# PAST NON-COMPLIANCE

## Avoiding Citations with HPNC

presented by

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# FACILITY REPORTED INCIDENTS

***Immediate Jeopardy Priority***

*•In cases where the initial report indicates the following, the SA must initiate an onsite survey within three business days of receipt of the initial report:*

*•1) The alleged noncompliance may have caused, or may likely cause, serious injury, harm, impairment, or death to a resident, and*

*•2) The facility has not implemented adequate protection for all residents, or the SA has not received sufficient evidence to conclude that residents are adequately protected.*

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*•In cases where the initial report indicates the following, the SA must initiate an onsite survey within seven business days of receipt of the initial report:*

*•1) The alleged noncompliance may have caused, or may likely cause, serious injury, harm, impairment, or death to a resident, and*

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*•2) The facility has potentially implemented adequate protection for all residents.*

# FRI'S CONTINUED

*•Investigating nursing home facility-reported incidents according to these timeframes will be implemented no later than October 1, 2023, to provide time for the SAs to prepare given the resource constraints in the SAs.*

*•Depending on the nature of the allegation, the facility would be expected to take immediate action(s) to ensure the protection of residents. Information provided by the facility may assist the SAs in determining whether there are potentially adequate protections provided to the resident.*

*Examples of such information include, but are not limited to:*
*•• Monitoring of the alleged victim and other identified residents who are at risk, such as conducting unannounced management visits at different times and shifts;*
*•• Evaluation of whether the alleged victim feels safe and if he/she does not feel safe, taking immediate steps to alleviate the fear, such as a room relocation, increased supervision, etc.;*

# FACILITY REPORTABLE INCIDENTS

- **They review the information submitted and make an immediate determination of priority. Our investigations, corrective actions, protection of the resident make or break whether it's an IJ. They will also prioritize based off how much information we provide**
- The role of the surveyor is not to validate whether the events contained in the allegation had occurred, but it is to determine whether the facility is in compliance with the Federal requirements for Medicare/Medicaid-certified providers/suppliers.

# **Immediate Jeopardy priority** for Facility-Reported Incidents (FRIs)

- Regardless of whether an immediate risk may continue to exist.
- Examples of intakes that are assigned this priority include, but are not limited to, the following:
  - All intakes alleging abuse of a resident/patient/client and it is uncertain that they are adequately protected.
  - All intakes alleging eviction of a resident to an unsafe location.

# Examples that indicate that a **resident(s) may not be protected** in the facility:

- The alleged perpetrator continues to have access to the alleged victim and/or
- Retaliation occurs against a resident who reports an alleged violation;
- A resident who repeatedly fondles other residents is moved to another unit, where he/she continues to exhibit the same behaviors to other residents; and
- A resident with a history of striking a resident is left unsupervised with a resident who has been targeted in the past. The SA may contact the resident/representative to determine whether adequate protections are provided to the resident

# "No further action" FRIs

incidents that are **not reportable events** under Federal law or regulations;

involving **injuries where the resident was able to explain or describe how he/she received the injury** as long as there is no other indication of abuse or neglect;

incidents involving **lost items, which are found,** and no theft is suspected; and

The alleged **event occurred before the last standard survey and there is sufficient evidence that the facility does not have continuing noncompliance** since the last standard survey.

**NOTE: Sufficient evidence that the facility does not have continuing noncompliance** may be indicated by a recent survey that reviewed the concern, no additional complaints or facility reported incidents have been received regarding the same issue, and interview with the Long-term Care Ombudsman which reveal no concerns. [pg. 21]

# Abuse Clarifications

## Resident to Resident Abuse of Any Type

A resident to resident altercation should be reviewed as a potential situation of abuse. The surveyor should not assume that every resident to resident altercation results in abuse.

For example, infrequent arguments or disagreements that occur during the course of normal social interactions (e.g., dinner table discussions) would not constitute abuse.

The surveyor must determine whether the incident would meet the definition of abuse. [pg. 70]

## Capacity and Consent

Residents have the right to engage in consensual sexual activity.

However, anytime the facility has reason to suspect that a resident may not have the capacity to consent to sexual activity, the facility must take steps to ensure that the resident is protected from abuse.

These steps should include *evaluating whether the resident has the capacity to consent to sexual activity*. [pg. 75]

# PAST NONCOMPLIANCE

- So what does this mean for you?

- This is a way for your interdisciplinary QAPI committee to work on root cause analysis post-incident/ event. Reduce the risk of high scope/severity deficiencies and document the community's " Good Faith Attempt"

# PAST NON COMPLIANCE

- Let's look at an example.

- Mrs. Ima Missin has experienced multiple elopements in the past few weeks. Fortunately, she was free from any injuries until today when she was discovered outside of the facility. She was nonresponsive related to heat exposure

# PAST NON-COMPLIANCE

- The QAPI committee reviewed Mrs. Ima Missin's incidents, care plan, evaluations, and documentation. They identified that her wandering/ elopement risk assessment has not been completed on admission or after her elopements, and after her first incident a wander guard had been recommended but was never put in place.
- What we learned from this analysis was IF we had identified her risk and put the appropriated intervention in place as recommended Mrs. Ima Missin wouldn't be at the hospital right now in ICU.
- This is a pretty simple example---- multiple elopement attempts, failure to identify Residents risk put interventions in to place to reduce those risk which equals root cause and leads to a negative outcome.
- Sounds ominous doesn't it? But here's the key: you identified it and you're going to do something about it.
- That's the intent of this regulation----things happen but are you DOING SOMETHING ABOUT IT?

# ELEMENTS OF HPNC

- The facility must not have been in compliance with a regulatory requirement at the time the situation occurred (i.e. We identified a deficient practice that could have resulted in a citation)
- The situation of noncompliance must have occurred after the exit date of the last survey and before the current survey ( this includes standard surveys, complaint surveys, and revisits)
- There must be specific evidence that the facility corrected the non-compliance at the time of the incident and is in substantial compliance at the current survey

# MUST MEET STANDARD AND REGULATORY LANGUAGE

- Past noncompliance that is NOT immediate jeopardy and for which a quality assurance program has corrected the non-compliance should NOT be cited. NOTE: The facility needs to bring this to the attention of the surveyor( they are not required to ask you for it)
- The facility must provide the evidence to the surveyor who will then contact his/her manager to review the information and make a determination if the evidence meets the criteria for past non-compliance. If a surveyor  is reviewing a resident's medical record or questions you regarding a specific incident and you have done a Past Noncompliance plan for , tell the surveyor and produce the documents for their review!

# CONTINUED PAST NONCOMPLIANCE

- When "Harm" has been determined, The CMS-2567 will include the appropriate F tag, date of deficiency, the date of the past non-compliance , and implementation of a plan of correction so the civil money penalty can be determined. So implementation of the plan timely is key!

- F865 QAPI PROGRAM/PLAN/DISCLOSURE/GOOD FAITH ATTEMPT
- 483.75(i) Good Faith Attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions

- No POC is required for PNC citations and No revisit is conducted unless attached to a 2567 with other deficiencies that will require a revisit.

# TAKE ADVANTAGE

- Sounds too good to be true? Follow the logic. An incident occurs, the facility self-identified a deficient practice and corrected it. Isn't that the goal of a QAPI committee?

- The Key is writing your plan and  having supportive documentation that the plan was completed and is being monitored appropriately.

- We can't just "fix" the problem and not have any supportive documentation.

# DEVELOPING YOUR PLAN

- Here's a checklist of things to assist you in developing a plan:

❖ Description of deficient practice ( why and how did it happen? )

❖ Plan of correction (internal, formatted to meet the CMS guidelines)

❖ In-depth analysis of how the deficiency occurred

❖ How the facility identified affected residents and residents having the potential to be affected by the same deficient practice. ( Documented)

# DEVELOPING YOUR PLAN

- Measures or systemic changes made to ensure that deficient practice will not recur and affect others, what system did you put in place? (Documentation)

- How the facility monitors its corrective actions to ensure deficient practice is corrected and will not recur. ( This is the key to process –ongoing monitoring and documentation is the only way to evaluate whether the plan of correction was effective!)

# DEVELOPING A PLAN

- To determine what procedures, systems, structures, and processes have been changed, expect the survey team to:

- Interview facility staff such as the administrator, nursing staff, social services, medical director, QAPI committee members etc.
- Review policies/procedures that address the areas of concern
- Observe for the provision of care and use of the new processes/equipment as necessary

- Observe for evidence of staff training required to assure ongoing compliance for the implementation and use of the new/ revised P&P's , especially with new or temporary staff

# DEVELOPING A PLAN

- Date of completion of the plan of correction ( must attach documents for evidence of compliance)
- Name (printed) and signature of person completing the report
- Create a "HPNC" notebook for all supporting documentation.

# PAST NON-COMPLIANCE

- These are basic guidelines. It is highly recommended that you educate yourself and your interdisciplinary team on the importance of identifying the root cause analysis of incidents in a timely manner and review the requirements for History of Past Noncompliance to determine if process would help prevent citations. A full description and regulatory language can be found at www.cms.gov

# EXAMPLE OF ACTUAL HPNC

- EXAMPLE OF ACTUAL SUCCESSFUL PNC PLAN

- **The facility self-identified process concerns related to post fall investigations and follow up after resident falls which leads to the potential for Repeat falls and of Fall with injury. One of the residents identified as having a fall with no F/U investigation had a subsequent fall resulting in a fracture.**

- **Corrective action:**
- **Facility IDT met to conduct an IDT review for the 3 Resident Falls that were identified as not having previously been reviewed. ( THIS REVIEW WAS DOCUMENTED WITH AN IDT NOTE AND ON AN AUDIT TOOL CREATED BY THE FACILITY AND SUPPORTING DOCUMENTATION FOR ANY ISSUE IDENTIFIED AND CORRECTED , THE IDT NOTE, AND THE REVIEWED/REVISED CARE PLAN WAS COPIED AND PLACED INTO A NOTEBOOK )**

# EXAMPLE

- CONTINUED:

- **On or prior to November 1, 2021 the facility reviewed all resident falls that had occurred from January 1, 2021 through November 1, 2021 to identify Residents who had fallen and had not had a review completed by the Interdisciplinary team. The facility identified several Residents that had not been evaluated post fall by the IDT. (THIS REVIEW WAS DOCUMENTED ON AN AUDIT TOOL AND PLACED IN THE NOTEBOOK)**

- **On or prior to November 3, 2021 the IDT met to review those residents identified as having 1 or more falls since January that had not be reviewed by the IDT. The Residents care plan was reviewed for its appropriateness at that time and revisions were made if indication. (THIS REVIEW WAS DOCUMENTED ON AN AUDIT TOOL AND PLACED IN THE NOTEBOOK ALONG WITH COPIES OF ANY UPDATED/REVIEWED/REVISED CARE PLANS)**

# continued

- On or prior to November 3, 2021 the Regional Director of Health Services will reeducate the Interdisciplinary team on the Fall Management system. A sign in sheet will be utilized. **(THIS INSERVICE AND SIGN IN SHEET WAS PLACED IN NOTEBOOK)**

- The facility determines that all residents on admission are considered to be at risk for falls. The facility will further review residents having the potential for accidents, i. e. falls, through Fall evaluations and record reviews. Fall risk is reviewed on admission, quarterly, annually, and with significant change in status through the RAI process. The residents identified with high risk for falls, will be further reviewed including evaluation of current preventative interventions. Resident care plans will be updated and will reflect any assessed needs. **( A COPY OF THE FALL MANAGEMENT POLICY WAS PLACED IN THE NOTEBOOK)**

- Charge nurses will monitor for residents receiving supervision and application of interventions via care rounds. **( AUDIT TOOL WAS CREATED AND COMPLETED REVIEWS KEPT WITH NOTEBOOK)**

- Members of the IDT will assist in monitoring by conducting administrative rounds and conducting random observations of for application of fall interventions. **( AUDIT TOOL WAS CREATED AND COMPLETED REVIEWS KEPT WITH NOTEBOOK)**

- In addition, the DON/designee will oversee the 24-hour reporting system through daily administrative rounds and fall reporting. The DON/Designee will monitor weekly to ensure any fall that occurred during the week was reviewed and followed up appropriately by the IDT. **( AUDIT TOOL WAS CREATED AND COMPLETED REVIEWS KEPT WITH NOTEBOOK)**

- The DON/ designee will report identified trends to the QA & A Committee monthly. Analysis of results for trends and patterns in residents falls discussed in the IDT meetings will be used as the basis for continues process improvement and reviewed in QA&A to ensure plan is implemented, sustained, and evaluated for its effectiveness. Follow up will be conducted as indicated by appropriate disciplines of the IDT

# RESULTS

- The facility did receive F 689 SS=G Past Non-Compliance
- The facility did receive recommended CMP's from Date of incident until plan was completed, however, the facility presented an IDR supporting the "Past Non-Compliance" and utilized Regulatory language regarding "Good Faith Attempts not being used as a basis for CMP's", and the tag was removed completely

# QUESTIONS

# Thank you

Quality Initiative and Leadership Committee

2023