SESSION 2 – NOVEMBER 14, 2023
ACHIEVING PAST NONCOMPLIANCE BY DEVELOPING *SUFFICIENT EVIDENCE* PRESURVEY

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MEET YOUR PRESENTERS

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3 WHAT IS PAST NONCOMPLIANCE

- Simply put – past noncompliance is correcting a deficient practice BEFORE the State Survey Agency enters for a standard, complaint or revisit.
- Past noncompliance is achieved by an effective and detailed internal Plan of Correction.
- Obtaining past non-compliance can prevent or limit civil money penalties and possible termination.
- If past noncompliance is confirmed, the facility does not have to file a Plan of Correction.

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4 ACHIEVING PAST NONCOMPLIANCE

- State Operations Manual 7510.1:
  - Past noncompliance may be identified **during any survey, not just for Immediate Jeopardy**.
  - To cite past noncompliance with a specific survey data tag (**F-tag or K-tag**), **ALL** of the following three criteria must be met:

    1. The facility was not in compliance with the specific regulatory requirement(s) (as referenced by the specific F-tag or K-tag) at the time the situation occurred;

    2. The noncompliance occurred after the exit date of the last standard (recertification) survey and before the survey (standard, complaint, or revisit) currently being conducted; and

    3. There is ***sufficient evidence*** that the facility corrected the noncompliance and is in substantial compliance at the time of the current survey for the specific regulatory requirement(s), as referenced by the specific F-tag or K-tag.

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PROCESS FOR PAST NONCOMPLIANCE

- The survey team is always expected to follow the investigative protocols and surveyor guidance.
- A facility does not provide a Plan of Correction for a deficiency cited as past noncompliance because the deficiency is confirmed corrected.
- The survey team documents the deficiency and facility's corrective actions on the CMS-2567.

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CIVIL MONEY PENALTIES FOR PAST NONCOMPLIANCE

- 42 CFR 488.430(b) provides that a civil money penalty (CMP) may be imposed for past noncompliance since the last standard survey.
- CMS strongly urges states to recommend the imposition of a CMP for past noncompliance cited at the level of Immediate Jeopardy.
- Facilities can often obtain a per instance civil money penalty versus a daily fine.
- When a CMP is recommended, the State Survey Agency notifies the CMS Regional Office (RO) within 20 days from the last day of the survey that determined past noncompliance of its recommendation to impose a CMP. The CMS RO responds to the recommendation within 10 days, and if accepted, sends out the formal notice in accordance with the notice requirements in §7305 and §7520.

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SERIOUS EVENTS THAT MAY TRIGGER COMPLAINT SURVEYS

- Respond Quickly to Serious Events

Frequent falls	Entrapment
Falls with injury	Hot water temps
Elopement	Sexual assault
Serious med error	Abuse/neglect
CPR	Failure to follow care plan (two person assist done by one)
Choking, wrong diet	Glucometers

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ANTICIPATING SURVEY

- Why and how quickly will the State Survey Agency perform a visit?
  - Adverse events, self-reports, hotline calls, complaints, annual visits, lawsuits, and potential plaintiffs all lead to the OIG coming on site.
  - Do **not** wait for the surveyors to identify and cite deficiencies before self-correcting.
  - The State Survey Agency prioritizes complaint surveys based on the nature of the self-report or complaint.
  - Typically, post-report you have time to begin and complete corrective action prior to the OIG's arrival.

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INVESTIGATION & ROOT CAUSE ANALYSIS

- First Things First
  - Notify your Medical Director.
  - Perform a thorough investigation and convene IDT Team and QAPI Committee to review the investigative findings, draw conclusions and perform a Root Cause Analysis.
  - Identify and correct every potential deficiency that could be cited in relation to the event.
  - Corrective action cannot and should not begin, including education, until you have identified the likely system failures that caused and/or contributed to the serious event and under what tags you will be cited as a result.
  - Work as a team to develop a comprehensive plan to protect residents, educate staff and monitor the education and interventions for success.

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HYPOTHETICAL ADVERSE EVENTS

- The following events/self-reports will almost always trigger an on-site OIG survey with the potential for Immediate Jeopardy or Actual Harm cited under multiple tags:
  - Elopement
    - Resident admitted post acute care hospitalization
    - Ambulatory, cognitively intact, planned to discharge home, frequent visitors in outside courtyard
    - Change in condition, decline, not reassessed, no elopement risk performed, care plan not updated
    - Resident ambulates into outdoor courtyard alone, falls, sustains injury, found by staff
  - Abuse – Staff to Resident
    - Staff #1 strikes and injures resident; event witnessed by Staff #2
    - Staff #1 tells charge nurse that resident was combative during care and sustained bruise to face by thrashing in bed
    - Charge nurse does not assess resident or question Staff #2
    - Staff #2 reports abuse to Charge Nurse when Staff #1 clocks out 3 hours later

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ROOT CAUSE ANALYSIS

- 5 **WHYS** for Serious Event
  - The team conducting this root cause analysis does the following: Develops the problem statement. Be clear and specific. ● The team facilitator asks **why** the problem happened and records the team response. To determine if the response is the root cause of the problem, the facilitator asks the team to consider "If the most recent response were corrected, is it likely the problem would recur?" If the answer is yes, it is likely this is a contributing factor, not a root cause. ● If the answer provided is a contributing factor to the problem, the team keeps asking "**Why?**" until there is agreement from the team that the root cause has been identified. It often takes three to five **whys**, but it can take more than five! Keep going until the team agrees the root cause has been identified.
  - Why did alarm/wander guard fail?
  - Why was the resident not identified to be at risk?
  - Why did Staff #2 not follow policy/procedure as trained?
  - Answering the **WHYs** drives the **Root Cause Analysis** which dictates the corrective action (4 prongs of the AOC/Plan of Correction)

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CORRECTIVE ACTION FOR RESIDENT AFFECTED

- How was THIS particular resident negatively affected
- Fully assess resident/s for injury
- Contact physician for orders if needed
- Keep facility's Medical Director informed and involved
- Notify family/DPOA
- Update medical record with incident, assessment, orders, and notification
- Care plans interventions fail or not present?? Update care plan if needed
- PHQ9 ongoing

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CORRECTIVE ACTION FOR OTHER RESIDENTS WITH POTENTIAL TO BE AFFECTED

- What was the failure identified by the Root Cause Analysis?
  - Assessment failure, why? No change in condition noted? Why?
  - Faulty alarm – if so, why? How many?
  - Resident removing bracelet or family refusing to allow placement of one – Why?
  - Staff members not following process (failed to go outside and perform head counts)
  - Interview residents with BIMS 8 and above – Why? What exactly are you asking?
  - Skin assessments on residents BIMS 7 and below – Why? current bruising? Patterns?

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MEASURES PUT IN PLACE TO ENSURE NO REPEAT DEFICIENT PRACTICE

- Develop all measures based on Root Cause Analysis
  - QAPI meets to discuss Root Cause Analysis and develop Corrective Action Plan
  - **Education – Do not rush**!
  - Do you need a policy change? Must go through QAPI
  - Do you need a system change? Must go through QAPI
  - Tailor education to what is broken
  - Educate your leaders FIRST
  - Develop a detailed plan regarding education, post tests, agency staff and return to work
  - Monitor your schedule to assure that education is occurring pre resuming work

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MONITORING AND QAPI

- Develop monitoring tools to confirm that the education and updated policies and procedures are working
- Assign specific individuals to perform the audits and report to QAPI
- Monitor for assessments and updated care plans after changes in condition
- Monitor staff understanding of reporting if feel unsafe with co-worker
- What qualifies as a QAPI meeting

  All members participate (INCLUDING MEDICAL DIRECTOR – via phone or zoom is acceptable)
- What is an *Ad hoc* QAPI meeting?

  - it means impromptu, specific, "as needed" so, in other words, it is scheduled outside of your normal QAPI schedule (quarterly, monthly, etc.)

  - it does **not** mean that the Medical Director or all members do not participate
- All monitoring results must be presented to QAPI – this confirms that the system failures are fixed or not. QAPI determines the duration of ongoing audits.

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IMPORTANT DOCUMENTATION

- Print and the following ready so facility is following the Corrective Action Plan and for surveyors to easily access
- ***Sufficient Evidence (federal standard for past non-compliance)*** proving all corrective elements were performed and completed
- Investigation summaries
- Evidence/Clinical Documentation related to resident affected
- Evidence of identifying other residents with the potential to be affected
- Evidence of in-service training, post-test and scheduling documentation so no person works without being re-educated
- Evidence of investigation summaries, employee names and phone numbers
- Evidence of QAPI tools, meeting agendas and sign in sheets (**NOT the audit results or meeting minutes**)

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INTERACTING WITH SURVEYORS

- Before the OIG enters your building, assign one or two persons as the contact
- This assures knowledge of Corrective Action documentation
- Streamlines document production, interviews and other requests
- Allege past noncompliance as soon as IJ alleged by the State Survey Agency
- Only allege corrective action related to the deficiencies cited
- Updated KY OIG self-report form https://www.chfs.ky.gov/agencies/os/oig/dhc/Pages/ltc.aspx#LongTermCareFacilitySelfReportedIncidents
  - Initial Report: https://www.chfs.ky.gov/agencies/os/oig/dhc/Documents/Initial%20Facility-Reported%20Incident%20Form.pdf
  - 5-Day Follow-Up https://www.chfs.ky.gov/agencies/os/oig/dhc/Documents/Follow%20Up%20Facility-Reported%20Incident%20Form.pdf

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QUESTIONS?

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