After the Survey
SECTION 7 - AFTER THE SURVEY

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

SECTION | PAGE #
--- | ---
Info Sheet: Reading a Nursing Home’s Survey/Statement of Deficiencies | 7.2-7.5
State Operations Manual: Guidelines for Determining Immediate Jeopardy Violation Class Distinctions | 7.6-7.41
The Appeal Process: IDR and IIDR | 7.43-7.54
Informal Dispute Resolution: 4-Step Checklist | 7.55
Facility IDR Request Process | 7.56-7.57
Primaris Independent IDR Intake Form | 7.58
How to Write a Plan of Correction | 7.59
Putting Together a “Credible Allegations” Book | 7.60
Getting Ready for Re-Visit | 7.61

Updated October 2015
Preface:
Your senses will give a general impression of the nursing home during several visits at different times of the day and different days of the week. The ability to read and understand a nursing home's survey/inspection, also known as a statement of deficiencies, will guide you to confirm positively or negatively the impressions formed by your firsthand experiences. The statement should be read and understood to assure the best quality of care and life for either you or your loved one.

Who is responsible for inspecting nursing homes and how may they be contacted?
The Department of Health and Senior Services is the state survey agency responsible for inspecting nursing homes and reporting the survey findings in the statement of deficiencies. The division/section within the department that performs the inspection is Division of Regulation and Licensure/Section for Long-Term Care. The section has regional offices throughout the state. The section’s central office may be contacted by writing the Section for Long-Term Care, PO Box 570, Jefferson City, MO 65102 or by calling 573-526-8524.

What is the purpose of the statement of deficiencies?
A statement of deficiencies is the document containing the division’s comprehensive inspection of a nursing home. It documents the degree to which a home meets the minimal federal requirements using a federal tag numbering system along with a detailed explanation of each deficiency. The inspection is necessary for the home to continue to receive funding from Medicare and Medicaid. It also documents compliance with state requirements to maintain the home’s state license. The statement of deficiencies serves as a tool for the home to use to correct those areas found to be below mandated, minimal federal and state standards of care.

Where can I find the statement of deficiencies on a particular nursing home?
The nursing home is required by law to have a copy of the document on display in a public location in the nursing home. The Department of Health and Senior Services also has an internet website http://www.dhss.mo.gov/showmelongtermcare/ and allows viewing of surveys and inspections for all long-term care facilities in Missouri. If you do not have internet access, copies of the statement of deficiencies are available for a small fee from the Section for Long-Term Care Central Files Unit by calling 573-526-3050. The regional section offices will also have the original survey to view by the public on request. The section office nearest you may be located by calling the Information and Referral Line at 1-800-235-5503.

What does a statement of deficiencies “F-tag” number mean?
An F-number, called a tag number, corresponds to a specific regulation within the Code of Federal Regulations. For example “F-312” relates to the regulation requiring nursing homes to provide dependent residents with care. State requirements will also appear on the statement of deficiencies with a Code of State Regulations number instead of an F-tag number. A statement of deficiencies for a state licensed only nursing home will only have the Code of State Regulations number.

What F-tag numbers will tell the most about how the nursing home cares for individual residents?
F-tags that relate to resident care/quality of life may be grouped into four (4) broad categories; see Page 2. A partial list of the F-tags in each of the categories may be found on page 3. The listing does not represent all the possible F-tags that may be cited in any given statement of deficiencies.
**Resident Behavior & Facility Practice** tags, F221-225, covering areas such as abuse and neglect and physical or chemical restraints.

**Quality of Life** tags, F240-258, covering areas such as activities (social and recreational), dignity (such as appropriate dress), accommodation of needs, homelike environment, and social services.

**Quality of Care** tags, F-309-333, covering areas such as nutrition (food), hydration (fluids), medications, pressure sores, and activities of daily living (eating, bathing, etc.)

**Staffing** tag, F353, covering numbers and kinds of staff present in the home and the effect a low number of staff or inadequately trained staff have on residents’ health, care and safety.

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**What part of the statement of deficiencies tells how the nursing home will correct the deficiencies found during the survey?**

Below find a page from a facsimile of a statement of deficiencies. Each page of the statement of deficiencies is divided into two columns with a multi-block header across the top. The _information in the header_ identifies the facility (1), and includes the date (2) the survey was completed. The _left hand column_ will contain the F-tag number (3), the citation from federal regulations regarding the F-tag number (4), and an incident(s) to support how the facility was deficient or violated the regulation (5). If a resident is involved, they will be identified by gender or number to protect their privacy and to ensure confidentiality (6). The _right hand column_ will contain the facility’s plan to correct the deficiency cited during the survey (7) and if necessary the date the correction is expected to be completed (8). The date of correction may also be found in the text explaining the plan of correction.

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<td>Resident Behavior &amp; Facility Practice</td>
<td>Quality of Life</td>
<td>Quality of Care</td>
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</tr>
<tr>
<td>F-221 Use of physical restraints</td>
<td>F-240 Residents’ quality of life</td>
<td>F-309 Highest practicable level of care provided</td>
</tr>
<tr>
<td>F-222 Use of chemical restraints</td>
<td>F-241 Resident dignity</td>
<td>F-310 Activities of Daily Living maintained (bathing, dressing, etc.)</td>
</tr>
<tr>
<td>F-223 Right to be free from all abuse</td>
<td>F-242 Resident choice in activities and schedule</td>
<td>F-311 Appropriate treatment and services</td>
</tr>
<tr>
<td>F-224 Mistreatment, neglect or misappropriation of resident property</td>
<td>F-243 Resident and family groups freedom to meet</td>
<td>F-312 Dependent resident receiving appropriate care</td>
</tr>
<tr>
<td>F-225 Resident abuse reporting record system and employing individuals found guilty of abuse, neglect or mistreatment of residents</td>
<td>F-245 Participate in community activities</td>
<td>F-313 Vision or hearing services available</td>
</tr>
<tr>
<td>F-226 Policies and procedures to prevent abuse and neglect</td>
<td>F-249 Qualified activity professionals</td>
<td>F-315 Urinary incontinence, catheter use, and urinary tract infection prevention</td>
</tr>
<tr>
<td></td>
<td>F-250 Social service needs</td>
<td>F-317 Maintain appropriate range of motion</td>
</tr>
<tr>
<td></td>
<td>F-251 Qualified social worker</td>
<td>F-318 Range of motion treatment</td>
</tr>
<tr>
<td></td>
<td>F-252 Homelike environment</td>
<td>F-319 Appropriate mental treatment and social adjustment services</td>
</tr>
<tr>
<td></td>
<td>F-253 Housekeeping</td>
<td>F-320 Development of avoidable mental and social adjustment problems</td>
</tr>
<tr>
<td></td>
<td>F-254 Clean linens</td>
<td>F-321 Naso-gastric tube use was avoidable</td>
</tr>
<tr>
<td></td>
<td>F-255 Private closet space available</td>
<td>F-322 Appropriate naso-gastric treatment</td>
</tr>
<tr>
<td></td>
<td>F-256 Adequate lighting</td>
<td>F-323 Hazard free environment</td>
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<td></td>
<td>F-257 Comfortable temperature level</td>
<td>F-324 Supervision to prevent accidents</td>
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<td>F-258 Comfortable sound level</td>
<td>F-325 Adequate nutrition maintained</td>
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### Staffing

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<th>Staffing</th>
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<tr>
<td>F-353 Necessary staff or training to meet all residents' needs</td>
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If you want to discuss the statement of deficiencies further, please contact your local Ombudsman whose name appears on the map below; or contact the State Long-Term Care Ombudsman Office at 800-309-3282; or visit our web page at <www.dhss.mo.gov/ombudsman/>.

The Long-Term Care Ombudsman Program is a nationwide program that works to assure the rights of residents. It does so through volunteers who visit many nursing homes and residential care facilities statewide. Each week volunteers visit with residents and listen to their concerns and problems. The volunteer encourages residents to work through problems on their own through helpful conversation between residents and staff. If the resident is unsuccessful in resolving the problem, they may give the volunteer permission to assist them in reaching a fair resolution.

**Missouri Long-Term Care Ombudsman Program**
PREAMBLE

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

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

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

I - Introduction

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

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

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

II - Definitions

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

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

Abuse - “The willful infliction of injury, unreasonable confinement, intimidation, or
punishment with resulting physical harm, pain, or mental anguish.” (See
42 CFR Part 488.301.)
Neglect - “Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.” (See 42 CFR Part 488.301.)

III - Principles

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

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

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

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

- Serious harm can result from both abuse and neglect.

- Psychological harm is as serious as physical harm.

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

- Any time a team cites abuse or neglect, it should consider Immediate.

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

- The entity either created a situation or allowed a situation to continue which resulted in serious harm or a potential for serious harm, injury, impairment or death to individuals.

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

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

IV - Immediate Jeopardy Triggers

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

Triggers that will assist the surveyor in considering Immediate Jeopardy accompany each issue. Triggers describe situations that will cause the surveyor to consider if further investigation is needed to determine the presence of Immediate Jeopardy. The listed triggers do not automatically equal Immediate Jeopardy. The team must investigate and use professional judgment to determine if the situation has caused or is likely to cause serious harm, injury, impairment or death. These triggers are general examples and are not all-inclusive. Many triggers may apply to more than one issue. A trigger for an issue such as C, “Failure to Protect from Psychological Harm,” could well be an example of A, “Failure to Prevent Abuse,” or B, “Failure to Prevent Neglect.” The team must rely on professional judgment and utilize the resources of the State survey agency, the Regional Office and/or, in the case of Medicaid-only facilities, the State Medicaid Agency to determine the presence of Immediate Jeopardy.

NOTE: Harm does NOT have to occur before considering Immediate Jeopardy. Consider both potential and actual harm when reviewing the triggers in the table.
<table>
<thead>
<tr>
<th>Issue</th>
<th>Triggers</th>
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<tr>
<td>A Failure to protect from abuse.</td>
<td>1. Serious injuries such as head trauma or fractures; 2. Non-consensual sexual interactions; e.g., sexual harassment, sexual coercion or sexual assault; 3. Unexplained serious injuries that have not been investigated; 4. Staff striking or roughly handling an individual; 5. Staff yelling, swearing, gesturing or calling an individual derogatory names; 6. Bruises around the breast or genital area; or Suspicious injuries; e.g., black eyes, rope marks, cigarette burns, unexplained bruising.</td>
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<td>B Failure to Prevent Neglect</td>
<td>1. Lack of timely assessment of individuals after injury; 2. Lack of supervision for individual with known special needs; 3. Failure to carry out doctor’s orders; 4. Repeated occurrences such as falls which place the individual at risk of harm without intervention; 5. Access to chemical and physical hazards by individuals who are at risk; 6. Access to hot water of sufficient temperature to cause tissue injury; 7. Non-functioning call system without compensatory measures; 8. Unsupervised smoking by an individual with a known safety risk; 9. Lack of supervision of cognitively impaired individuals with known elopement risk; 10. Failure to adequately monitor individuals with known severe self-injurious behavior; 11. Failure to adequately monitor and intervene for serious medical/surgical conditions; 12. Use of chemical/physical restraints without adequate monitoring; 13. Lack of security to prevent abduction of infants; 14. Improper feeding/positioning of individual with known aspiration risk; or 15. Inadequate supervision to prevent physical altercations.</td>
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<td>C Failure to protect from psychological harm</td>
<td>1. Application of chemical/physical restraints without clinical indications; 2. Presence of behaviors by staff such as threatening or demeaning, resulting in displays of fear, unwillingness to communicate, and recent or sudden changes in behavior by individuals; or 3. Lack of intervention to prevent individuals from creating an environment of fear.</td>
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<td>D Failure to protect from undue adverse medication consequences and/or failure to provide medications as prescribed.</td>
<td>1. Administration of medication to an individual with a known history of allergic reaction to that medication; 2. Lack of monitoring and identification of potential serious drug interaction, side effects, and adverse reactions; 3. Administration of contraindicated medications; 4. Pattern of repeated medication errors without intervention; 5. Lack of diabetic monitoring resulting or likely to result in serious hypoglycemic or hyperglycemic reaction; or 6. Lack of timely and appropriate monitoring required for drug titration.</td>
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<td>E Failure to provide adequate nutrition and hydration to support and maintain health.</td>
<td>1. Food supply inadequate to meet the nutritional needs of the individual; 2. Failure to provide adequate nutrition and hydration resulting in malnutrition; e.g., severe weight loss, abnormal laboratory values; 3. Withholding nutrition and hydration without advance directive; or 4. Lack of potable water supply.</td>
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<td>F Failure to protect from widespread nosocomial infections; e.g., failure to practice standard precautions, failure to maintain sterile techniques during invasive procedures and/or failure to identify and treat nosocomial infections</td>
<td>1. Pervasive improper handling of body fluids or substances from an individual with an infectious disease; 2. High number of infections or contagious diseases without appropriate reporting, intervention and care; 3. Pattern of ineffective infection control precautions; or 4. High number of nosocomial infections caused by cross contamination from staff and/or equipment/supplies.</td>
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<td>G Failure to correctly identify individuals.</td>
<td>1. Blood products given to wrong individual; 2. Surgical procedure/treatment performed on wrong individual or wrong body part; 3. Administration of medication or treatments to wrong individual; or 4. Discharge of an infant to the wrong individual.</td>
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<td>Issue</td>
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| **H Failure to safely administer blood products and safely monitor organ transplantation.** | 1. Wrong blood type transfused;  
2. Improper storage of blood products;  
3. High number of serious blood reactions;  
4. Incorrect cross match and utilization of blood products or transplantation organs; or  
5. Lack of monitoring for reactions during transfusions.                                                                                                                                                                                                                      |
| **I Failure to provide safety from fire, smoke and environment hazards and/or failure to educate staff in handling emergency situations.** | 1. Nonfunctioning or lack of emergency equipment and/or power source;  
2. Smoking in high risk areas;  
3. Incidents such as electrical shock, fires;  
4. Ungrounded/unsafe electrical equipment;  
5. Widespread lack of knowledge of emergency procedures by staff;  
6. Widespread infestation by insects/rodents;  
7. Lack of functioning ventilation, heating or cooling system placing individuals at risk;  
8. Use of non-approved space heaters, such as kerosene, electrical, in resident or patient areas;  
9. Improper handling/disposal of hazardous materials, chemicals and waste;  
10. Locking exit doors in a manner that does not comply with NFPA 101;  
11. Obstructed hallways and exits preventing egress;  
12. Lack of maintenance of fire or life safety systems; or  
13. Unsafe dietary practices resulting in high potential for food borne illnesses. |
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| J Failure to provide initial medical screening, stabilization of emergency medical conditions and safe transfer for individuals and women in active labor seeking emergency treatment (Emergency Medical Treatment and Active Labor Act). | 1. Individuals turned away from ER without medical screening exam;  
2. Women with contractions not medically screened for status of labor;  
3. Absence of ER and OB medical screening records;  
4. Failure to stabilize emergency medical condition; or  
5. Failure to appropriately transfer an individual with an unstabilized emergency medical condition. |
Guidelines for Determining Immediate Jeopardy

V - Procedures

A - Preparation

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

B - Investigation

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

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

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

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

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

5. Team Actions

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

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

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

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

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

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

**WHEN**: When did the situation first occur?

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

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

**WHY**: Why did the potential/actual harm occur?

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

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

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

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

**TRIGGER**: Lack of supervision of cognitively impaired individuals with known elopement risk.
Investigation:

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

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

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

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

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

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

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

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

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

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

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

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

**C - Decision-Making**

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

1. Harm

   a. Actual - Was there an outcome of harm? Does the harm meet the definition of Immediate Jeopardy, e.g., has the provider’s noncompliance caused serious injury, harm, impairment, or death to an individual?

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

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

3. Culpability

   a. Did the entity know about the situation? If so when did the entity first become aware?

   b. Should the entity have known about the situation?

   c. Did the entity thoroughly investigate the circumstances?

   d. Did the entity implement corrective measures?

   e. Has the entity re-evaluated the measures to ensure the situation was corrected?

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

Team Actions:

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

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

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

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

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

Outcome:

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

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

**Decision Making:**

- Has actual harm occurred? No.
- Is there a likelihood of potential serious harm? Yes.
- Does the potential serious harm meet the definition of Immediate Jeopardy, e.g., serious injury, harm, impairment, or death? Yes.
- Is the potential serious harm likely to occur in the very near future, if immediate action is not taken? Yes.
- Did the facility have knowledge of the situation? Yes.
- If so, when did they first become aware? After the doctor’s order was written?
- Did they thoroughly investigate the circumstances? No.
- Did they implement corrective measures? No.
- Does this meet the definition of Immediate Jeopardy? Yes.
- Which is the most appropriate tag to define the failed practice?

**Outcome:**

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

• The RO proceeds with termination actions.

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

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

**Decision-Making:**

• Has actual harm occurred? Yes.

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

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

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

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

• Did they thoroughly investigate the circumstances? Yes.

• Did they implement corrective measures? Yes.

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

Outcome:

- The team gathered sufficient data to reach the conclusion that the facility had no predictable way of knowing that residents were at risk for harm from an intruder.
- The team also gathered sufficient data to reach a decision that the facility reacted immediately to protect residents when they had knowledge of a potential risk.
- The team concludes that there was no failed practice.
- The team concludes their investigation of this complaint.

VI - Implementation

A - Team Actions

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

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

B - SA Actions

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

C - Team Action

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

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

VII - Documentation

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

1 - Confirmation of Removal of Immediate Jeopardy

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

2 - Immediate Jeopardy Removed, Deficient Practice Corrected

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

3 - Immediate Jeopardy Removed, Deficient Practice Present

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

4 - Immediate Jeopardy Not Removed

If the facility is unable or unwilling to remove the Immediate Jeopardy before the end of the survey, inform the administration that the RO will be notified of the Immediate Jeopardy and termination procedures will be initiated. Use the appropriate SOM reference to define the end of the survey.
B - All Entities Not Noted Above

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

1 - Confirmation of Removal of Immediate Jeopardy

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

2 - Immediate Jeopardy Removed, Deficient Practice Corrected

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

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

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

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

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

5 - Immediate Jeopardy Not Removed

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

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

Refer to SOM §3005 E for specific instructions.

B - Enforcement for SNF/NF

Refer to SOM §§7307-7309 for specific instructions.

C - Termination for all other Medicare Entities

Refer to SOM §3010.

IX - References

- SOM Appendices (Excluding Appendix C, CLIA)
- Principles of Documentation
- SOM §3005 E
- SOM §§3010-3012
- SOM §§7307-7309
Attachment A

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

IMMEDIATE JEOPARDY NOT REMOVED BEFORE EXIT

ICF/MR Failed Practice

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

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

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

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

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

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

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

**Decision Making:**

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

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

**IMMEDIATE JEOPARDY NOT REMOVED PRIOR TO EXIT**

**Home Health Agency Failed Practice**

**Condition of Participation** - The agency failed to assure medications were provided to patients in accordance with physician’s orders and the patient’s plans of care.

**Summary** - Patient #1: The patient was admitted on x/x/x with a diagnosis of Insulin Dependent Diabetes Mellitus. Orders were: Humulin Insulin N 2 units and Regular (Reg) Insulin 3 units subcutaneously every morning and evening plus sliding scale Regular insulin coverage for blood sugar ranges of: 200-299=2 units Reg. Insulin, 300-399=4 units Reg. Insulin, 400+=6 units Reg. Insulin. The frequency of the sliding scale coverage was not included in the physician’s orders, nor was the frequency of blood glucose testing. A subsequent physician’s order for NPH 3u BID was transcribed as NPH 3 units every evening.
The Director of Professional Services made an assumption that the blood glucose testing and sliding scale insulin coverage was two times a day. Because of missing documentation, it was unclear when the patient actually received the correct dose of insulin. On 11 occasions, the patient’s blood glucose levels were between 200-299 or 300-399. There was no documentation that the sliding scale was followed. On 6 occasions, the patient’s blood glucose levels were below 200 and regular insulin was giving contrary to the sliding scale. On x/x/x, the patient’s blood glucose was 431 and 4 units of regular insulin were given, rather than 6 units per the sliding scale.

Patient #2 - The patient had a diagnosis of Insulin Dependent Diabetes Mellitus and orders for routine insulin coverage BID. The plan of care included teaching the patient’s caregiver diabetes management. There were no orders for blood glucose testing in the plan of care. The nurse directed the caregiver to perform blood glucose levels twice a day. Subsequent nursing notes indicated the caregiver was performing the blood glucose levels four times a day. On x/x/x, new orders for sliding scale insulin were received and implemented by the nurse without a frequency for administration. The nurse did not address the sliding scale insulin coverage or the caregiver’s ability to carry out the insulin administration during subsequent visits. There was no documentation of the sliding scale insulin being administered to the patient.

**Issue** - Failure to protect from undue adverse medication consequences and/or failure to provide medications as prescribed.

**Trigger** - Pattern of repeated medication errors without intervention, lack of diabetic monitoring resulting or likely to result in serious hypoglycemic or hyperglycemic reaction.

**Issue** - Failure to prevent neglect

**Trigger** - Failure to carry out doctor’s orders

**Decision Making:**

- Has actual harm occurred? No
- Is there a likelihood of potential serious harm? Yes
- Does the potential serious harm meet the definition of Immediate Jeopardy, e.g., serious injury, harm, impairment, or death to an individual? Yes
- Is the potential outcome likely to occur in the very near future, if no action is taken? Yes.
- Did the entity have knowledge of the situation? Yes
• If so, when did they first become aware? When an incomplete doctor’s order was received.

• Did they thoroughly investigate the circumstances? No

• Did they implement corrective measures? No

• Does this meet the definition of Immediate Jeopardy? Yes

• Which is the most appropriate tag to define the failed practice? Cite the most appropriate tag at the Condition of Participation level for Immediate Jeopardy.

**Outcome** - The State Agency attempted to hand deliver the completed Form CMS-2567. The HHA was closed with a sign posted on the door indicating the agency was moving and the administrative staff was in the field making discharge plans for the patients. An on-call number was given. The on-call nurse stated that all of the agency’s patients had been discharged. The agency submitted a written notice of closure upon request. State Agency completed a referral to the Board of Nursing regarding the Director of Nursing.

**IMMEDIATE JEOPARDY REMOVED, DEFICIENT PRACTICE STILL REMAINS**

**SNF/NF Failed Practice**

**Severity** - Level 4, Scope - Isolated--The facility failed to prevent neglect, failed to provide appropriate emergency care, and failed to provide supervision to prevent accidents.

**Summary** - The resident had a diagnosis of Alzheimer’s dementia with a history of falls and wandering. The resident ambulated with a special walker. The resident was found lying at the base of a flight of stairs, in a pool of blood, bleeding from the nose and ears with a large laceration on his head. The alarm on the door leading to the stairs had not been reset after a fire alarm. Following the resident’s fall down the flight of stairs, the nurse talked to the resident, helped him to his walker and asked an aide to take him back to his room. The resident was not transported to his room, but was requested to ambulate using his walker with the stand-by assistance of an aide. The nurse returned to the unit, completed pending tasks and then called the doctor who directed her to call an ambulance. The resident was taken to the hospital and returned to the facility after a decision not to perform neurosurgery. The resident died 36 hours after the injury.

The resident fell while the nurse was off the unit in the boarding home giving medication. This was a regular part of the assigned duties for the nurse.

**Issue** - Failure to prevent neglect.
**Trigger** - Lack of timely assessment of individuals after injury and lack of supervision for individual with known special needs.

**Decision-Making:**

- Has as actual harm occurred? Yes
- Does the harm meet the definition of Immediate Jeopardy, e.g., serious injury, harm, impairment, or death to an individual? Yes
- Is the harm likely to recur in the very near future to this individual or others in the entity, if immediate action is not taken? Yes
- Did the entity have knowledge of the situation? Yes. If so, when did they first become aware? Prior to the fall, when a history of falls and wandering was documented.
- Did they thoroughly investigate the circumstances? Yes
- Did they implement corrective measures? No
- Does this meet the definition of Immediate Jeopardy? Yes
- Which is the most appropriate tag to define the failed practice? Cite the Immediate Jeopardy at the appropriate tag. Also document the remaining deficient practice under the same tag. Define the level of harm for the residents in the failed practice statement (e.g., the facility failed to prevent neglect for 1 of 10 residents (#8) which resulted in Immediate Jeopardy, and for 2 of 10 residents (#4 and #5) which resulted in harm).

**Outcome** - Revisit confirmed the removal of the Immediate Jeopardy; however, during revisit, another Immediate Jeopardy was recognized. A subsequent revisit confirmed the removal of the second Immediate Jeopardy identified. A deficient practice still remained. Termination stopped. Substantial compliance was reached 30 days later.
Attachment B

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

Example for LTC: Failure to Prevent Abuse

F223

483(b) Requirements: Abuse

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

This requirement is not met as evidenced by the following:

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

Findings include:

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

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

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

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

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

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

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

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

485.723 Condition: Physical Environment

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

This Condition is not met as evidenced by the following:

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

The organization satisfies the following requirements:

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

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

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

This Standard is not met as evidenced by the following:

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

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

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

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

I 158

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

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

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

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

This Standard is not met as evidenced by the following:

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

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

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

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

Key Components Applicable To All Providers

1. Prevent

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

Nursing Homes

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

**Survey Guidance - Surveyors determine if:**

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

ICFs/MR

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

**Survey Guidance - Surveyors determine if:**

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

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

**Nursing Homes**

**Regulation Authority - 483.13(c)(1)(ii) (A)&(B)**

**Survey Guidance - Surveyors determine if:** The facility screens potential employees for a history of abuse, neglect, or mistreating residents as defined by the applicable requirements.

**ICFs/MR**

**Regulation Authority - 483.420(c)(1)(iii)**

**Survey Guidance - Surveyors determine if:** The facility screens potential employees to prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect, or mistreatment.

3. Identify

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

**Nursing Homes**

**Regulation Authority - 483.13(c)(2)**

**Survey Guidance - Surveyors determine if:** The facility identifies events such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse; and determine the direction of the investigation.

**ICFs/MR**

**Regulation Authority - 483.420(a)(5)**

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

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

**Nursing Homes**

**Regulation Authority - 483.74(e)**

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

**ICFs/MR**

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

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

5. Protect

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

**Nursing Homes**

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

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

**ICFs/MR**

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

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

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

Nursing Homes

Regulation Authority - 483.13(c)(2)(3)&(4)

Survey Guidance - Surveyors determine if: The facility has procedures to investigate different types of abuse; and identify staff member responsible for the initial reporting of results to the proper authorities.

ICFs/MR

Regulation Authority - 483.420(d)(3)

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

7. Report/ Respond

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

Nursing Homes

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

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

ICFs/MR

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

Survey Guidance - Surveyors determine if: The results of all investigations are reported to the administrator or designated representative or to other
officials in accordance with State law within 5 working days of the incident and, if the alleged violation is verified, appropriate corrective action is taken.
Class I, I/II, II, II/III, or III is noted in the Requirements column of the Inspection Results, usually at the end of the regulatory text

Class I

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

Class II

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

Class III

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

Class I/II

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

Class II/III

This violation may be cited as a Class II or a Class III. It will be cited at the lower classification, Class III, unless there is sufficient evidence to support the more severe classification of Class II.
The APPEAL PROCESS (IDR, IIDR)

INFORMAL DISPUTE RESOLUTION & INDEPENDENT INFORMAL DISPUTE RESOLUTION

What is IDR?

The acronym IDR represents a process known as the Informal Dispute Resolution. The IDR process constitutes an informal administrative process, not to be construed as a formal evidentiary hearing and is used to determine if a cited deficiency of a facility should be upheld. The purpose of this informal process: to give providers one opportunity to refute cited deficiencies after any survey.

What are valid reasons for dispute?

A provider may dispute a deficiency on the SOD for the following reasons:

1. Wrong Scope for I, J, Substandard Quality Care (SQC) or State Class I violations.
2. Wrong Severity for I, J, Substandard Quality Care (SQC) or State Class I violations.
3. Evidence exists that indicates there was no deficiency which the surveyor failed to review.
4. New evidence has surfaced that the surveyor did not review.
5. Interpretation error on the part of the surveyor.
6. Wrong Tag.
7. SOD misstates the evidence.

Types of IDR Review

A provider may choose from three types of review which include:

1. Desk review: SOD and Facility Exhibits are reviewed. There is no live participation.
2. Telephonic: DHSS, Facility and Reviewer on a conference call
3. Face to face: Facility, DHSS and Reviewer in person usually at the Primaris office

IIDR – new provision

A new dispute resolution process became effective on 01-01-12. The acronym IIDR represents the process for Independent Informal Dispute Resolution (IIDR). This process is available for the provider and may be requested if CMS imposes a CMP against the facility and CMP amounts are subject to being collected.

This is a separate process from IDR. The IIDR must be associated with a CMP imposed and subject to collection and placement in escrow.
Is there a cost to me or my facility?

The provider does not incur charges for the process unless they choose to involve their own legal counsel. No fees are charged by Primaris or DHSS. In telephonic or face to face types of IDR review the provider will have the cost of time associated with gathering exhibits and in the case of face-to-face types of IDR review, the cost of time and travel to the IDR review site.

Legal Counsel

Legal counsel for the provider is a decision made by the provider and any charges for that representation are the responsibility of the provider regardless of the determination. DHSS must be notified of your intent to involve legal counsel and prepare to have their legal counsel present. The cost of their legal counsel is not your responsibility.

Is there a penalty for disputing tags?

No, the regulations provide this one opportunity to have disputes reviewed by a third party. DHSS is extremely sensitive to any concern regarding survey(s) objectivity and/or retaliation. Reviewers are trained to keep the conference objective and professional so as to avoid adversity in the process.

What are the steps to the process?

You can download the tool “Primaris-Facility IDR Request Process”

Upon receipt and review of the Statement of Deficiencies (SOD), determine if you agree or disagree with the citation(s), the scope(s) and severity(s) or examples cited by the surveyor.

1. The first step is to send a request for the IDR.
2. The request for IDR must be faxed to Primaris:
   a. At: 573-817-8344
3. The request must be faxed to Primaris within 10 calendar days of receipt of the SOD.
4. A copy of the request should also be sent to DHSS.

Upon receipt of the request Primaris will send an IDR request form to the facility for completion and return. The request must specifically list the following:

1. Disputed tag #.
2. Regulation number.
3. The reason for the dispute. Why do you disagree?
4. If there is an accompanying state tag to a federal violation you should request review for both the state and federal tag.
5. The request must include the type of review requested: Desk Review, Telephonic, Face to Face.
6. The request must disclose any legal counsel involvement on the part of the facility.
Scope and or severity can only be challenged if:

1. The tag rises to a Substandard Quality of Care level (SQC),
2. Is an I/J on the SS Grid or
3. A State Class I violation.

Once the request is faxed to Primaris and DHSS the facility has 5 working days after submitting the request to submit additional exhibits to Primaris.

A copy should be sent for each exhibit to Primaris which will be used by the reviewer and Primaris will forward a copy to DHSS.

The facility can request, as can the reviewer, a onetime delay in order to prepare exhibits or obtain additional information.

Submitting the exhibits untimely or failure to request a delay if more time is needed, may jeopardize full consideration of all information submitted.

A conference date is scheduled by Primaris and all parties are notified. Note that even a desk review is set for date in order to keep determinations timely.

Primaris reviewers will make determinations within 10 working days of the date the conference is scheduled.

For dually participating facilities (Medicare/Medicaid Certified) Determination, letters are sent to DHSS first for revision of SOD, if applicable.

For Licensed only facilities (RCF/ALF), determination letters are sent to DHSS and the facility simultaneously.

What can determinations include?

Determinations can include:

1. Leaving the SOD intact; upholding the deficiency.
2. Removing the deficiency entirely from the SOD and any resulting scope and severity.
3. Removing examples from the SOD that may or may not change scope and severity. (I/J, SQC or State Class I).
4. Recommending a reduction of scope and or severity on the tag/deficiency.

How does this help my facility?

The IDR process can benefit the facility in that anything changed or removed will reduce the impact on:

1. The Five Star Ratings are impacted by survey, removing tags and/or decreasing scope and severity protect those ratings.
2. The Statement of Deficiencies (SOD) is submitted for “Nursing Home Compare”, removing tags and/or decreasing scope and severity can improve the status of the facility on “Nursing Home Compare”.
3. Deficiencies removed will not require follow-up interim surveys to review correction.
4. When tags are removed or SS is decreased the facility may have less exposure to liability for certain claims.
5. Individual licenses of the administrator and the facility would be better protected, especially when there is valid reason to dispute the tag.
6. The facility has an opportunity to review its policy and procedure when analyzing disputed deficiencies and can make a determination as to the benefit of modification to prevent further concern in the area.
7. It is not required to continue with a plan of correction for violations that are removed.

What is the best way for me to prepare exhibits and presentation for an IDR?

The first step is to carefully review the citation(s) and break the components of the regulation and the citation down individually as follows:

1. What are the elements of the regulation?
2. What are the elements of the citation?
3. Do they merge or is there conflict?

For Example:

Regulation Cited F 155: Resident Rights

The regulations read “The resident has the right to refuse treatment, to refuse to participate in experimental research and to formulate an advance directive as specified in paragraph (8) of this section...”

The citation read “Based on observation, interview and record review, the facility failed to allow the resident to exercise his/her right to refuse treatment. The facility continued bathing Resident #1 despite his/her repeated verbal refusal of the bath. One of 18 sampled residents was impacted.

The elements of the regulation include:

1. Right to refuse treatment
2. Right to refuse to participate in experimental research
3. Right to formulate an advanced directive.

The elements of the citation include:

1. The facility failed to allow the resident to exercise his/her right to refuse treatment.

Now we look to see if they merge anywhere and they do. The element which is similar or the same is “The right to refuse treatment.”
We now know that the only area of the regulation that applies here is the residents right to refuse. You do not need to prove that you were in compliance with the rest of the elements of the regulation as they were not cited as deficient. Spending time on preparing exhibits for those elements is not necessary.

Review guidance to Surveyors, State Operations Manuals and other practice standards to form a basis. For each element:

1. Determine which apply.
2. Which did your facility positively meet?
3. Which are in question?

Let’s look at another example of a disputed deficiency. This one is at F-164 SS=D 483.10(e), 483.75(I)(4) Personal Privacy/Confidentiality of Records:

The SOD reads: “Based on observation, interview and record review the facility failed to provide full visual privacy while providing personal care to two of 18 sampled residents. (Resident #1 and Resident #14). The census was 90.”

The Regulation at F-164:

The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident;

(2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility;

(3) The resident’s right to refuse release of personal and clinical records does not apply when--
  (i) The resident is transferred to another health care institution; or
  (ii) Record release is required by law

The Elements of the Regulation

1. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.
2. Personal privacy includes:
   a. Accommodations,
   b. Medical treatment,
   c. Written and telephone communications,
   d. Personal care,
   e. Visits,
   f. Meetings of family and resident groups,
3. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility;
4. The resident’s right to refuse release of personal and clinical records does not apply when--
   a. The resident is transferred to another health care institution; or
   b. Record release is required by law

The Elements of the Citation

The SOD reads: “Based on observation, interview and record review the facility failed to provide full visual privacy while providing personal care to two of 18 sampled residents.”

The Matching Element(s) of the Regulation & Citation

Regulation:

Element 2: Personal privacy includes: accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident;

Citation:

Based on observation, interview and record review the facility failed to provide full visual privacy while providing personal care.

Privacy in personal care is the issue in this citation that matches Element 2 of the Regulation.

Remember for each element, determine which apply, which your facility positively met, and which are in question.

In our example we determined that it was element #2, Personal privacy which includes:

Element 2 D: privacy during personal care

Once the basis for the dispute (in this case privacy during personal care) is formed and you know which elements are at question, build your presentation and exhibits around those elements.

Keep in mind that only relevant information can be considered.

Corrections after the citation are not relevant to determining whether or not in fact the citation existed as stated in the SOD on or before the date on the SOD.

Prepare the exhibits as follows:

   a) Label exhibits per each disputed tag on the SOD to which they pertain
   b) Put a page number on each exhibit for each citation group
   c) Submit exhibits supporting your dispute at least 5 days prior to the scheduled conference.
You may download the tool “Primaris IDR Exhibit Preparation by Facility”

Building Exhibits

A cover page for Exhibits pertaining to this tag:

a) F-164 Exhibits (Ask how can I prove my case and remember number each page.)
   1. Facility Policy & Procedure regarding Shower (Pages 1-2)
   2. Facility policy & procedure regarding privacy during personal care (Page 3)
   3. C.N.A statements which might contradict the example provided by the surveyor in the SOD (Page 4)
   4. The C.N.A Shower competency sheet from the C.N.A manual. (Page 5)
   5. Care Plan which indicates dementia and resistance to shower. (Page 6-7)
   6. Any notes that document facility’s awareness of resistance and attempts to reduce the residents’ anxiety. (Nurses note Page 8-12)

Preparing for the Conference

Once your exhibits are prepared send a copy to Primaris.

Prepare your opening statement to summarize what you are disputing and why. An example might be as follows:

“We are disputing the citation at F-164 which stated; “Based on observation, interview and record review the facility failed to provide full visual privacy while providing personal care...” We are specifically disputing that Resident #1 was not provided visual privacy during perineal care in his/her private room and again during a shower in his/her private bath. We will present exhibits which detail information that was shared at the time of survey but was not included in the determination of deficient practice. The resident resides in a private room and has a private shower. There is no requirement for a privacy curtain in a private room.”

This opening summarizes:

1. What we are disputing. F-164 full visual privacy for Resident #1 during perineal care and a shower.
2. Why we are disputing. The resident resides in a private room, the shower occurred in his/her private bathroom and information existed but was not considered at the time of the observations made by the surveyor.

For your presentation describe each exhibit and how you believe that it supports that the practice is not deficient in the facility. Remember only relevant content can be considered so you should be able to state why the exhibit you are referring to is relevant to the review.

Refer to the Exhibit Page # so the reviewer and DHSS can focus on what you are presenting.
Example:

Under F-164 Exhibit 1 on pages 1-2 of that exhibit is the Facility Policy & Procedure regarding Shower. You will note that paragraph 5 describes bathing the resident in his/her private bath which contains a shower. The facility does not require the CNA to shut the bathroom door if the resident room door is shut. The CNA did not shut the bathroom door; there was no one else in the room but the CNA, Resident and surveyor. The door to the residents’ room was shut.

Under F-164 Exhibit 2 on page 3 is the Facility policy & procedure regarding privacy during personal care. The facility would point out the highlighted areas on this policy & procedure. Specifically that privacy curtains are not utilized in private rooms. That when providing direct care to the resident expose only those portions that are necessary and protect the residents privacy by draping or covering other areas of his/her body. Assure that the window curtain is pulled.

Also please see exhibit 3, page 4 under F-164, in which the CNA describes providing care in the manner described in Exhibit 1 and 2.

Prepare your closing statement to summarize why you believe the facility met the element of the regulation in dispute.

“In closing we have provided evidence that Resident #1 resides in a private room, has a private bath with a shower and that his/her privacy was not compromised nor did the facility fail to provide full visual privacy during perineal care and a shower. Thank you for the consideration of this review.”

What is the process for a conference?

Once everyone is on the phone or in attendance, the reviewer will begin the tape recording of the conference. The reviewer will:

1. Ask all parties to identify themselves
2. Determine legal counsel participation
3. Read into the record the citation and the reason for the dispute
4. Ask the facility to open with its presentation
5. Then DHSS will provide their presentation and any changes after review of facility exhibits, etc.
6. The reviewer will then ask the facility to provide closing remarks and then DHSS to provide closing remarks.

The reviewer can ask questions at any time as can DHSS or the facility.

Reviewers make every effort to make all parties comfortable and to maintain objectivity, as well as professional conduct, throughout the process.

The IDR Process and the conference is not a forum for airing grievances from either the facility or DHSS. Rather it is an opportunity to objectively look at the information presented. The goal of the conference and the process is to elicit relevant information pertinent to disputed citation.
How is the IDR process different?

This is a third party review in which the reviewer is neither an employee of the facility nor of DHSS and is ideally more objective. The process was mandated by legislative action in HB 385, signed by the governor on August 28, 2009. DHSS contracted with Primaris to be a neutral, third party reviewer on the basis of their Quality Improvement Organization status. CMS established a contract with Primaris to provide this service.

Benefits for the Industry

The modification of a neutral party to the IDR process can improve consistency in citations across regions within the state by communicating decisions. It also can contribute to data collection and monitoring regarding disputed deficiencies and determinations. Finally it brings, customer friendly third party review, by Reviewers who bring working knowledge and experience of the long-term care industry to the review process.

IIDR-Independent Informal Dispute Resolution

“The focus of the IIDR process is the cited deficiency or deficiencies that led to the imposition of the CMP. However, while such factors such as the scope and severity classification, and the amount of the CMP, are not the subjects of the IIDR, States or CMS, in the case of Federal surveys, will take into consideration any changes in deficiency findings that result pursuant to State or CMS review of the completed IIDR process.”

Based on such review, States or CMS in the case of Federal surveys will assess whether any changes to S/S or CMP amount are warranted.

IIDR Process

Only CMP’s which are imposed on a deficiency(s) cited for actual harm or immediate jeopardy to resident health and safety. (S/S level G or above) will be subject to the new collection and escrow provisions on 1-1-2012.

For deficiency(s) below G (S/S D, E, F) CMP’s will be collected without the offer of IIDR.

The opportunity for IIDR is offered within 30 calendar days of the Notice of Imposition of a CMP that will be collected and placed in escrow.

CMS RO (Regional Office) will communicate the offer for an IIDR, along with SA Contact Information in the Notice of Imposition of a CMP letter to the facility.

Facility must respond within 10 calendar days of receipt of the offer.

The SA will then provide to the facility the following:

1. When and how the process is accomplished i.e. telephones, desktop, face to face.
2. Name and/or position/title of the person(s) who will be conducting the IIDR, if known.

The IIDR must be completed within 60 calendar days of receipt of the facility request for the IIDR. Completed is defined in the CMS letter as follows:

1. Final decision from IIDR process has been made.
2. A written report/record is generated.
3. SA (or RO if a federal survey) has provided written notice of this decision to the facility.
4. IIDR must generate a written record prior to collection of the CMP.
5. IIDR entity forwards written record to SA or to RO if it is a federal survey for retention by the surveying entity.
6. SA/RO will make a decision based on the written record of the IIDR process and will provide the final results to the facility which shall contain the results for each deficiency challenged in the IIDR process and a brief summary of the rationale for that result.

The written record shall include the following:

1. Each deficiency or survey finding what was disputed.
2. A summary of the IIDR recommendation for each deficiency or finding and the rationale for that result.
3. Documents submitted by the facility to dispute a deficiency, to demonstrate that a deficiency should not have been cited, or to demonstrate a deficit practice should not have been cited as immediate jeopardy or a SQC.
4. Any comments submitted by the Ombudsman, effected resident(s) and or resident(s) representatives.

If the SA disagrees with the recommendation of the IIDR entity the complete written record will be sent to the CMS RO for review and final decision. (CMS retains ultimate authority for survey findings.)

The IIDR process must ensure notification of the opportunity to submit comments prior to the completion of the IIDR process. This notification is provided by the SA to:

1. Involved resident(s) or appropriate representative(s)
2. The State LTC Ombudsman

Page 15126: Subpart E 488.331 Informal Dispute Resolution: “However, a facility may not use the dispute resolution processes at both 488.331(IDR) and 488.431 (IIDR) for the same deficiency citation arising from the same survey unless the informal dispute resolution process at 488.331 (IDR) was completed prior to the imposition of the civil money penalty.”

Page 15126 Subpart E 488.431 Civil Money penalties imposed by CMS and Independent Informal Dispute resolution: for SNFs, dually-participating SNF/NFs, and NF-only facilities:

(4) “Be approved by CMS and conducted by the State under section 1864 of the Act, or by an entity approved by the State and CMS, or by CMS or its agent in the case of surveys conducted only by
federal surveyors where the State independent process is not used and which has no conflict of interest...”

The facility has the option of selecting from one of the following regarding the type or review (similar to IDR):

1. Desk Review
2. Telephonic
3. Face to Face

Primaris will also continue at DHSS’ request to process IIDR’s in the tighter time frame than is provided for in the new CMS guidance.

Primaris staff will work with the Ombudsman to review submitted comments by the Ombudsman, affected resident(s), and/or resident(s) representative(s).

Preparing for IIDR would be the same as preparing for IDR.

**IIDR Process - CMP’s**

§ 488.436 civil money penalties: Waiver of hearing, reduction of penalty amount.

(1) “If the facility waives its right to a hearing in accordance with the procedures specified in paragraph (a) of this section, CMS or the State reduces the civil money penalty by 35 percent, as long as the civil money penalty has not also been reduced by 50 percent...”

§ 488.438 civil money penalties: Amount of penalty.

(c) *Decreased penalty amounts.*

(1) Except as specified in paragraph (d)(2) of this section, if immediate jeopardy is removed, but the noncompliance continues, CMS or the State will shift the penalty amount imposed per day to the lower range.

(2) “When CMS determines that a SNF, dually participating SNF/NF, or NF only facility subject to a civil money penalty imposed by CMS self-reports and promptly corrects the noncompliance for which the civil money penalty was imposed, CMS will reduce the amount of the penalty by 50 percent, provided that all of the following apply...”

The facility self-reported the noncompliance to CMS or the State before it was identified by CMS or the State and before it was reported to CMS or the State by means of a complaint lodged by a person other than an official representative of the nursing home;
Correction of the self-reported noncompliance occurred on whichever of the following occurs first:

(A) 15 calendar days from the date of the circumstance or incident that later resulted in a finding of noncompliance; or

(B) 10 calendar days from the date the civil money penalty was imposed;

(iii) The facility waives its right to a hearing under § 488.436;

(iv) The noncompliance that was self-reported and corrected and did not constitute a pattern of harm, widespread harm, immediate jeopardy, or result in the death of a resident;

(v) The civil money penalty was not imposed for a repeated deficiency, as defined in paragraph (d)(3) of this section, that was the basis of a civil money penalty that previously received a reduction under this section; and

(vi) The facility has met mandatory reporting requirements for the incident or circumstance upon which the civil money penalty is based, as required by Federal and State law.

(3) Under no circumstances will a facility receive both the 50 percent civil money penalty reduction for self-reporting and correcting under this section and the 35 percent civil money penalty reduction for waiving its right to a hearing under § 488.436.

(1) “Before a hearing requested in accordance with § 488.431(d) or § 488.432(a), CMS or the State may propose to increase the per day penalty amount for facility noncompliance which, after imposition of a lower level penalty amount, becomes sufficiently serious to pose immediate jeopardy.”
Missouri nursing homes have an opportunity, under state law, to refute citations issued by the state Department of Health & Senior Services. DHSS inspectors are required to survey every licensed long-term care facility in the state at least twice per fiscal year.

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

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

**NEED IDR ASSISTANCE? PRIMARIS CAN HELP**

In informal dispute resolution is a simple process, and it all starts with completing our one-page intake form. You can find the form online at www.primaris.org or contact our IDR department at 800-735-6776, ext. 213.
Primaris-Facility IDR Request Process

Statement of Deficiencies (SOD) arrive from DHSS Day 1

IDR Request

Complete Plan of Correction (POC) within the time specified in the accompanying letter to the SOD from DHSS

NOTE

Valid Reasons for Dispute Include:
- Error in Citation detail
- Incorrect Scope (only if I/J, SQC or State Class I)
- Incorrect Severity (only if I/J, SQC or State Class I)
- Wrong Tag/Code
- New or Overlooked Information Available
- Code Interpretation

Fax the Request Letter to Primaris at 573-817-8344

- Request letters must be sent within 10 calendar days of receipt of SOD. The day of receipt is day one (1).
- The facility has an additional five working days to submit exhibits (one copy is all that is necessary) to Primaris at 573-817-8344. Count of days begins from the date Intake Form is submitted via fax to Primaris.

Deficiency(s) Disputed

Determine deficiency(s) disputed and note tag number/regulation or statute number

Determine reason your facility disputes the tag(s)/regulation(s) cited. See Valid Reasons for Dispute.

Determine if legal counsel will be involved with the IDR process. If so, gather name, contact information including phone and fax.

Determine the type of conference that best meets the facility’s needs. See Types of IDR Conferences to Select From.

Prepare a request letter with the facility’s name, address, phone and fax, facility license number and licensure type, administrator name, tag(s) disputed, valid reasons for dispute, whether legal counsel will be involved and the type of conference requested. Do not forget to include both federal and state tags if applicable.
**Determination of Relevant Information**

Information as it applies to the element of each citation is likely relevant—If it tends to make a fact more or less probable and it is of consequence to the determination. (Does it matter?)

Evidence which is almost never relevant includes:
- Time, event or person other than involved in the SOD
- Events occurring after the date of the SOD
- Subsequent remedial measures (Policy change after an alleged deficiency.)
- Offers to pay medical expenses
- Past determination of deficiencies
- Evidences relating to the SOD which are not disputed

*Example, the facility presents an exhibit which shows a previous survey from another facility in which the same deficiency was removed during IDR. This exhibit is non-relevant to the current disputed deficiency and should be disregarded from consideration.)*

**Determination of Standard of Proof**

Standard of Proof is the level of proof required. Because the purpose of IDR is to give the facility an opportunity to refute the cited deficiencies, it is the facility that has burden of proof of presenting evidence which can persuade the reviewer that the necessary elements of the regulations were met and no deficient practice(s) exist. The standard of proof for the facility is then a Preponderance of Evidence (more likely than not or greater than a 50% chance).
**Primaris IDR Intake Form**

1. **Today's Date:**
2. **Facility Name:**
3. **Contact Person:**

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

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

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

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

**NOTE: Helpful tips and hints for preparing your exhibits and frequently asked Q & As can be found on our website @**


16. **Will the facility have legal counsel involved in the IDR Process:**
   - Yes [ ] No [ ]

17. **Attorney’s Name:**
18. **Attorney’s Phone # and Email:**
19. **Review Type Requested:**
   - Telephonic [ ]
   - Face-to-Face [ ]
   - Desk Review [ ]

20. **Attorney’s Street Address:**
21. **Attorney's City, State:**
22. **Attorney’s Zip:**

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

<table>
<thead>
<tr>
<th>Disputed Tag/Code</th>
<th>Reason for Dispute (See Codes)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fed Tag _____ State Tag_______</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Fed Tag _____ State Tag_______</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Fed Tag _____ State Tag_______</td>
<td>24</td>
<td></td>
</tr>
</tbody>
</table>

25. **If Requesting an Independent Informal Dispute Resolution (IIDR) for CMP's please check: Yes [ ]**

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

Involved Residents'/Representatives' First and Last Name and HIC#:

26. **Signature :**
27. **Date:**
HOW TO WRITE A PLAN OF CORRECTION

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

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

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

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

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

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

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

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

3. Be careful not to put something in your POC that may be difficult or impossible for the facility to comply or keep in place.
PUTTING TOGETHER A “CREDIBLE ALLEGATIONS” BOOK

After the survey the facility should immediately start working on their plan of correction. The facility should have some idea what deficiencies the state has identified and why. A plan needs to be put into place for in-servicing, reviewing/updating chart information, completing assessments, auditing processes etc. Everything that is done after the survey should be documented and maintained for the “re-visit”.

Once the 2567 (statement of deficiencies) is received and your plan of correction has been completed a “Credible Allegations” book should be put together. In this book there should be a divider for each deficiency. A copy of that specific deficiency and your plan of correction should be placed behind each divider. Everything that is done to clear that deficiency should be copied and added to the binder. This will include audits, reviews, in-services, updates of any information that may have been changed such as the care plan, assessments, physician orders, etc. The idea of the book is to provide the surveyor with all the information necessary to clear the tag without ever leaving the office. Most surveyors will still be on the floor and looking at the items, but they should not have to ask for any information. Everything they need to validate your plan of correction should be in the book. If an in-service is completed and it covers more than one deficiency, make a copy of that in-service for each deficiency covered. A copy of the facility employee roster should be obtained with any information other than name and job title erased. This can then be used as your in-service sign-in sheet which will ensure that all the employees for that respective deficiency has been in-serviced. For each deficiency, highlight the area that speaks of the specific deficiency and place a copy behind each divider. (Example: you in-service nursing staff on hand-washing for the infection control tag (F-441) and peri-care for the ADL tag (F-312) during the same in-service. You will make two copies of the in-service. You will highlight the first copy where you covered hand-washing and place that copy under F-441. Then highlight the 2nd copy where you covered peri-care and place that copy under F-312. Be sure to copy the signature sheet also.

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

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

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

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

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

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

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

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

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