NOTES FROM THE DIRECTOR

Greetings from the Office of the Inspector General, Division of Health Care:

This month I have an important topic to discuss that I hope will be helpful to you. As you may know, we have had several instances of Immediate Jeopardy deficiencies in the past few months. In many of these cases, if the facility had taken appropriate action prior to our entrance into the building for the complaint investigation or survey, these cases would still have been cited at a scope/severity of Jeopardy, but with a notation in the plan of correction column that it is past non-compliance with no plan of correction required.

In Past Jeopardy/Past Non-compliance cases, the civil money penalties (CMP's) imposed by CMS will often be a per instance penalty up to $10,000. This is generally significantly less than a per day CMP which starts back at the date the Immediate Jeopardy situation occurred. If the Immediate Jeopardy situation occurred several months prior to our visit to conduct the survey or complaint investigation, those CMP's can accrue to very high dollar amounts.

If you do not understand what types of situations might constitute Immediate Jeopardy or the definition of Immediate Jeopardy, please read Appendix Q of the CMS State Operations Manual (SOM). If your facility has a situation that you believe might rise to the level of Immediate Jeopardy, we strongly recommend that you take immediate action to address the situation. That might include training of staff, new policies and procedures and making sure that staff are aware of and understand the new policies, addressing environmental issues in the building, moving duties to a different staff person, updating care plans and ensuring that new interventions are actually carried out, determining which residents may have been affected by the practice and assessing them, developing and ensuring staff are knowledgeable of new systems for provision of care, monitoring through your quality improvement process to ensure that the interventions put in place are actually effective, etc. Obviously, each situation will require a different approach and different interventions, but the things described above are a good beginning.

Here is the vital piece of the puzzle to understand. For the survey agency to call a situation Past Jeopardy or Past Non-compliance, the facility must have implemented all needed interventions to remove the Immediate Jeopardy, and monitored through their quality improvement process to ensure that the interventions were effective and that the facility has achieved substantial compliance. There must be documentation of interventions. For example, if staff training was carried out, there needs to be a description of the training, who conducted it, and sign-in sheets to show who attended. This is your proof that you did carry out these interventions. Most importantly, to call a situation Past Jeopardy, ALL THE INTERVENTIONS AND MONITORING MUST HAVE BEEN COMPLETED BEFORE THE SURVEY AGENCY ENTERS THE BUILDING. If you are still assessing residents, doing training or whatever when we enter the building and during the survey/complaint investigation, then we cannot call it Past Jeopardy. (See Below: S&C – 06-01 Nursing Homes: Citations of Past Noncompliance – Revised Guidance)

As you can see, it is vital that you begin interventions to address a possible jeopardy situation immediately. Further, it is in the facility's best interests as well as the residents' best interest to fix the problem as soon as possible.

I am hopeful that this information will help decrease the number of current Immediate Jeopardy situations, decrease the amount of CMP's that are imposed by the Centers for Medicare and Medicaid Services (CMS), and result in more rapid correction of non-compliance situations to improve the quality of care to our residents. Thank you all and if you have questions, feel free to contact our agency.

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CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-06-01

DATE: **October 20, 2005**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: **Nursing Homes:** Citations of Past Noncompliance – Revised Guidance

Letter Summary

The guidance contained in this memorandum:

1) Reinforces the importance of making determinations of current compliance with specific regulatory tags before considering a citation of past noncompliance;
2) Replaces current guidance in the State Operations Manual related to the recommendation of a civil money penalty for a citation of past noncompliance; and
3) Provides instructions for data entry of past noncompliance as users will no longer reference survey data tag number F698 for citations of past noncompliance.

Background

This memorandum clarifies survey and certification actions related to citations of past noncompliance.

The nursing home enforcement regulations provide that the Centers for Medicare & Medicaid Services (CMS) or the state may impose a civil money penalty for the number of days of past noncompliance since the last standard survey, including the number of days of immediate jeopardy.[1] Although citations of past noncompliance account for approximately less than one percent of all nursing home deficiencies cited in 2004, CMS recognizes that the current guidance in the State Operations Manual (SOM) merits further clarification. Attachment 1 clarifies the citation of past noncompliance for nursing homes. This guidance will be incorporated in a future release of the SOM to replace the existing guidance.

[1] 42 CFR 488.430(b)

Discontinued Use of Tag-F698
The use of the generic survey data tag F698 for all past noncompliance citations will be discontinued for all surveys that have a survey exit date beginning on or after November 1, 2005. CMS is proceeding to modify the data system so that the specific nursing home survey data tag (F-tags for health deficiencies or K-tags for life safety code deficiencies) for which there was a finding of past noncompliance may be identified appropriately. Attachment 2 provides technical instructions for documenting past noncompliance at the specific survey data/deficiency tag in the Automated Survey Processing Environment (ASPEN).

The changes incorporated in this final policy and procedure guidance include many of the helpful comments we received from states, CMS regional offices, and interested stakeholders. We appreciate the time and effort reviewers expended to improve upon policies and procedures to assure that our beneficiaries receive quality care in our nation's nursing homes.

Effective Date: The information contained in this memorandum replaces current guidance on past noncompliance in the SOM. This policy is effective for all surveys that have a survey exit date beginning on or after November 1, 2005.

Training: This clarification must be shared with all survey and certification staff, surveyors, their managers, and the state and CMS regional office training coordinators. This information must be shared with nursing home providers in each state.

/s/
Thomas E. Hamilton

Attachments:
Attachment 1 - Determining Citations of Past Noncompliance at the Time of the Current Survey in a Nursing Home
Attachment 2 – Technical Instructions for Entering Nursing Home Citations of Past Noncompliance into ASPEN

cc: Survey and Certification Regional Office Management (G-5)
Jack Williams, Division of National Systems

Attachment 1

Determining Citations of Past Noncompliance at the Time of the Current Survey in a Nursing Home

Past noncompliance may be identified during any survey of a nursing home. Findings of past noncompliance may come to light more frequently during investigations of complaints about the care and services provided to residents in a nursing home.

To cite past noncompliance with a specific survey data tag (F-tag or K-tag), all of the following three criteria must be met:

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

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

For the purpose of making determinations of current noncompliance or past noncompliance using the current sampled residents, the survey team is expected to follow the investigative protocols and surveyor guidance found in Appendices P and PP and Chapter 5 of the State Operations Manual (SOM).

When noncompliance at a deficiency tag is identified, the surveyor may have identified concerns related to other outcome, process, or structure requirements. The surveyor should investigate the identified requirements before determining whether noncompliance is present at those additional tags. Noncompliance in these additional requirements could be an indication of systemic problems in the delivery of care and services within the facility.

For example: In Appendix PP, if noncompliance is identified at tag F314 (pressure ulcer), guidance is provided that directs the surveyor, if concerns were identified in other outcome, process and/or structure requirements, to investigate those concerns before determining whether noncompliance was present at the additional tags. Examples of additional requirements that may have been identified as areas of concern during the investigation of pressure ulcer care include but are not limited to:

- 42 CFR 483.10(b)(11), F157, Notification of Changes
- 42 CFR 483.15(b)(1), F272, Comprehensive Assessments
- 42 CFR 483.20(k), F279, Comprehensive Care Plans
- 42 CFR 483.20(k)(2)(iii), F280, Comprehensive Care Plan Revision
- 42 CFR 483.20(k)(3)(i), F281, Services Provided Meet Professional Standards
- 42 CFR 483.25, F309, Quality of Care
- 42 CFR 483.30(a), F353, Sufficient Staff

- 42 CFR 483.40(a), F385, Physician Supervision
- 42 CFR 483.75(f), F498, Proficiency of Nurse Aides
- 42 CFR 483.75(i)(2), F501, Medical Director

NOTE: The surveyor is not required to investigate all of the above requirements, but only those in which the surveyor had identified specific concerns.

Similar to verifying correction of current noncompliance on a revisit, surveyors should use a variety of methods to determine whether correction of the past noncompliance occurred and continues. This may include, but is not limited to, the following:

- Interviews with facility staff, such as the administrator, nursing staff, social services staff, medical director, quality assessment and assurance committee members, and/or other facility staff, as indicated, to determine what procedures, systems, structures, and processes have been changed.

- Reviewing through observation, interview and record review, how the facility identified and implemented interventions to address the noncompliance. Examples of interventions may include, but are not limited to:

    - The facility's review, revision, or development of policies and/or procedures to address the areas of concerns;
    - The provision and use of new equipment, as necessary;
    - The provision of staff training required to assure ongoing compliance for the implementation and use of new and/or revised policies, procedures, and/or equipment, especially with new and/or temporary staff;
    - The provision of additional staffing, changes in assignments or deployment of staff, as needed; and
    - The provision of a monitoring mechanism to assure that the changes made are being supervised, evaluated, and reinforced by responsible facility staff.

- Evaluating whether the facility has a functioning quality assessment and assurance committee, whose responsibilities include the identification of quality issues; providing timely response to ascertain the cause; implementing corrective action; implementing monitoring mechanisms in place to assure continued correction and revision of approaches as necessary to eliminate the potential risk of occurrence to other residents and to assure continued compliance.

Enforcement Action Subsequent to the Citation of Past Noncompliance

The nursing home enforcement regulation provides that a civil money penalty (CMP) may be imposed for the number of days of past noncompliance since the last standard survey. If the State Survey Agency (SA) chooses to recommend the imposition of a remedy for a citation of past noncompliance, the only applicable enforcement response is the imposition of a CMP. CMS strongly urges the SAs to recommend the imposition of a CMP for past noncompliance cited at the level of immediate jeopardy.

The SA makes this recommendation to the CMS regional office or the State Medicaid Agency, or both, as determined in accordance with the survey and certification responsibility found in §7300B of the SOM. The Per-Day or Per-Instance CMP may be selected as an enforcement response for past noncompliance. When it is difficult to accurately establish when the past noncompliance occurred, the selection of a Per-Instance CMP would be appropriate. (The procedures related to CMPs may be found at §§7510 through 7536 of the SOM.)

References: Related State Operations Manual Sections

- Chapter 5 – Complaint Procedures (will be revised to incorporate this policy)
- §7300 B – Survey and Certification Responsibility
- §7306C – When State Recommends a Civil Money Penalty for Past Noncompliance
- §§7400 through 7400F3- Enforcement Remedies for Skilled Nursing Facilities and Nursing Facilities
- §§7510 through 7536B – Civil Money Penalties (will be revised to incorporate this policy)
- §§7809 through 7809F – Nurse Aide Training and Competency Evaluation Program and Competency Evaluation Program Disapprovals
- Appendix P – Survey Protocol for Long Term Care Facilities (will be revised to incorporate this policy)
- Appendix PP - Guidance to Surveyors for Long Term Care Facilities

This policy is effective for all surveys that have a survey exit date beginning on or after November 1, 2005.