- **Exclude bed holds** from the facility census number.
- Request for the **Facility Assessment** - only review if there are **systemic concerns** identified in **resident-specific areas** (e.g., hospice, dialysis, ventilators, activities, nutrition, behavioral/emotional, dementia) or **systemic concern with a lack of adequate resources** (e.g., specialized rehabilitation, pharmacy).
- Indicate whether the facility has asked a resident or his/her representative to enter into a **binding arbitration agreement.**

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FACILITY ENTRANCE

3) Kitchen Observation: Surveyor assigned to the kitchen will conduct an initial brief visit to the kitchen and then goes to his/her assigned area. ***(Kitchen Task Pathway)***

4) All other surveyors: Go to assigned areas. Each surveyor goes to his/her assigned area. Surveyors will ask for a resident roster for their respective assigned areas.

They will indicate the **"New Admissions"** in the last 30 days, and they will then begin their Initial Pool Process.

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TIPS FOR SUCCESS

SURVEY BINDER: *Utilize Entrance Conference Worksheet to determine what documents needs to be maintained in a print survey binder or digital survey binder*

- ✓***Who will maintain what documents?***
- ✓***When will they be updated?***
- ✓***Where will they be kept?***
- ✓***Who will audit the documents & when will this be done?***
- ❑*Prepare Roster Matrix for New Admissions in past 30 days**
- ❑*Prepare Roster Matrix for all residents in each unit**
- ❑*Prepare LISTS of Residents as indicated in page 3 of Entrance Conference Worksheet**

**Update at least weekly and as needed.*

- ❑*Conduct "Kitchen Observation" Audits utilizing the Kitchen Observation Pathway*

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INITIAL POOL PROCESS

IMPORTANCE OF ACCURATELY COMPLETED AND UPDATED CMS-802 (MATRIX FOR PROVIDERS)

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INITIAL POOL PROCESS

- **Surveyors go room to room without staff**
- **Surveyors complete a full observation, interview, and a limited record review for initial pool residents**
- Identify the initial pool of about 8 residents including:

1) Residents selected off-site
2) On-Site Selected Residents:
   - Vulnerable residents (dependent on staff such as a resident who has Alzheimer's, dependent on staff for care, or is quadriplegic);
   - New admissions within the last 30 days
   - Identified Concern residents - those who have serious concerns but do not meet the definition of the other subgroups above.

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INITIAL POOL PROCESS

Process Steps for Initial Pool Residents: SURVEYORS

- Review the MDS indicators, matrix information, PBJ staffing data concerns, and active complaint/FRI allegations prior to entering the room.
- Complaint/FRI information – NOTE: In surveyors' tablet - allegation details displayed under the MDS indicators and next to the applicable area. *The complainant's phone number(s) also displayed on the far right on the Complaint link details pop-up*
- CASPER PBJ Staffing Data information is flagged as "PBJ Staffing" with a link to the staffing details

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RESIDENT OBSERVATIONS

- ❑Cover all Care Areas and Probes
- ❑Conduct rounds; identify repositioning & incontinence care concerns based on whether resident is in same positioning extended periods of time during your rounds
- ❑Complete formal observations
- ❑Investigate further or no issue

e.g. *Surveyor may complete formal observations for wounds or incontinence care if the situation presents itself or is necessary—for example, if a resident has not been assisted to the bathroom for a long period of time or is covered in bed.*

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RESIDENT INTERVIEWS

- ❑Process: Room-to-Room WITHOUT Staff
- ❑Screen every resident (full observation, interview, and limited record review)
- ❑Suggested questions—but not a specific surveyor script
- ❑Must cover all Care Areas.
- ❑Identify potential MDS coding discrepancies.
- ❑Includes Residents' Rights, Quality of Life & Quality of Care
- ❑Investigate further if issue identified. If addressed, then no issue
  - e.g. Resident says he lost weight because loose dentures unaddressed by facility; then this is a problem
  - Resident says that she has an issue with her roommate, but facility addressed; therefore, no issue

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RESIDENT REPRESENTATIVE / FAMILY INTERVIEWS

- ❑Non-interviewable residents
- ❑Familiar with the resident's care
- ❑Complete **at least three** across the team on the first day of the survey to be better informed for sampling decisions. May call the resident representative/ family, especially if observational concerns with a resident in the initial pool noted
- ❑Sampled residents if possible
- ❑Investigate further or no issue

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LIMITED RECORD REVIEW

- ❑Conduct limited record review after interviews and observations are completed prior to sample selection.
- ❑All initial pool residents: **advance directives** and confirm specific information based on interviews and observations, and other concerns
- ❑If interview not conducted: review certain care areas in record – **P/U's, dialysis, infections, nutrition, falls in the last 120 days, ADL decline in the last 120 days, low risk B&B, unplanned hospitalizations, elopement and change of condition in the last 120 days.**
- ❑Insulin, anticoagulant, antipsychotic with Dx of Alzheimer's or dementia, an antibiotic, 65+ years with new Dx schizophrenia with antipsychotic, or has an appropriate diagnosis but is not receiving PASARR Level II services

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LIMITED RECORD REVIEW

- ❑New admissions – broad range of high-risk medications
- ❑Extenuating circumstances, interview staff
- ❑Investigate further or no issue

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ADDITIONAL INITIAL POOL PROCESS INFORMATION

- ❑The facility should complete the facility matrix **within four hours**
- ❑Once the matrix is received, each surveyor will **review the matrix** for residents in their assigned area to identify any substantial concern that should be followed up on.
- ❑At least **1 resident who Smokes**, **1 resident who is receiving Dialysis**, **1 resident on Hospice**, **1 resident on a Ventilator**, and **2 residents on Transmission-Based Precautions** should be included in the initial pool for the team if available.

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DINING –FIRST FULL MEAL

- Dining – Observe First Full Meal
  - Cover all dining rooms and room trays
  - Observe enough to adequately identify concerns
  - If feasible, observe initial pool residents with weight loss
  - If concerns identified, observe another meal

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General Observation of the Facility

- During the initial pool process, all surveyors should make general observations of the facility to determine whether there are concerns in the common areas.
- During the team meeting, discuss any of these concerns to determine whether the Environment task should be initiated.

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TEAM MEETINGS

- ❑ Surveyors Meet for 15 to 30 minutes at the end of Day 1.
- ❑Surveyors have a meeting at the end of each day
  - ○Workload; Coverage; Concerns
  - ○Synchronize/share data (if needed)
- ❑*If SQC (Substandard Care) is suspected, sample is expanded as necessary to determine scope and whether there is sufficient evidence to rule out SQC.*
- ❑***If the team verifies the existence of SQC, the Administrator should be informed that the facility is in SQC and an extended survey will be conducted.***

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TIPS FOR SUCCESS

- ❑*Utilize the Tools for "Resident Interviews", "Resident Observation", "Resident Representative/Family Interviews" and "Limited Record Review" in conducting MOCK SURVEYS.*
- ❑*Establish Lists of "Target Residents": e.g., Residents who Smoker; Dialysis Patients; Hospice Residents; Residents on Ventilator; Residents on Transmission-based precautions". Have the IDCP Team review their charts*

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SAMPLE SELECTION

- ❑SELECT SAMPLE. After Initial Pool Process, the Survey Team will meet for about an hour to select the sample.
- ❑Prioritize using sampling considerations:
  - ○Replace discharged residents selected offsite with those selected onsite
  - ○Can replace residents selected offsite with rationale
  - ○**Harm, SQC if suspected, IJ if identified**
  - ○**Abuse Concern**
  - ○**Transmission Based precautions**
  - ○**All MDS indicator areas if not already included**
- ❑**Closed Record Reviews (Death; Hospitalization; Community D/C)**

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- ❑**Unnecessary medication review** - System selects five residents for full medication review
  - ○Based on observation, interview, record review, and MDS
  - ○Broad range of high-risk medications & adverse consequences
  - ○Residents may or may not be in sample

**The selection process considers all psychotropic medications, insulin, anticoagulants, opioids, diuretics and antibiotics, as well as some adverse consequences, including falls, weight loss, and sedation.*

Finalize the Sample, and Make Investigation Assignments

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TIPS FOR SUCCESS

- *Review Discharge Charts for Closed Record Reviews – Hospital; Death in facility; Discharge to Home*
- *Review charts of residents who have high triggers for sample selection. *The selection process considers all psychotropic medications, insulin, anticoagulants, opioids, diuretics and antibiotics, as well as some adverse consequences, including falls, weight loss, and sedation.*

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INVESTIGATIONS

RESIDENT INVESTIGATION GENERAL GUIDELINES

- Conduct investigations for all concerns that warrant further investigation for sampled residents
- Continuous observations, if required
- Interview representative, if appropriate, when concerns are identified
- Majority of time spent observing and interviewing with relevant review of record to complete investigation

- Use Appendix PP and Critical Element (CE) Pathways

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ON-GOING & OTHER SURVEY ACTIVITIES

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CLOSED RECORD REVIEWS

- ❑**Unexpected death, hospitalization, and community discharge last 90 days**
- ❑System selected or discharged resident
- ❑Use Appendix PP and CE pathways

FACILITY TASK INVESTIGATIONS

- ❑Use Facility Task Pathways
- ❑CE Compliance Decision

DINING – SUBSEQUENT MEAL, IF NEEDED

- ❑Second meal observed if concerns noted
- ❑Use Appendix PP and CE Pathway for Dining
- ❑Dining task is completed outside any resident specific investigation into nutrition and/or weight loss

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INFECTION CONTROL

- ❑All surveyors observe for breaks in infection control throughout the survey, as specified on the pathways and investigative protocols.
- ❑Review of the IPC program, review of relative infection prevention and control policies and procedures, interview of qualified designated infection preventionist), testing of staff and residents for communicable diseases (e.g., COVID-19) in accordance with national standards, **antibiotic stewardship program, and the influenza, pneumococcal and COVID-19 immunizations for residents**

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- ❑**Sample one staff** to verify compliance with staff-related requirements and national standards, such as offering and educating on immunization and testing
- ❑Sample **three residents** for purposes of determining compliance with infection prevention and control national standards such as **transmission-based precautions (TBP), as well as resident care, screening, testing, and reporting.**
- ❑Sample **five residents for influenza, pneumococcal and COVID-19 immunizations.**
- ❑If there is a concern about a **water management program in the facility,** ask the facility to identify if any residents have been diagnosed with **Legionnaires' disease.**
- ❑Concerns with the Antibiotic Stewardship Program: Unnecessary Medication Review CE Pathway for a resident on antibiotic

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SNF BENEFICIARY PROTECTION NOTIFICATION REVIEW

- ❑List of residents (home and in-facility)
- ❑Randomly select three residents
- ❑Review worksheet and notices

RESIDENT COUNCIL MEETING

- ❑Group interview with active members of the council
- ❑**Complete early to ensure investigation if concerns identified**
- ❑**Refer to updated P**athway

KITCHEN OBSERVATION

- ❑In addition to the brief kitchen observation upon entrance, conduct full kitchen investigation
- ❑Follow Appendix PP and Facility Task Pathway to complete kitchen investigation

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MEDICATION ADMINISTRATION
MEDICATION STORAGE & LABELING

Medication Administration

- ❑Recommend nurse or pharmacist
- ❑Include sample residents, if opportunity presents itself
- ❑Reconcile controlled medications if observed during medication administration
- ❑Observe different routes, units, and shifts
- ❑Observe 25 medication opportunities

*****MAJOR FOCUS ON CONTROLLED SUBSTANCES – RECONCILIATION COUNTS**

Medication Storage

- ❑Observe half of medication storage rooms and half of medication carts. If issues noted, expand medication room/cart observations

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SUFFICIENT & COMPETENT NURSE STAFFING REVIEW

- ❑Is a mandatory task, refer to revised Facility Task Pathway
- ❑Throughout the survey, consider if staffing concerns can be linked to QOL and QOC concerns
- ❑CASPER PBJ Staffing Data information
- ❑If the facility failed to submit PBJ data, CE1 (F851) on the Sufficient and Competent Nurse Staffing pathway was automatically marked as No, from information input by the Team Coordinator completed on the Offsite Preparation screen. **F851 should be cited at an F-level so severity level 2 will be marked.** It should be an extremely rare circumstance when a facility is not cited if the PBJ data report indicates they did not submit PBJ data for the quarter. If the team thinks the facility should not be cited, the team coordinator must email NHStaffing@cms.hhs.gov.
- ❑CMS will respond by the end of the next business day and copy the CMS location.

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ENVIRONMENT

- ❑Investigate specific concerns
- ❑Eliminate redundancy with LSC
  - ○Disaster and Emergency Preparedness
  - ○O2 storage
  - ○Generator

Binding Arbitration Agreement

- ❑Complete this review if a resident or representative was asked to enter into a binding arbitration agreement.
- ❑Select three residents, as available.

Extended Survey

- ❑**If SQC is cited, the team will complete the extended survey.**

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TRIGGERED TASKS COMPLETED IF CONCERNS ARE IDENTIFIED

- ❑Personal Funds
- ❑Environment
- ❑Resident Assessment (e.g., Late Completion or late Submission of MDS Assessments) AND/OR **MDS discrepancies for care areas that were not marked for further investigation.**

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End of the day meeting

- ❑Survey Team meets for about 30 minutes at the end of each day to discuss the areas noted on the Team Meeting screen.
  - *Are there newly identified harm or IJ concerns (system populates only if severity 3 or 4 is marked)?*
  - *How much work does each surveyor have left to complete?*
  - *Review the list of investigation concerns (i.e., CEs = No) and ensure the team discusses potential staffing concerns. CASPER PBJ Staffing Data information is flagged as "PBJ Staffing" with a link to the staffing details.*
  - *Have at least three resident representative interviews been completed?*

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End of the day meeting

- ❑The team discusses whether there are any concerns regarding unethical, criminal, civil or administrative violations by the facility. If Yes, the assigned surveyor will initiate **F895, Compliance and Ethics,** for the Facility on the Investigation screen.
- ❑If the team determines SQC at any point during the survey, the extended survey should be completed. extended.

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Complete QAPI/QAA

- ❑This facility task should take place at the end of the survey; however, with enough time to investigate & follow-on potential concerns.
- ❑Prior to interviewing the facility staff about the QAA program, review the Facility Rates for MDS Indicators, prior survey history, FRIs, and complaints - present concerns and repeat deficiencies.
- ❑Review the QAPI plan.
- ❑Any list of concerns the facility should be aware of (e.g., high-risk areas, harm or IJ, pattern or widespread issues, or concerns identified by two or more surveyors).
- ❑**If a surveyor cites F600 (abuse or neglect), the information will be displayed on the QAPI/QAA screen to ensure the TC determines whether the QAA committee also identified the issue and made a "Good Faith Attempt" to correct it.**
- ❑Final citation and severity decision

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TIPS FOR SUCCESS

- ❑ *Utilize Facility Task Pathways and/or Critical Element Pathways to prepare for Survey.*
- ❑ *Conduct "Mock Interviews" with the residents and Resident's families*
- ❑ *Review Resident Council Meeting Minutes and ensure that any concerns/issues are addressed on a timely basis and resolutions are documented accordingly.*
- ❑ *Review and prepare QAPI Meeting Minutes*

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LONG-TERM CARE SURVEY - CEP'S

LTCSP Survey Resources FOLDER - Survey Pathways:

- ❑ *SNF Beneficiary Protection Notification Review*
- ❑ *Dining Observation*
- ❑ *Infection Prevention, Control & Immunizations.*
- ❑ *Kitchen Observation*
- ❑ *Medication Administration Observation*
- ❑ *Resident Council Interview*
- ❑ *QAA and QAPI Plan Review*
- ❑ *Abuse Critical Element Pathway*
- ❑ *Environmental Observations*
- ❑ *Sufficient and Competent Nurse Staffing Review*
- ❑ *Personal Funds Review*
- ❑ *Activities Critical Element Pathway*
- ❑ *Activities of Daily Living (ADL) Critical Element Pathway*

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- ❑*Behavioral and Emotional Status Critical Element Pathway*
- ❑*Urinary Catheter or Urinary Tract Infection CEP*
- ❑*Communication and Sensory Problems (Includes Hearing and Vision) Critical Element Pathway*
- ❑*Dental Status and Services Critical Element Pathway*
- ❑*Dialysis Critical Element Pathway*
- ❑*General Critical Element Pathway*
- ❑*Hospice and End of Life Care & Services CEP*
- ❑*Death Critical Element Pathway*
- ❑*Nutrition Critical Element Pathway*
- ❑*Pain Recognition and Management CEP*
- ❑*Physical Restraints Critical Element Pathway*
- ❑*Pressure Ulcer/Injury Critical Element Pathway*
- ❑*Medication Storage and Labeling*
- ❑*Preadmission Screening and Resident Review CEP*

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- ❑*Extended Survey*
- ❑*Hydration Critical Element Pathway*
- ❑*Tube Feeding Status Critical Element Pathway*
- ❑*Positioning, Mobility & Range of Motion (ROM/ADL) CEP*
- ❑*Hospitalization Critical Element Pathway*
- ❑*Bladder or Bowel Incontinence Critical Element Pathway*
- ❑*Accidents Critical Element Pathway*
- ❑*Neglect Critical Element Pathway*
- ❑*Resident Assessment Critical Element Pathway*
- ❑*Discharge Critical Element Pathway*
- ❑*Dementia Care Critical Element Pathway*
- ❑*Specialized Rehabilitative or Restorative Services CEP*
- ❑*Respiratory Care Critical Element Pathway*
- ❑*Unnecessary Medications, Psychotropic Medications, and Medication Regimen Review Critical Element Pathway*

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EXIT CONFERENCE / POTENTIAL CITATIONS

- ❑ Team makes compliance determination. Compliance decisions reviewed by team. Scope and Severity (S/S)
- ❑ The meeting takes about an hour on average. Team makes a compliance decision for every Tag that came forward from each surveyor.
- ❑ **Survey Team conducts exit conference and relay potential areas of deficient practice**
- ❑ Surveyors will describe the team's preliminary deficiency findings to the facility and let them know they will receive a report of the survey that will contain any deficiencies that have been cited (Form CMS-2567).

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EXIT CONFERENCE

- ❑During the exit conference, provide the facility with the opportunity to discuss and supply additional information that they believe is pertinent to the identified findings.
- ❑*Because of the ongoing dialogue between surveyors and facility staff during the survey, there should be few instances where the facility is not aware of surveyor concerns or has not had an opportunity to present additional information prior to the exit conference.*
- ❑Surveyors will describe the team's preliminary deficiency findings to the facility and let them know they will receive a report of the survey that will contain any deficiencies that have been cited (Form CMS-2567).
- ❑*During the exit conference, provide the facility with the opportunity to discuss and supply additional information that they believe is pertinent to the identified findings.*

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EXIT CONFERENCE

- *Because of the ongoing dialogue between surveyors and facility staff during the survey, there should be few instances where the facility is not aware of surveyor concerns or has not had an opportunity to present additional information prior to the exit conference.*

Key Point

- During the exit conference, it is very beneficial to write down each deficiency and the criteria surveyors used to establish that the deficiency exists. This enables the facility to quickly begin to review each deficiency for accuracy and possibly provide information that may not have been noted by the surveyors during the survey but may impact the final outcome of the survey

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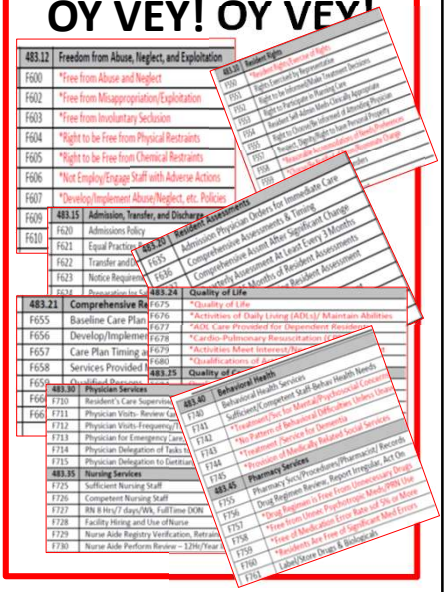
GOODBYE, SURVEYORS!

- **UNTIL NEXT YEAR…..**

OR

OY VEY! OY VEY! OY VEY! OY VEY!



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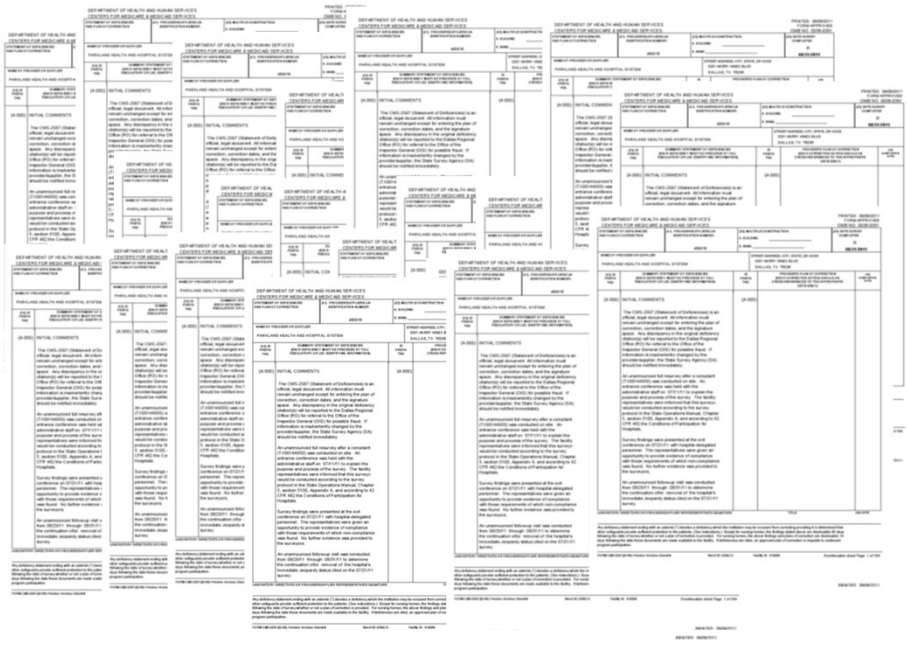
THE AFTERMATH: 2567



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SCOPE AND SEVERITY GRID:

Assessment Factors Used to Determine the Seriousness of Deficiencies Matrix

	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	J PoC Required [redacted]	K PoC Required [redacted]	L PoC Required [redacted]
Actual harm that is not immediate	G PoC Required	H PoC Required [redacted]	I PoC Required [redacted]
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D PoC Required	E PoC Required	F PoC Required [redacted]
No actual harm with potential for minimal harm	A No PoC Required [redacted] No remedies Commitment to Correct Not on CMS-2567	B PoC Required [redacted]	C PoC Required [redacted]

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Substandard quality of care means one or more deficiencies related to participation requirements under §483.10 "Resident rights", paragraphs (a)(1) through (a)(2), (b)(1) through (b)(2), (e) (except for (e)(2), (e)(7), and (e)(8)), (f)(1) through (f)(3), (f)(5) through (f)(8), and (i) of this chapter; §483.12 of this chapter "Freedom from abuse, neglect, and exploitation"; §483.24 of this chapter "Quality of life"; §483.25 of this chapter "Quality of care"; §483.40 "Behavioral health services", paragraphs (b) and (d) of this chapter; §483.45 "Pharmacy services", paragraphs (d), (e), and (f) of this chapter; §483.70 "Administration", paragraph (p) of this chapter, and §483.80 "Infection control", paragraph (d) of this chapter, 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.

Substantial compliance

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Guidance on SEVERITY LEVELS

- **Level 1 - No actual harm with potential for minimal harm:** A deficiency that has the potential for causing no more than a minor negative impact on the resident(s).
- **Level 2 - No actual harm with a potential for more than minimal harm that is not immediate jeopardy:** Noncompliance with the Requirements for Participation that results in the potential for no more than minimal physical, mental, and/or psychosocial harm to the resident and/or that result in minimal discomfort to the residents of the facility but has the potential to result in more than minimal harm that is not immediate jeopardy.

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Guidance on SEVERITY LEVELS

- **Level 3** - **Actual harm that is not Immediate Jeopardy:** Noncompliance with the Requirements for Participation that results in actual harm to residents that is not immediate jeopardy.
- **Level 4 - Immediate Jeopardy to resident health or safety:** Noncompliance with the Requirements for Participation that results in Immediate Jeopardy to resident health or safety in which immediate corrective action is necessary because the provider's noncompliance with one or more of those requirements has caused, or is likely to cause, serious injury, harm, impairment or death to a resident receiving care in a facility. (See Appendix Q)

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Guidance on SCOPE LEVELS

- Scope is **isolated** when one or a very limited number of residents are affected and/or one or a very limited number of staff are involved, and/or the situation has occurred only occasionally or in a very limited number of locations.
- Scope is a **pattern** when more than a very limited number of residents are affected, and/or more than a very limited number of staff are involved, and/or the situation has occurred in several locations, and/or the same resident(s) have been affected by repeated occurrences of the same deficient practice. The effect of the deficient practice is not found to be pervasive throughout the facility.

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Guidance on SCOPE LEVELS

- Scope is **widespread** when the problems causing the deficiencies are pervasive in the facility and/or represent systemic failure that affected or has the potential to affect a large portion or all of the facility's residents.
  Widespread scope refers to the entire facility population, not a subset of residents or one unit of a facility.
  In addition, widespread scope may be identified if a systemic failure in the facility (e.g., failure to maintain food at safe temperatures) would be likely to affect a large number of residents and is, therefore, pervasive in the facility.

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WHAT TO DO WHEN YOU RECEIVE YOUR 2567 (SOD)

- Review each F-Tag
- Create a Spreadsheet

[redacted]

TAG #	DESCRIPTION	S/S	Resident's Involved
F623	Notice Requirements Before Transfer/Discharge	D	50
F625	Notice of Bed Hold Policy Before/Upon Transfer	D	8, 50, 60
F658	Services Provided Meet Professional Standards	D	8, 78, 358
F677	ADL Care Provided for Dependent Residents	G	20, 70, 101
F684	Quality of Care	G	256
F695	Respiratory/Tracheostomy Care and Suctioning	D	23
F697	Pain Management	D	60
F698	Dialysis	E	23, 60, 156
F755	Pharmacy	E	47, 63, 78
F756	Drug Regimen Review, Report Irregular, Act On	D	101
F758	Free from Unnecessary Psychotropic Meds/PRN Use	E	101
F761	Label/Store Drugs and Biologicals	D	2 Med Carts-#5 for Resident #84, Med Cart #7 for Resident #78 #86, #20, #4, #20,
F836	License/Comply w/Fed/State/Local Law/Professional Standards	F	Diamond, Emeral & Sapphire Units Residents 20, 70, 101
F865	QAPI Program/Plan, Disclosure/Good Faith Attempt	D	Residents 84, 78, 86, 20, 4, 20 and Med Carts
F880	Infection Prevention & Control	E	Linens, Hand Hygiene CNA #1
F888	COVID-19 Vaccination of Facility Staff	C	Staff w/Religious Exemptions and/or Medical Exemptions - Not Donning Proper PPE as per
F921	Safe/Functional/Sanitary/Comfortable Environment	D	Laundry, Washing Room, Trash, Discarded PPE
[redacted]	[redacted]	[redacted]	[redacted]

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TIMELINE and DUE DATES:

WITHIN 10 WORKING DAYS FROM THE EXIT DATE OF SURVEY, STATE SURVEY AGENCY SHOULD SEND:

- ❑**NOTICE OF THE STATEMENT OF DEFICIENCIES**
- ❑**INITIAL NOTICE (NOTIFICATION LETTER) TO THE PROVIDER**

WITHIN 10 CALENDAR DAYS FROM RECEIVING THE SOD (2567), FACILITY MUST SUBMIT:

- ❑**PLAN OF CORRECTION**

WITHIN 10 CALENDAR DAYS FROM RECEIVING THE INITIAL NOTICE, A REQUEST FOR IDR MUST BE SUBMITTED BY THE FACILITY TO BE CONSIDERED VALID

- ❑**REQUEST FOR IDR** (The request for Informal Dispute Resolution (IDR) to refute deficiencies, must be submitted to the state within 10 calendar days from the date the facility received the Initial Notice (in most states, it is the same date of CMS-2567)

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INITIAL NOTICE SAMPLE

NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL, Governor | JAMES V. McDONALD, M.D., M.P.H., Commissioner | JOHANNE E. MORNE, M.S., Executive Deputy Commissioner

[redacted]

Administrator

Facility:
Medicare Provider #:
Type of Survey:
Survey Exit Date:
POC Required by
Termination Date:

Dear

Enclosed is a copy of the survey report resulting from the Article 28 and Medicare/Medicaid survey of your facility by staff from this office. This is being sent to you as the Administrator of the facility. It is your responsibility to communicate this survey report to the Operator who has the ultimate responsibility for the facility. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations. Compliance with all State and Federal program requirements is necessary for continued participation in the Medicare/Medicaid programs.

The most serious deficiencies found during this survey were isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not Immediate Jeopardy **whereby corrections are required (D).**

New York State can impose Federal Category One remedies for the deficiencies found during this survey. Currently, this office is imposing no Category One remedies.

A detailed electronic Plan of Correction must be completed and returned to this office by the above referenced date. A copy should be retained for the records of the facility.

Your Plan of Correction must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken
- What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur

Empire State Plaza, Corning Tower, Albany, NY 12237 | health.ny.gov

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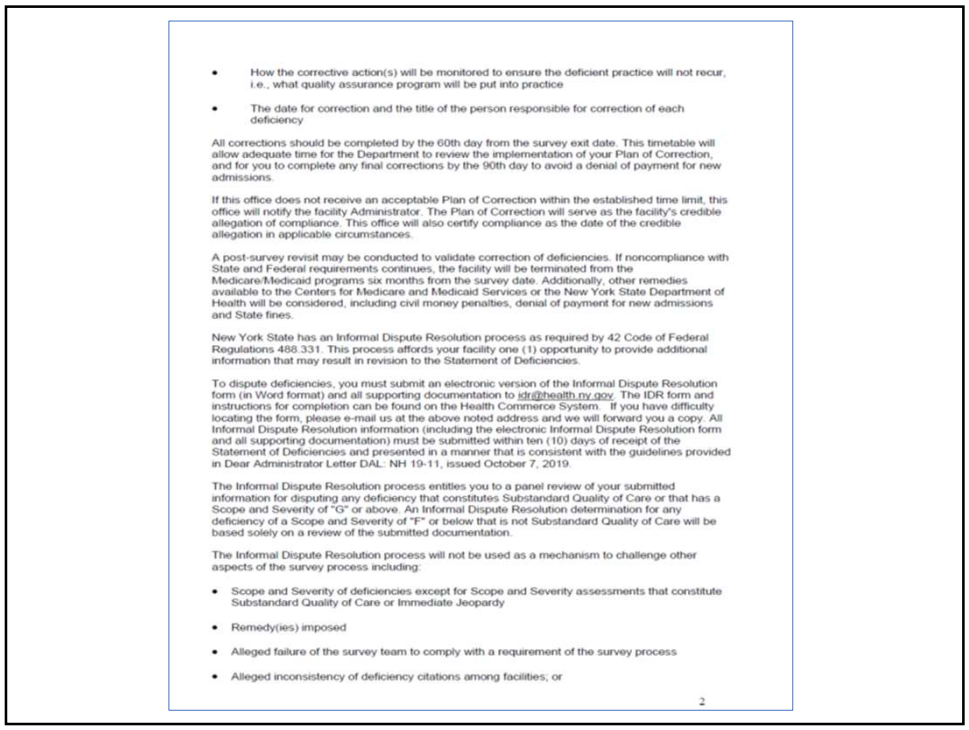

- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into practice
- The date for correction and the title of the person responsible for correction of each deficiency

All corrections should be completed by the 60th day from the survey exit date. This timetable will allow adequate time for the Department to review the implementation of your Plan of Correction, and for you to complete any final corrections by the 90th day to avoid a denial of payment for new admissions.

If this office does not receive an acceptable Plan of Correction within the established time limit, this office will notify the facility Administrator. The Plan of Correction will serve as the facility's credible allegation of compliance. This office will also certify compliance as the date of the credible allegation in applicable circumstances.

A post-survey revisit may be conducted to validate correction of deficiencies. If noncompliance with State and Federal requirements continues, the facility will be terminated from the Medicare/Medicaid programs six months from the survey date. Additionally, other remedies available to the Centers for Medicare and Medicaid Services or the New York State Department of Health will be considered, including civil money penalties, denial of payment for new admissions and State fines.

New York State has an Informal Dispute Resolution process as required by 42 Code of Federal Regulations 488.331. This process affords your facility one (1) opportunity to provide additional information that may result in revision to the Statement of Deficiencies.

To dispute deficiencies, you must submit an electronic version of the Informal Dispute Resolution form (in Word format) and all supporting documentation to idr@health.ny.gov. The IDR form and instructions for completion can be found on the Health Commerce System. If you have difficulty locating the form, please e-mail us at the above noted address and we will forward you a copy. All Informal Dispute Resolution information (including the electronic Informal Dispute Resolution form and all supporting documentation) must be submitted within ten (10) days of receipt of the Statement of Deficiencies and presented in a manner that is consistent with the guidelines provided in Dear Administrator Letter DAL: NH 19-11, issued October 7, 2019.

The Informal Dispute Resolution process entitles you to a panel review of your submitted information for disputing any deficiency that constitutes Substandard Quality of Care or that has a Scope and Severity of "G" or above. An Informal Dispute Resolution determination for any deficiency of a Scope and Severity of "F" or below that is not Substandard Quality of Care will be based solely on a review of the submitted documentation.

The Informal Dispute Resolution process will not be used as a mechanism to challenge other aspects of the survey process including:

- Scope and Severity of deficiencies except for Scope and Severity assessments that constitute Substandard Quality of Care or Immediate Jeopardy
- Remedy(ies) imposed
- Alleged failure of the survey team to comply with a requirement of the survey process
- Alleged inconsistency of deficiency citations among facilities; or

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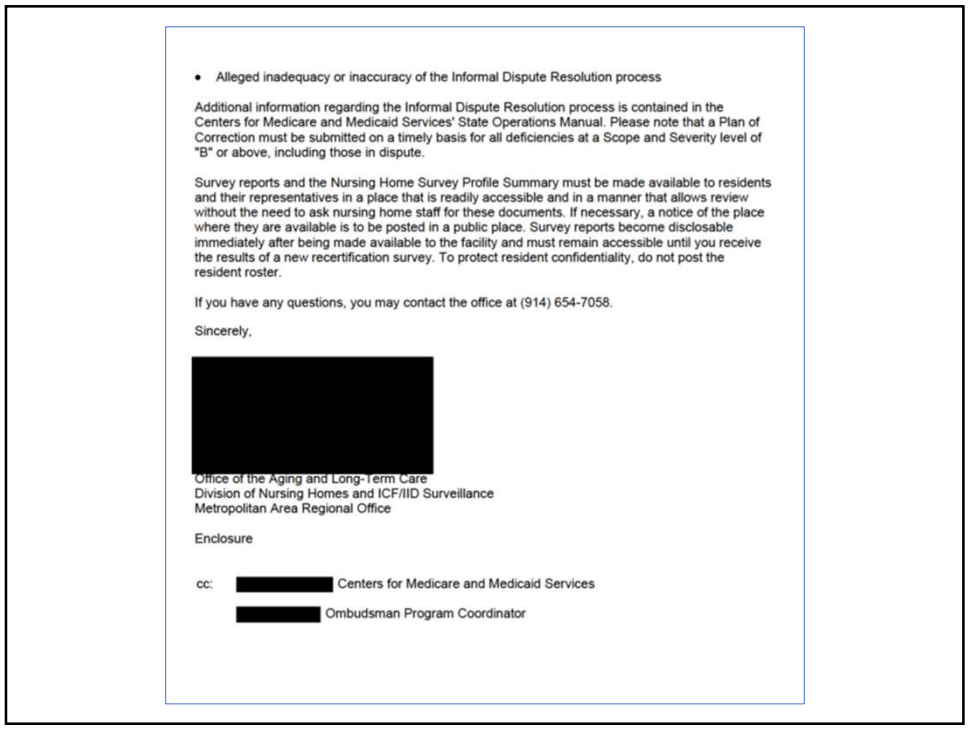

- Alleged inadequacy or inaccuracy of the Informal Dispute Resolution process

Additional information regarding the Informal Dispute Resolution process is contained in the Centers for Medicare and Medicaid Services' State Operations Manual. Please note that a Plan of Correction must be submitted on a timely basis for all deficiencies at a Scope and Severity level of "B" or above, including those in dispute.

Survey reports and the Nursing Home Survey Profile Summary must be made available to residents and their representatives in a place that is readily accessible and in a manner that allows review without the need to ask nursing home staff for these documents. If necessary, a notice of the place where they are available is to be posted in a public place. Survey reports become disclosable immediately after being made available to the facility and must remain accessible until you receive the results of a new recertification survey. To protect resident confidentiality, do not post the resident roster.

If you have any questions, you may contact the office at (914) 654-7058.

Sincerely,

[redacted]
Office of the Aging and Long-Term Care
Division of Nursing Homes and ICF/IID Surveillance
Metropolitan Area Regional Office

Enclosure

cc: [redacted] Centers for Medicare and Medicaid Services
[redacted] Ombudsman Program Coordinator

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PLAN OF CORRECTION

An acceptable plan of correction must address the following:

1) Address how **corrective action will be accomplished for those residents found to have been affected by the deficient practice**;
2) Address **how the facility will identify other residents having the potential to be affected by the same deficient practice**;
3) Address **what measures will be put into place or systemic changes made** to ensure that the deficient practice will not recur
4) Indicate **how the facility plans to monitor its performance to make sure that solutions are sustained**; and
5) Include **dates when corrective action will be completed.**

**Facilities 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 will serve as the facility's allegation of compliance*

*** The first page of the plan of correction must be signed, titled, and dated by the administrator or authorized representative*

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EXAMPLE

PLAN OF CORRECTION

This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law.

F550: Resident Rights/Exercise of Rights

I. **CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:**

- ☐ On 11/14/2024, the RN Manager in the Ventilator Unit immediately removed the signs specifying care for residents #41, #39, and #6. Residents' families were notified about the removal of the signages. Families of the 3 residents asked that the signs be put back on as they previously requested. Resident/Resident's Families put their requests in writing, indicating the specific sign that they requested to be placed above the respective resident's bed and attesting to the fact that they did not consider the placement of the signs to be a violation of the residents' dignity or privacy. Written Requests were uploaded in the electronic records and documented in each of the resident's care plan.

II. **IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE**

- ☐ All residents have the potential to be affected by the same deficient practice. Observation rounds were conducted in all residents' rooms. No other residents had signs posted above their beds.

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III. **MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR:**

- Facility Policy was updated to state that "Signs indicating the resident's clinical status or care needs shall not be openly posted in the room unless specifically requested by resident or family member. **Requests will be documented and will be incorporated in the individual resident's care plan."**
- Nursing staff and the IDCP Team were in-serviced on the facility's policy and procedure for resident's rights, specifically their right to a dignified existence and privacy. Emphasis was made on making sure that any requests made by a resident and/or resident's family (to post a sign above the bed) will be done in writing, documented in the electronic medical records, and incorporated in the resident's care plan.

IV. **MONITORING OF CORRECTIVE ACTIONS:**

- The Unit Manager /Designee will conduct audits on 5 residents weekly x 4 weeks, and then monthly thereafter x 3 months. Audit will consist of checking for the presence of signage above the resident's bed. If a signage is present, Unit Manager/Designee will conduct a Chart Review to make sure that the request is documented in the resident's care plan. Any issues will be corrected immediately. Findings will be reported to the Director of Nursing monthly and will be presented in quarterly QAPI Meeting. The QAPI Committee will determine the need for further audits and/or action plans.

V. **COMPLETION DATE: 12/10/2024**

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INFORMAL DISPUTE RESOLUTION (IDR)

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INFORMAL DISPUTE RESOLUTION (IDR) REQUEST

- ❑ Regulations require that CMS and the States, as appropriate, offer SNFs, nursing facilities, and dually participating facilities an informal opportunity to dispute cited deficiencies upon the facility's receipt of the official Initial Notice and Form CMS-2567.
- ❑ 7212.3 -Mandatory Elements of IDR

The following elements must be included in each informal dispute resolution process offered:

1. Upon their receipt of the Form CMS-2567, facilities must be offered an informal opportunity, to dispute deficiencies with the entity that conducted the survey.
2. Facilities may **NOT** use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

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- *Scope and severity assessments of deficiencies **with the exception of scope and severity assessments that constitute substandard quality of care or immediate jeopardy;***
- ***Remedy(ies)** imposed by the enforcing agency;*
- ***Alleged failure of the survey team to comply with a requirement of the survey process**;*
- ***Alleged inconsistency of the survey team** in citing deficiencies among facilities;*
- ***Alleged inadequacy or inaccuracy of the informal dispute resolution process***

3. Facilities must be notified of the availability of IDR in the letter transmitting the official Form CMS-2567. Notification of this process should inform the facility:

- *That it may request the opportunity IDR, and that if it requests, it must be submitted in writing along with an explanation of the specific deficiencies that are being disputed. The request must be made within the same 10 calendar day period the facility has for submitting an acceptable plan of correction to the surveying entity;*

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INFORMAL DISPUTE RESOLUTION (IDR) REQUEST

- *Of the name, address, and telephone number of the person the facility must contact to request IDR.*
- *How informal dispute resolution may be accomplished in that State, e.g., by telephone, in writing, or in a face-to-face meeting.*
- *Of the name and/or the position title of the person who will be conducting the informal dispute resolution, if known.*

4. Failure to complete IDR timely will not delay the effective date of any enforcement action against the facility.

5. When a facility is unsuccessful at demonstrating that a deficiency should not have been cited, the surveying entity must notify the facility in writing that it was unsuccessful.

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INFORMAL DISPUTE RESOLUTION (IDR) REQUEST

6. When a facility is successful during the IDR: On the CMS Form-2567, annotate deficiency (ies) citations as "deleted" and/or change deficiency (ies) citation findings, as recommended

Adjust the scope and severity assessment for deficiencies, if warranted & in accordance with CMS policy.

- ❑ *The SSA will recommend to CMS that any enforcement action(s) imposed solely because of deleted or altered deficiency citations be reviewed, changed or rescinded.*
- ❑ *The facility has the option to request a clean (new) copy of the Form CMS-2567*
- ❑ *Any Form CMS-2567 and/or plan of correction that is revised or changed as a result of informal dispute resolution must be disclosed to the ombudsman*
- ❑ ***Deficiencies pending informal dispute resolution should***

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IDR REQUEST SAMPLE

New York State Department of Health
INDEPENDENT & INFORMAL DISPUTE RESOLUTION FORM

Administrative IDR: ☒ Panel IDR: ☐ Panel IIDR: ☐

A. FACILITY NAME: HAPPY VALLEY NURSING CARE CENTER

B. SURVEY EXIT DATE: 11/14/2024

C. DATE ELECTRONIC IIDR/IDR FORM SUBMITTED: 12/10/2024

D. DATE IIDR/IDR SUPPORTING DOCUMENTATION SUBMITTED: 12/10/2024

E. INDICATE THE APPROPRIATE REGIONAL OFFICE:

☐	Western – Buffalo	☐	Western – Rochester
☐	Capital District	☐	Central New York
☐	Metropolitan – New Rochelle	☒	Metropolitan – New York City
☐	Metropolitan – Long Island		

F. DISPUTED DEFICIENCY: F550 G. SCOPE & SEVERITY: D

89

H. LIST DOCUMENTS YOU ARE ENCLOSING THAT ARE RELEVANT AND SUPPORT YOUR CLAIM: (label the attachments accordingly.

1) ATTESTATION LETTERS: Signed Letters from the 3 Residents/Resident's Families attesting to the fact that they requested for the signs to be placed above the Residents' respective beds, specifying specific reminders related to their individualized care. They attest to the fact that they did not consider this as a violation to their rights to privacy or a dignified existence. (EXHIBIT "1")
2) SS Notes reflecting documentation of the requests from Resident/Resident's Families (EXHIBIT "2")

I. FACILITY DISPUTE:

We respectfully dispute the allegation that the facility did not ensure residents have a right to dignified existence. Specifically, the surveyors took umbrage to signs that were placed above the beds of 3 residents (Resident #41, #39 and #6). In all 3 cases, the resident or the resident's family requested for these signs. In fact, one of the families put up the sign on his/her own.
Please see attached Attestation Letters from Resident #41, the mother of Resident #39 and the daughter of Resident #6. Each of them specified the contents of each sign that they wanted posted above the residents' beds - to cue the staff on specific care to be provided. They all felt strongly that they did not consider this a violation of residents' dignified existence or rights to privacy. Instead, they all expressed that they found comfort and felt better having the signs up. Also attached are the Social Worker's Notes that memorialized the requests made by the Resident/Resident's Family and were filed in the resident's non-electronic records.
Please also note that the facility has 196 BEDS. The fact that only these 3 residents have signs above their beds indicate that this is NOT a normal or routine practice for the facility. This was something that the facility had to do - to respect and comply with the wishes of Resident #41 and the families of Resident #39 and Resident #6. It is also significant to consider that all 3 residents were in the facility's Ventilator Unit, and the respective families of the Residents are extremely involved in the management and implementation of care provided to these specific Residents
The facility takes residents' rights and their right to a dignified existence very seriously. Based on the facts, the assignment of the F550 citation was not warranted. For the above-mentioned reasons (supported by the attached documents), we respectfully request that the citation given to the facility under F550 be reconsidered and dismissed.

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IDR RESULTS

NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

January 4, 2025

, Administrator
[redacted]

Facility: [redacted]
Medicare Provider #: [redacted]
Type of Survey: **Health Recertification**
Survey Exit Date: **11/14/2024**
Date of Informal Dispute Resolution: **December 12, 2024**

Dear Administrator:

The Department's Informal Dispute Resolution (IDR) process provides the framework for providers and surveyors to informally resolve differences over deficiencies issued during a survey. It affords the provider one (1) opportunity to submit additional information that may result in revision to the Statement of Deficiencies.

Following the facility's survey, you requested an IDR for:

Fed - F - 0550 - 483.10(a)(1)(2)(b)(1)(2) - Resident Rights/exercise Of Rights S-S= D

Fed - F - 0761 - 483.45(g)(h)(1)(2) - Label/store Drugs And Biologicals S-S= D

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As a result of an administrative review of your information regarding the disputed deficiencies at a Scope and Severity of "F" or below that are not Substandard Quality of Care (SQC), the following determinations were made:

- **The review resulted in the deficiency, F -0550, being withdrawn**

A new Statement of Deficiencies has been reposted. You must resubmit your plan of correction on the new Statement of Deficiencies, as this will now become the document of record.

Every effort has been made throughout the IDR process to evaluate the information submitted and to give consideration to the provider's position regarding the deficiencies cited by survey staff. This concludes the IDR process.

You have 7 calendar days from the date of this notices to request an explanation of the IDR result(s). This is not intended as an opportunity to provide additional information or dispute the IDR outcome, but rather to obtain feedback and education. Information will be provided via a teleconference, which will be limited to no more than 15 minutes.

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INFORMAL DISPUTE RESOLUTION (IDR) REQUEST

- ***Deficiencies pending informal dispute resolution should be entered into the Automated Survey Processing Environment system (ASPEN) and the ASPEN Informal Dispute Resolution (IDR) Manager within ten (10) calendar days of receiving the request for an IDR***
- ***This information however will not be uploaded to the Certification and Survey Provider Enhanced Reporting system (CASPER) for posting to the Nursing Home Compare website until IDR has been completed.***

93

REALITY CHECK: "SINCERELY, NELIA (To CMS)"

Subject: Calculation of a Facility's Star Rating PENDING an IDR
Dear _____,
Good Morning! Hope that all is well.
I just want to obtain clarification on an issue that we are currently encountering regarding the calculation of points from "deficiencies pending Informal Dispute Resolution."
It has been brought to my attention that deficiencies cited during a survey in a __Facility were calculated towards the Five Star Rating, PENDING AN INFORMAL DISPUTE RESOLUTION.
We called the State IDR Coordinator, and she recommended that we contact CMS. We then reached out to CMS via email at BetterCare@cms.hhs.gov. (Please see below the email thread).
In our correspondences with the _State DOH and CMS, we referred to the excerpt from the SOM Chapter 7 – (Survey and Enforcement Process for SNFs and NFs (Rev. 213, 02-10-23). We were referred back by CMS to the January 18, 2023 Memo - Ref: QSO-23-05-NH, which we were aware of.

94

We understand and appreciate CMS's commitment towards transparency; hence, the posting of the deficiencies. However, the memo also clearly states that "CMS will post deficiency citations under IDR/IIDR in each section of NH Care Compare that currently displays citations and will indicate if a citation is under dispute." In addition, p. 4 of the QSO Memo indicates that "While the citations will be publicly displayed, we will not include them in the calculation of a facility's star rating until the dispute is complete (and the survey is considered final)." I am not sure where the breakdown is but I would sincerely appreciate your assistance in clarifying this matter as it has significant implications. ***We are extremely proud of the quality of care that we provide in this facility; therefore, we are disputing the validity of the IJ deficiencies (and other deficiencies related to the same circumstances) in all avenues that are afforded to us – informal and formal.***
Thank you so much for your time and I look forward to hearing back from you.
Sincerely,
Nelia

95

DEAR NELIA (Highlights are mine ☺)

Dear Nelia,
Thanks for the information. ***The Care Compare website and Five Star System basically use the data as entered by state agencies****.*
In other words, if the state didn't enter the IDR request into the system, the deficiencies will be used in the star rating calculation. The website and ratings are updated each month based on data entered by the end of the previous month.
For example, if the IDR request was entered prior to 7/1, the deficiencies would not be used in the ratings.
If the IDR request was entered after 7/1, the deficiency was used in the ratings posted on 7/26.

96

DEAR NELIA (Highlights are mine ☺)

Another possibility is that the IDR request was not made until after 7/1, which would prevent the state from being able to enter it prior to 7/1, and it would be included in the ratings on 7/26.
If that changed during the month of July, such as the IDR request gets entered into the system before 8/1, the deficiency will be no longer be used in the ratings that will be posted on 8/30.
Hope this helps… it basically comes down to when the IDR was requested, and when the state entered the IDR request in the system.

Sincerely,
_____

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SINCERELY, NELIA (again)

Dear _____,
We submitted our IDR Requested on June 19, 2024.
We hand-delivered 11 copies of our request to the __ Department of Health State Survey Agency Office in _____and have a signed acknowledgement receipt from the State .
Our IDR Hearing is scheduled on August 17, 2024.

*So based on the different possible scenarios, the only explanation to this is that **the state did not enter our IDR request in the system.***
We will call again them again and hopefully, they will know how to proceed.
However, is there a more expeditious way to rectify this since we were not responsible for the error?

Thank you very much again for your prompt response to my emails. I sincerely appreciate it.

98

HI, NELIA (Highlights are mine ☺ - again)

Hi, Nelia,
I'm not sure, although it is unlikely. We calculate the information for all 15,000+ nursing homes at once through a very complex set of programming (the system does not do each nursing home one at a time).
So, it is extremely difficult to make changes to the website for individual facilities.
At this point, please follow up with the state. Also, please communicate with our bettercare email (as you correctly started doing), and they'll be happy to respond to your questions.
Thank you,

_____

[WHAT HAPPENED NEXT? ….. (Another saga. Good News – Before ALJ Hearing at the DAB Level, CMS lawyer reached out to us with a settlement offer – NO IJ's but NO Lawsuits.)]

99

ENFORCEMENT ACTION REMEDIES

100

ENFORCEMENT ACTION

Process of imposing 1 or more of the following remedies:

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

101

NOTIFICATION OF SANCTIONS

- Opportunity to correct deficiencies before remedies are imposed
- Date the facility is expected to achieve substantial compliance (date certain)
- Date the state agency and/or CMS will impose denial of payment (DPNA) for new admissions if substantial compliance is not achieved within three months of the last day of the survey
- Date recommended by the state agency to CMS to terminate the facility's provider agreement if substantial compliance is not achieved within six months from the last day of the survey
- Dates related to any other remedies being imposed

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Mandatory Immediate Imposition of Remedies

Immediate imposition of federal remedies, prior to an opportunity to correct deficiencies in any one or more of the following circumstances:

Immediate Jeopardy (IJ) (scope and severity levels J, K, and L);

OR

Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey;

OR

Any G level deficiency is identified on the current survey in Resident Behavior and Facility Practices, Quality of Life, Quality of Care;

OR

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Mandatory Immediate Imposition of Remedies

Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or LSC survey;

OR

Deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles);

OR

A facility is classified as a Special Focus Facility (SFF) AND has a deficiency citation at level "F" or higher for the current health survey or "G" or higher for the current Life Safety Code (LSC) survey

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Mandatory Immediate Imposition of Remedies

- *Once remedies have been imposed for noncompliance, the remedies will not be lifted until the facility provides evidence of compliance.*
- *Once substantial compliance has been achieved following an annual, revisit, or complaint survey, the facility's certification cycle will begin again.*
- *Because facilities are expected to be in compliance at all times, if during a revisit, surveyors find that cited deficiencies have been corrected but new deficiencies are found, the survey cycle will continue, but for no more than six months.*
- *If substantial compliance is not achieved within six months, termination will be implemented.*

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INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

7213.1 - SNFs, NFs and SNF/NFs are provided the opportunity to request and participate in an **Independent IDR if CMS imposes civil money penalties against the facility and these penalties are subject to being collected and placed in an escrow account pending a final administrative decision.**

- NOTE: **All CMP funds are subject to escrow.** If the nursing home elects not to request an Independent IDR or to appeal, then after any IDR (if requested), CMP amount becomes due and payable in accordance with the process in §7528.3.
- CMS retains ultimate authority for the survey findings and imposition of civil money penalties.
- However, an opportunity for an Independent IDR is provided within 30 calendar days of the notice of imposition of a civil money penalty that is subject to being collected and placed in escrow.

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7213.4 -Applicability of the IIDR Process

- The Independent IDR is conducted only upon the facility's timely request. **The facility must request an Independent IDR within 10 calendar days of receipt of the offer.**
- A facility may request an Independent IDR for each survey that cites deficiencies for which a CMP has been imposed that is subject to collection & placement in an escrow
- The focus of the IIDR process is the deficiency or deficiencies from a survey that led to the imposition of a CMP that is subject to being collected and placed in escrow
- However, while such factors as the scope and severity classification, and the CMP, are not the subjects of the IIDR, SSA's and CMS, will take into consideration any changes in deficiency findings that result pursuant to State or CMS review of the completed Independent IDR process.

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- Based on such review, States and CMS will assess whether any changes to scope/severity or CMP amount are warranted.
- IIDR is not intended to be a formal or evidentiary hearing nor are the results of the IIDR an initial determination that gives rise to appeal rights
- The Independent IDR results are recommendations to the State and CMS and are not subject to a formal appeal.
- Upon a facility's timely request for an Independent IDR, the State survey agency, or the Independent IDR entity or person (as appropriate) will provide the following information to the facility:
- Information on the Independent IDR process including where, when and how the process may be accomplished, e.g., by telephone, in writing, or in a face-to-face meeting, and
- Contact information of the person(s) who will be conducting the Independent IDR, if appropriate.

109

I-IDR EXAMPLE

110

SOD

F677 SS=G	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) 483.24(a)(2) A resident who is unable to carry	
F677	Continued From page 18 out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: COMPLAINT #: NJ 152792 Based on observation, interview, and review of facility documents it was determined that the facility failed to: a.) ensure timely incontinence care to residents dependent on staff for care, b.) initiate a plan of care to prevent moisture-associated skin damage and fungal rash as a result of the incontinence. This deficient practice was identified for 3 of 5 residents reviewed for incontinence (Resident #20, #70, and #101).	F677

111

ALLEGED DEFICIENT PRACTICE AND REGULATION THAT FACILITY ALLEGEDLY VIOLATED: F677

4) F-677: ADL Care Provided for Dependent Residents: SS = G

ALLEGED DEFICIENT PRACTICE:

"Based on observation, interview, and review of facility documents it was determined that the facility failed to: a.) ensure timely incontinence care to residents dependent on staff for care, b.) initiate a plan of care to prevent moisture- associated skin damage and fungal rash as a result of the incontinence. This deficient practice was identified for 3 of 5 residents reviewed for incontinence (Resident #20, #70, and #101)."

REGULATION

ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)

483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

112

GENERAL PREMISE OF DISPUTE

WHY WE ARE DISPUTING:

A comprehensive review of the medical records of Resident #20, Resident #70, and Resident #101 reveal that the serious accusations made by the Surveyors were "SUBJECTIVE CONCLUSIONS" that were not sufficiently and irrefutably substantiated by facts.

Many of the allegations were based on **"Hearsay" and "Assumptive Conclusions."**

The lack of a "formal plan of care to prevent moisture- associated skin damage and fungal rash as a result of the incontinence" was not found by the surveyors in the records does not mean that the residents' needs were not met. The Physician's Orders, TARs and other aspects of the Medical Records prove otherwise.

Therefore, the allegations that the facility caused "ACTUAL HARM" to the above-mentioned residents are unfair and unwarranted. The fact is – skin-related damage related to incontinence would have been far worse if the assertions by the surveyors were true.

113

THE INTERPRETIVE GUIDANCE

Appendix PP of the SOM on F677 (EXHIBIT "J") provides the following guidance:

Conditions which may demonstrate an unavoidable decline in the resident's ability to perform ADLs include but are not limited to the following:

- The natural progression of a debilitating disease with known functional decline
- The onset of an acute episode causing physical or mental disability while the resident is receiving care to restore or maintain functional abilities: and
- The resident's or his/her representative's decision to refuse care and treatment to restore or maintain functional abilities after efforts by the facility to inform and educate about the benefits/risks of the proposed care and treatment; counsel and/or offer alternatives to the resident or representative. The decision to refuse care and treatment must be documented in the clinical record. Documentation must include interventions identified on the care plan and in place to minimize or decrease functional loss that were refused by the resident or resident's representative and any interventions that were substituted with consent of the resident and/or representative to minimize further decline.

114

FACTUAL CONSIDERATIONS

This F-Tag mentioned 3 residents:

FACTUAL CONSIDERATIONS:

RESIDENT #20:

- The focus of scrutiny on Resident #20 originated from a a phone interview with the resident's responsible party (RP). According to the CMS Form 2567, *"the RP informed the surveyor that the family visited Resident #20 almost every day. The RP stated that while they were satisfied with the individual staff who were assigned to care for Resident #20, the RP elaborated that those staff were only able to do so much on their shift because there was such a shortage of staff working each shift. **The RP concluded that the shortage of staff resulted in Resident #20 developing some rashes on the skin to the perineal area due to incontinence, because the resident could not receive incontinence care in a timely manner because available staff could only do so much on shift. The RP also stated that he/she was informed that the resident since had a physician's order for a prescription cream to treat the skin rashes."***
- **With all due respect, a citation of "ACTUAL HARM" should not and could not be based primarily on a family member's "perceived conclusion." In fact, a complete chronological narrative of resident's entire stay in the facility will shed light to the facts: SEE ATTACHED EXHIBIT "K" (PROGRESS NOTES FOR RESIDENT #20)**

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Resident is a [redacted]-old male who was admitted from home on [redacted] initially just for respite while mother was undergoing medical treatments. Resident arrived in facility accompanied by family. Resident AAO x 1 and is able to verbalize needs. Diagnoses on admission included the following: **Schizophrenia, Bipolar d/o, Alzheimer's Disease, Dementia, Parkinson's ds, HTN, DM, Hypoparathyroidism, hypercholesterolemia, epilepsy**. Meds include the following: **Basaglar, B12, D3, Fycompa, HCTZ, Lamotrigine, Loratadine, Metformin, Namenda, Norvasc, Paxil, Quetiapine, Simvastatin, Sinemet and Steglatro.**

Admission Note indicated **"Skin: sacral redness on admission"**

- **Resident was noted with behavior issues including "physical aggression" and "resisting care."** Resident's mother acknowledged that these were issues that she had to deal with at home.
- On [redacted], Resident #20 was admitted in the hospital secondary to Pneumonia and to R/O CVA.
- On [redacted], resident returned to the facility at **6:30 PM** from [redacted] via Stretcher accompanied by [redacted] The CMS Form 2567 (Statement of Deficiencies) goes into a narration on whether the resident was assessed for skin integrity issues or not. It then stated that: *"The resident's Nursing Progress Note (writer LPN) dated [redacted] at 10:10 PM, reflected the resident's skin assessment was done and was "intact pink and warm to the touch."*
- *The surveyors found issue in the fact that on [redacted] **at 2:24 PM,** According to the resident's Nursing Progress Note (writer Licensed Practical Nurse/Unit Manager) reflected that **"Resident noted to have rash on left side of body. Resident complains of rash being itchy and red. Primary MD [physician] made aware and gave orders for nystatin [used to treat fungal skin infections) BID [twice a day] for 3 weeks. Orders carried out. The resident's diagnoses list included the updated new diagnosis for Candidiasis (Candida is a common fungal infection that causes rash on the moist areas of the body) of skin and nail dated [redacted]"***

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CLINICAL CONSIDERATIONS

CLINICAL CONSIDERATIONS:

The 2567 alludes to the simplified assumption that the fungal-related skin issues/rashes (candidiasis) were directly related to facility's alleged failure to (a) ensure timely incontinence care to residents who are dependent on staff for care, b.) initiate a plan of care to prevent moisture- associated skin damage and fungal rash as a result of the incontinence. This is **a FALSE and UNFAIR ASSUMPTION.**

Studies based on evidence-based research refutes this oversimplification of the etiological factors that may lead to fungal infections. PLEASE REFER TO "EXHIBIT L" (Candida sp. Infections in Patients with Diabetes Mellitus). The abstract clearly states that Diabetes mellitus (DM) is a metabolic disorder that predisposes individuals to fungal infections, including those related to Candida sp., due to an immunosuppressive effect on the patient.

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Resident #70: [redacted]

- ☐ PLEASE SEE **"EXHIBIT M"** - Progress Notes for Resident #70 that reflect resident's diagnoses and comorbidities, and the fact that resident was on Hospice Care.
  "Resident is a 92 y'/ male with PMH of GERD, Constipation, Vertigo, BPH, MDRO UTIs, MDD, Bipolar, COVID-19 in 09/20, GI Bleed, Peg with recent hospitalization for AMS, **now on hospice.**
  FACILITY DID NOT CAUSE ANY ACTUAL HARM TO RESIDENT.

Resident #101: [redacted]

PLEASE SEE **"EXHIBIT N"** - Progress Notes for Resident #101 that reflect resident's diagnoses, functional status, comorbidities, and documentation that clearly shows that resident is well taken cared of by facility staff. **FACILITY DID NOT CAUSE ANY ACTUAL HARM TO RESIDENT.**

CONCLUSION:

Based on the above explanations, and supported by documentation, **the citation of F677 with a Scope and Severity of "G" (ACTUAL HARM) IS NOT WARRANTED BASED ON FACTUAL, CLINICAL AND REGULATORY CONSIDERATIONS.**

WE THEREFORE RESPECTFULLY REQUEST THAT THE F677 CITATION WITH A SCOPE AND SEVERITY OF "G" BE REMOVED, OR AT THE VERY LEAST, BE REDUCED.

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ALLEGED DEFICIENT PRACTICE AND REGULATION THAT FACILITY ALLEGEDLY VIOLATED: F684

F684 SS=G	Quality of Care CFR(s): 483.25 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to administer an antianxiety medication for a period of 14-hours which caused a resident increased anxiety resulting in psychological harm. This deficient practice was identified for 1 of 5 residents reviewed for medication management (Resident #256).	F684

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WHY WE ARE DISPUTING

WHY WE ARE DISPUTING

With all due respect, this statement is misleading. It imputes deliberate neglect on the part of the facility. It unfairly suggests that the facility intentionally withheld or neglected the immediate need of a resident. The timeline of events shows a different scenario.

On 5/2/[redacted] at around 10 AM, Resident #256 met with his/her primary physician who agreed to prescribe Xanax to address his/her anxiety. This was the first time that Xanax would be prescribed to Resident #256. Before this date and time, resident had not experienced any anxiety.

The anxiety was related to his/her discharge planning. At around 11:43 AM, the progress notes reflected that the resident's status was "Discussed with Nursing." At around 2:15 of the same date, the order for Xanax was placed. The diagnosis for Generalized anxiety Disorder was electronically entered on 5/2/[redacted] When Xanax was already available and administered, it was already 1:18 in the morning of 5/3/[redacted]

By the time the surveyors interviewed Resident #256 on 5/3/[redacted] at 10:18 AM (more or less 24 hours from the first sign of anxiety), Resident #256 was already calm.

The facility did its best to get hold of the Xanax. But of course, it had to go through a process beyond the facility's control. Any facility back up medication was not accessed due to the need of 2 people to authorize access. **The assignment of a Scope and Severity of G (Actual Harm) is unwarranted.**

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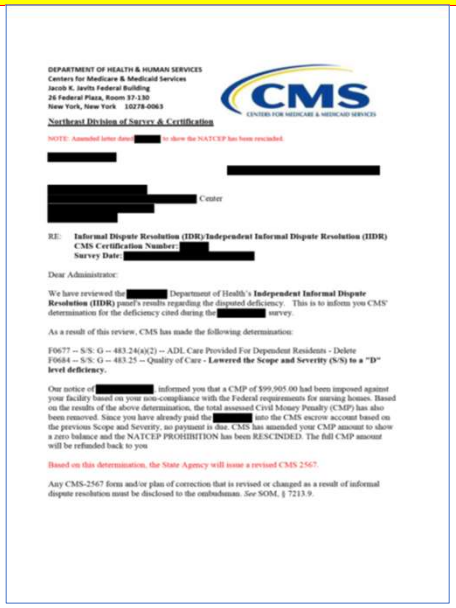
IIDR RESULTS



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Jacob K. Javits Federal Building
26 Federal Plaza, Room 37-130
New York, New York 10278-0063

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Northeast Division of Survey & Certification

NOTE: Amended letter dated [redacted] to show the NATCEP has been rescinded.

[redacted]

[redacted] Center

RE: **Informal Dispute Resolution (IDR)/Independent Informal Dispute Resolution (IIDR)**
CMS Certification Number: [redacted]
Survey Date: [redacted]

Dear Administrator:

We have reviewed the [redacted] Department of Health's **Independent Informal Dispute Resolution (IIDR)** panel's results regarding the disputed deficiency. This is to inform you CMS' determination for the deficiency cited during the [redacted] survey.

As a result of this review, CMS has made the following determination:

F0677 -- S/S: G -- 483.24(a)(2) -- ADL Care Provided For Dependent Residents - Delete
F0684 -- S/S: G -- 483.25 -- Quality of Care - **Lowered the Scope and Severity (S/S) to a "D" level deficiency.**

Our notice of [redacted], informed you that a CMP of $99,905.00 had been imposed against your facility based on your non-compliance with the Federal requirements for nursing homes. Based on the results of the above determination, the total assessed Civil Money Penalty (CMP) has also been removed. Since you have already paid the [redacted] into the CMS escrow account based on the previous Scope and Severity, no payment is due. CMS has amended your CMP amount to show a zero balance and the NATCEP PROHIBITION has been RESCINDED. The full CMP amount will be refunded back to you

Based on this determination, the State Agency will issue a revised CMS 2567.

Any CMS-2567 form and/or plan of correction that is revised or changed as a result of informal dispute resolution must be disclosed to the ombudsman. *See* SOM, § 7213.9.

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As a result of this review, CMS has made the following determination:

F0677 -- S/S: G -- 483.24(a)(2) -- ADL Care Provided For Dependent Residents - Delete
F0684 -- S/S: G -- 483.25 -- Quality of Care - **Lowered the Scope and Severity (S/S) to a "D" level deficiency.**

Our notice of [redacted], informed you that a CMP of $99,905.00 had been imposed against your facility based on your non-compliance with the Federal requirements for nursing homes. Based on the results of the above determination, the total assessed Civil Money Penalty (CMP) has also been removed. Since you have already paid the [redacted] into the CMS escrow account based on the previous Scope and Severity, no payment is due. CMS has amended your CMP amount to show a zero balance and the NATCEP PROHIBITION has been RESCINDED. The full CMP amount will be refunded back to you

Based on this determination, the State Agency will issue a revised CMS 2567.

Any CMS-2567 form and/or plan of correction that is revised or changed as a result of informal dispute resolution must be disclosed to the ombudsman. *See* SOM, § 7213.9.

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FORMAL APPEALS PROCESS

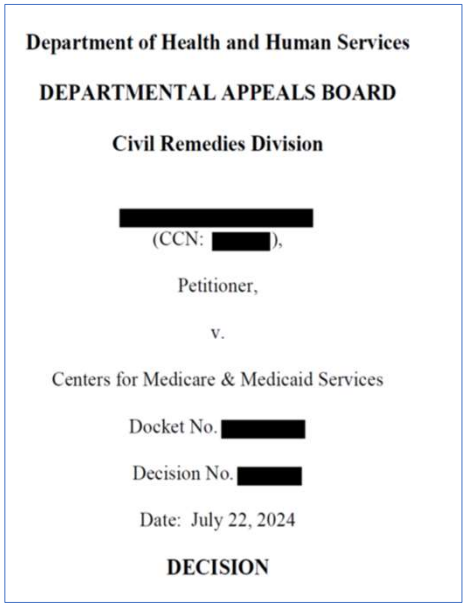
When CMS imposes an enforcement action (a "remedy"), a provider has 60 calendar days to file a formal appeal with the Department of Health and Human Services (HHS) Departmental Appeals Board.

- ❑ The first level is a hearing before an administrative law judge (ALJ). It typically takes at least three years from the time an appeal is filed to receive the ALJ's decision.
- ❑ Either CMS or the provider may appeal ALJ's decision to the board of appeals.
- ❑ A SNF can further appeal to a federal court of appeals or the district court in that jurisdiction depending on the enforcement action.

SUCCESS RATE HISTORICALLY FOR PROVIDERS – NOT GOOD

123

HOWEVER, …… MIRACLES DO HAPPEN



Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

[redacted]

(CCN: [redacted]),

Petitioner,

v.

Centers for Medicare & Medicaid Services

Docket No. [redacted]

Decision No. [redacted]

Date: July 22, 2024

DECISION

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- Resident was an 85-year-old male who was admitted to P. facility on November 12, 2020, for rehabilitation and wound care. At the time of admission and throughout his stay at P facility, the goal for Resident 2 was discharge to a LTC facility and not to home.
- At **11:40 pm** on December 5, 2020, LPN 1 observed Resident to be upset and "broken hearted" following a phone call with his wife in which she informed Resident 2 that he needed to remain at P's facility and could not come home. LPN 1 reported and testified that Resident 2 indicated that his wife did not want him home and said, "I'm not sure if I want to live anymore." LPN 1 consoled Resident 2 for **approximately five minutes** stating that they could talk through everything more and that they could call his family the next day to clarify any misunderstanding. Resident 2 then **appeared to be calm and stated that he "wanted to get some sleep.**" LPN 1 recalled a conversation that had occurred a few days earlier when Resident 2 had stated he knew he would live at Petitioner's facility now and that he had made his peace with it. **LPN 1 left Resident 2 and turned out the lights to his room so he could rest.**

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- At around **11:57 PM** on December 5, 2020, **approximately 12 minutes after LPN 1 left Resident 2 with eyes closed to sleep,** LPN 1 and a CNA went to check on Resident 2 and found Resident 2 on both knees on the floor with the right side of his body leaning against the bed. When LPN 1 went to assist Resident 2, he discovered that Resident 2's call bell cord was wrapped around his neck. LPN 1 removed the cord and placed Resident 2 on his back on the floor. No pulse or respiration was observed. No attempt to resuscitate Resident 2 was made due to his advanced directives. The Director of Nursing was immediately notified.

SURVEYORS CAME AND GAVE FACILITY THE FF. F-TAGS:

- 42 C.F.R. § 483.12 (Tag F600)[1] (Free From Abuse and Neglect), Scope and severity (S/S) level J (an isolated deficiency that involves immediate jeopardy to resident health or safety)[2];
- 42 C.F.R. § 483.21(b)(1) (Tag F656) (Develop/Implement Comprehensive Care Plan), S/S level G (an isolated deficiency that causes actual harm that does not amount to immediate jeopardy);
- 42 C.F.R. § 483.40(a)(1)(2) (Tag F741) (Sufficient/Competent Staff-Behavioral Health Needs), S/S level E (Pattern of deficiency with no actual harm with the potential for more than minimal harm).

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☒ IDR = FACILITY LOST
☒ IIDR = FACILITY LOST
✓ **ALJ HEARING: ALJ'S DECISION AND ANALYSIS:**

"First, an analysis of the plain meaning of Resident 2's statement does not indicate that he was threatening suicide. "I'm not sure if I want to live anymore," taken literally, indicates an uncertainty about the desire to continue living and is not a threat to take action to end one's own life.

Second, the statement taken in context further supports communication of emotional upset and not a threat of suicide. Resident 2 was eighty-five years, had not lived at home for many months prior to admission to Petitioner's facility and previously acknowledged to LPN 1 that he knew he would not be discharged home and had made peace with it. Resident 2 had calmed down quickly after becoming upset from a phone call with his wife that maintained Resident 2 would not live with his wife anymore. Resident 2 then indicated he wanted to sleep after LPN 1 comforted him and counselled him that he could communicate with his wife the next day.

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Third, LPN 1 had conducted an admission assessment of Resident 2, known as the PHQ-9, approximately three weeks prior to the night in question.

Resident 2 specifically indicated that he did not have thoughts of harming himself or that he was better off dead.

The **Level 1 PASRR was also negative** upon admission less than three weeks prior to Resident 2's suicide, which indicated that Resident 2 was neither a danger to himself nor others.

In the **MDS on November 19, 2020, Resident 2 reported that he did not have thoughts of harming himself or that he was better off dead.**

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Fourth and finally, Petitioner put forth unrebutted expert testimony from Nelia S. Adaci, R.N., an expert in gerontological nursing. Nurse Adaci testified that Resident 2's statement, "I'm not sure if I want to live anymore" was not, considering the totality of the circumstances, a threat of suicide. Tr. 1 at 304 (Q: "So that statement, I'm not sure if I want to live anymore, is it your testimony that those words uttered by the resident is not necessarily a suicidal ideation?" A: "That is my testimony, Your Honor."); Nurse Adaci opined that the statement was not suicidal ideation or a threat of suicide required to trigger Petitioner's Suicide Threats Policy given the fact that **Resident 2 was able to be calmed by LPN 1 shortly after the statement was made and the total context in which it was made**. Tr. 1 at 247-48, 280-290, 299-302, 304-305.

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"I agree with Nurse Adaci's unrebutted opinion on this issue. The phrase, "I'm not sure if I want to live anymore" is not, per se, a threat of suicide. Given that LPN 1 was able to calm Resident 2 in a short period of time after the statement was made among all the factors discussed above supports that it was reasonable to not interpret the statement as a threat of suicide. **While Resident 2 did ultimately and unfortunately take his own life, we must look at the circumstances objectively at the time, and not with the benefit of hindsight. Accordingly, I find that Petitioner has met its burden to show that it was reasonable not to interpret Resident 2's statement as a threat of suicide and that Petitioner did not abuse or neglect Resident 2 in so doing. Therefore, I find that Petitioner did not violate 42 C.F.R. § 483.12(a)(1) for its alleged failures to investigate Resident 2's intent to self-harm, secure the resident's environment, immediately notify Resident 2's physician and maintain constant supervision of Resident 2 until instructions were received from Resident 2's physician."**

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TO IDR/IIDR OR NOT TO IDR/IIDR?

THINGS TO CONSIDER:

- ✓ ACCURACY AND VALIDITY OF THE ALLEGED DEFICIENCIES
- ✓ ANALYZE THE IMPACT (even low-level deficiencies) can have on the facility's public reputation and your 5 star rating and potential implications for participation in APM'S.
- ✓ Carefully select citations that are incomplete, inaccurate, or not correctly cited —
- ✓ Consider NOT just those with high scope and severity BUT also the volume of F-tag citations.

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CONCLUSION:

- **Prevention is better than Cure.**
- **The Best Defense is Offense.**
- **KNOWLEDGE IS NOT JUST POWER. IT IS SURVIVAL!**

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PREPARE SURVEY BINDER

"You have one chance to make a first impression!"

Review and/or Write Policies & Procedures

"Mirror the requirements"

(NOTE: This is not the time to show off your creative & extensive writing skills!)

IN-SERVICE STAFF ON POLICIES AND PROCEDURES.

Review TOOLS, FORMS & Medical Records

"Be practical and realistic. It is not about quantity; it is about accuracy and quality!"

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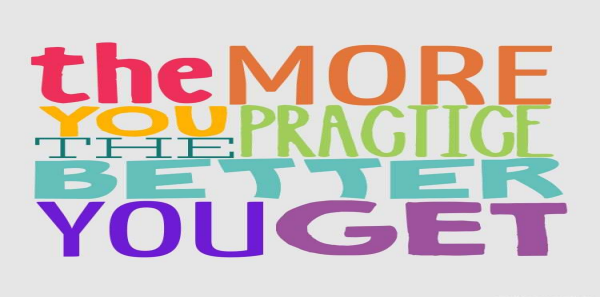
STAFF RESOURCES & COMPETENCIES

"ENSURE STAFF KNOWLEDGE AND COMPLIANCE WITH REGULATIONS AND FACILITY POLICIES;

SKILLS COMPETENCIES BASED ON RESIDENTS' NEEDS, AS REFLECTED IN FACILITY ASSESSMENT.

HAVE A ROBUST AND FUNCTIONING QAPI PROGRAM "



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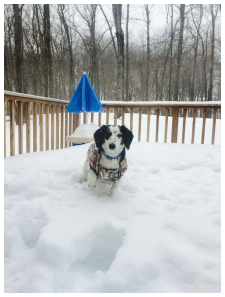
THANK YOU!!!



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