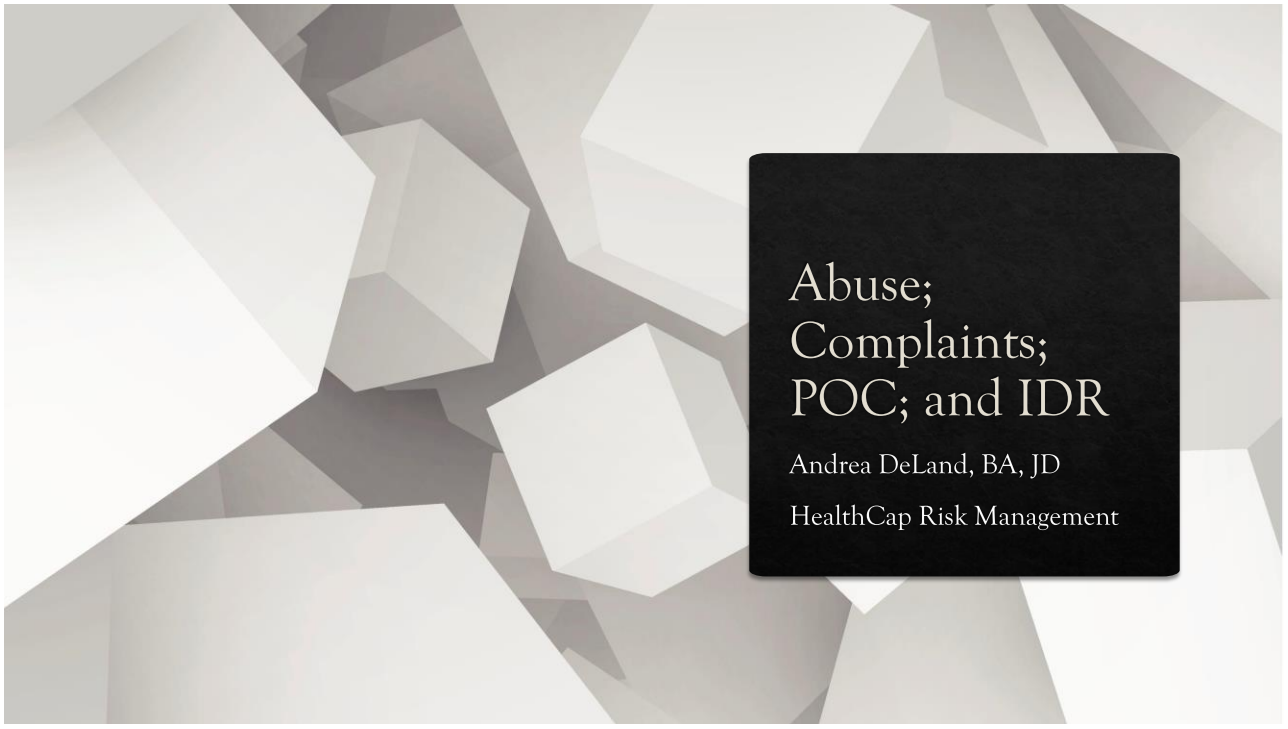
Abuse;
Complaints;
POC; and IDR
Andrea DeLand, BA, JD
HealthCap Risk Management

Topics

- Abuse & Neglect
  - Allegations & Reporting
  - Investigations & Reporting
  - Prevention & Detection
- Grievances & Complaints
  - Complaint Investigations
  - Grievance Policy & Procedure
  - QAPI & Corporate Compliance
- Plan of Correction (POC)
  - Required Components
- IDR & IIDR
  - Key Distinctions
  - Resources for Effective Argument Development


Abuse

Abuse: Regulatory Definition

- DEFINITIONS §483.12(a)(1) "Abuse," is defined at §483.5 as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with **resulting** physical **harm,** pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology."

Abuse: 2 Primary Components

ACTION & OUTCOME

(1) Action for Abuse Deficiency: The willful infliction of injury, unreasonable confinement, intimidation, or punishment.

(2) Outcome for Abuse Deficiency: Harm.

Component One: Action

The willful infliction of injury, unreasonable confinement, intimidation, or punishment.

- Distinction between “willful” and “intentional”.
- “Intentional” acts and advanced dementia resident argument.

Component 2: Harm

- Harm – A negative outcome that has compromised the resident's ability to maintain or reach the highest practicable physical, mental, or psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. (CMS definition)
  - NOTE: This is not "actual harm" as used for scope and determinations.

Examples of Harm

- Resident is intimidated/threatened resulting in mental or psychosocial status change.
- Resident is physically abused-spitting/slapping/sticking with sharp object/pushing/pinching.
- Falls resulting in fracture (e.g. handrails not secured);
- Inappropriate use of restraints resulting in injury.
- Inadequate staffing which negatively impacts on resident health and safety.
- Failure to obtain appropriate care or medical intervention, i.e. failure to respond to a significant change in the resident's condition.

Federal Regulations

Abuse Deficiencies

Abuse Deficiencies

- F600 – Abuse and Neglect
- F602 -Misappropriation of Resident Property and Exploitation
- F603 –Involuntary Seclusion
- F604 – Physical Restraints
- F605 – Chemical Restraints
- F608 - Reporting of Suspected Crimes

Abuse Deficiencies

- F606 – Prohibit Employment for Individuals with Adverse Actions
- F607 – Policies and Procedures
- F608 – Reporting of Suspected Crimes
- F609 – Reporting of Alleged Violations
- F610 – Response to Alleged Violations

F 600

- **§483.12 Freedom from Abuse, Neglect, and Exploitation**
- The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.
- §483.12(a) The facility must— §483.12(a)(1) **Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;**

F 603 Involuntary Seclusion

- Each resident has the right to be free from involuntary seclusion.
  - Think about how situations like this arose with COVID-19.

F 604: Restraints

- §483.10(e) Respect and Dignity.

The resident has a right to be treated with respect and dignity, including:

§483.10(e)(1) **The right to be free from any physical or chemical restraints** imposed for **purposes of discipline or convenience, <u>and</u> not required to treat the resident's medical symptoms**, consistent with §483.12(a)(2)

F 604: Restraints

- Prohibits the use of physical restraints for discipline or convenience;
- Prohibits the use of physical restraints to unnecessarily inhibit a resident's freedom of movement or activity; and
- Limits physical restraint use to circumstances in which the resident has medical symptoms that may warrant the use of restraints.

When a physical restraint is used, the facility must:

- Use the least restrictive restraint for the least amount of time; and
- Provide ongoing re-evaluation of the need for the physical restraint

F 606: Risks Associated with Employees & Contractors

§483.12(a) The facility must— §483.12(a)(3) Not employ **or** otherwise engage individuals who—

(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;

(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or

(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff

F 607: Abuse Policies & Procedures

§483.12(b) The facility must develop and implement written policies and procedures that:

- §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,
- §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and
- §483.12(b)(3) Include training as required at paragraph §483.95,
- §483.12(b)(4) ***Establish coordination with the QAPI program required under §483.75.***

F 609 Reporting
"Allegation" vs "Reasonable Suspicion"

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are **reported immediately**, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) **Report the results of all investigations** to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

Reporting to SSA

- Willful injury, verbal, sexual, physical or mental/emotional abuse.
- Involuntary seclusion or unreasonable confinement, intimidation or punishment.
- Mistreatment.
- Injury of an unknown source.
- Neglect, the failure to provide goods or services.
- Misappropriation of a resident's property of any value.

These are reportable at any severity.

Elder Justice Act

Elder Justice Act Requirements

The facility must develop and implement written policies and procedures that:

§483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act.

Elder Justice Act Requirements

The policies and procedures must include but are not limited to the following elements.

(i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements.

(A) Each covered individual shall report to the State Agency **and** one or more law enforcement entities for the political subdivision in which the facility is located any **reasonable suspicion** of a crime against any individual who is a resident of, or is receiving care from, the facility.

Elder Justice Act Requirements

(B) Each covered individual shall report immediately, but not later than 2 hours after forming the **suspicion**, if the events that cause the suspicion result in serious bodily injury, or **not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury**.

(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.

(iii) Prohibiting **and** preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.

F 610: Investigating Allegations

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(1)

§483.12(c)(4) **Report the results of all investigations** to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

F 610 Reporting & Timing

- Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are **reported immediately**, **but not later than 2 hours after the allegation is made**, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than **24 hours** if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

Abuse Deficiencies

And Consequences

Abuse Deficiencies & Consequences

- Evidence of negligence in civil claims & criminal charges.
- All abuse deficiencies are subject to a "substandard quality of care" finding by the State Survey Agency.
  - Substandard Quality of Care = Deficiencies with s/s levels of F, H, I, J, K, or L.
- Red Hand – Nursing Home Compare (CMS)
  - NH Compare overall rating - Correlation with number of claims asserted against a provider.
  - Public Opinion.
- Special Focus Facility (SFF) implications.

Immediate Jeopardy: Abuse

An incident that caused or is likely to cause serious injury, serious harm, impairment or death to a resident.

- Injury or incident involving a death or criminal activity under investigation by a state of local law enforcement agency.
- Abuse with serious injury.
- Injuries of unknown origin that result in interference with physiologic functions that are an immediate threat to life or have a strong potential to become an immediate threat to life.

Immediate Jeopardy Scenarios

- Elopement of a resident missing for more than two hours.
  - Less than 2 hours when there is a strong potential to become an immediate threat to life, e.g., either because of inclement weather conditions or known hazards outside the facility.
- Resident to resident physical altercation with serious injury.
- Serious injury that is life threatening to a resident.
- Sexual assault.

Assess & Reduce Your Risk: Abuse Deficiencies

- Gain a working understanding of the regulatory definitions and interpretive guidance.
- Be sure to protect the risk assessment process through utilization of the QAPI committee procedures.
- Evaluate Facility *policies* and procedures currently in place and modify, if necessary, to be consistent with current regulation and/or current *practice*.
- Effective and documented education for *everyone at least* annually after hire.
- Assess Grievance Policy and Procedure in its effectiveness and timeliness in addressing concerns.

Assess & Reduce Your Risk: Abuse Deficiencies

- All allegations: Look at the facts – through different lenses - and objectively document interviews.
  - Direct care staff member;
  - Spouse of resident;
  - Daughter/son of resident;
  - Plaintiff attorney;
  - Owner of the company/facility.
- Review clinical documentation –
  - Would it make each of those categories of people feel better about the situation (demonstrate the staff/facility commitment to resident safety and well-being)? Why?
  - Can it stand, on its own, to support that facility/staff substantially complied with regulatory requirements?
- Conduct mock surveys using CMS resources to identify potential risk areas and implement measures aimed at reducing regulatory and civil risk.


Neglect

Neglect

- "Neglect" as defined under the regulations at 42 CFR §483.5, means: "the failure of the facility, its **employees *or* service providers** to provide goods and services to a resident that are necessary to avoid physical harm, pain, **mental anguish or emotional distress**."
  - Separate and distinct scope/severity guidance for mental anguish and emotional distress: *Psychosocial Severity Guide*.
- Neglect identifies the facility's failure to provide the required structures and processes in order to meet the needs of one or more residents. This may include, but is not necessarily limited to, the facility's failure to provide necessary staff, supplies, services, policies, training, or staff supervision and oversight to meet the resident's needs.

Neglect

- Neglect of goods or services may occur when staff are aware, or should be aware, of residents' care needs, based on assessment and care planning, but are unable to meet the identified needs due to other circumstances, such as lack of training to perform an intervention (e.g., suctioning, transfers, use of equipment), lack of sufficient staffing to be able to provide the services, lack of supplies, or staff lack of knowledge of the needs of the resident.

Examples: Neglect

- The nursing home utilizes temporary staffing agencies but does not have processes in place to provide orientation, or medical or care plan information for the temporary staff regarding the individual resident's needs on the unit to which the temporary employee is assigned.
- The nursing home failed to respond to residents refusing to bathe/shower, based on complaints of cold water during bathing/showering. Maintenance staff identified equipment failures and reported them to the facility's administrator with recommendations to replace the water heating system. However, the administrator did not address these failures, resulting in the diminished quality of life for residents.

Detection & Prevention

Abuse and Neglect

Prevention & Detection: Abuse & Neglect

- Effective inservice training role play with Abuse Pathway scenarios.
- Care plan reviews and audit timeliness/attendance at care conferences.
- Training records.
- Personnel action.
- Revise policies and procedures.
- Monitoring.
- Installation of new equipment.

Preventing Abuse: Complaints & Grievances

QAPI Considerations for Assessment of Grievance Procedure(s):

- Care Compare.
- Complaint Surveys.
- Number of Substantiated Complaints.
- The extent to which facility efforts to satisfactorily identify, address and ultimately resolve concerns to the satisfaction of all involved.
  - Is the SSA in the facility as the result of an unresolved grievance?

Complaint Survey Investigations

Facility Reported Incident (FRI)

vs.

Complaint Hotline

Plan of Correction

(POC)

Purpose of the POC

- Serves as the facility's *allegation* of compliance.
  - Compliance determination is made by SSA; not by submission of POC alone.
- Without it, CMS and the survey agency cannot verify compliance with the federal and state regulatory requirements.
  - Penalties accrue until SSA accepts the POC and compliance is verified.
- Outlines the plan to achieve and maintain compliance leading to improved quality of care.

POC Timing

- Must submit the POC within 10 calendar days of receiving a 2567.
- Submission does not mean acceptance by the SSA.
- If an acceptable POC is not received within 10 calendar days, the survey agency will notify the facility that it is recommending to the Regional Office imposition of category 1 remedies and/or denial of payment for new admissions.

POC Timing Tip

Stress Reduction Tip:

- On the day of SSA Exit:
  - Plan an all-staff meeting to explain survey outcomes
  - Begin the POC immediately.
  - Write the POC based on information received from the exit and immediately begin working the plan.
    - Make adjustments to the POC once the final 2567 is received.

POC Substance Tips

- Thoroughly read every example cited.
- Multiple issues can be written under the citation for one tag.
- Each issue requires corrective action.

POC: Five Elements

1. How the corrective action will be accomplished for identified affected individuals.
2. How will other individuals with the potential to be affected or in similar situations be identified and protected.
3. What systemic changes will ensure that the deficient practice will not recur.
4. How the facility will monitor its corrective actions/performance.
5. When will corrective action be accomplished?

POC: Element 1

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- Identify what the corrective action is/was.
- Identify the date of implementation.
- Identify who is/was responsible for making the corrections (position title).

POC: Element 2

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.
  - How the facility determined no other residents were affected by the deficient practice.
  - The date this was determined; and, by whom.
  - Not acceptable to state “all residents have the potential to be affected”.

POC: Element 3

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
- Detail the actions taken.
  - Policy reviews/revisions.
  - Staff training.
    - Provide the dates of action and the titles of staff completing the action.

POC: Element 4

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.
  - Include the title of who will monitor the corrective action.
  - Identify how the actions will be monitored.
  - Identify when the monitoring will occur (frequency);
    - Explain how the results will be evaluated and by whom.
  - Cannot be for a limited number of months and stop completely. Needs to be ongoing system of how you are going to monitor through QAPI process.

POC: Element 5

- Include dates when corrective action will be completed.
  - The date of compliance for the deficient practice cannot be a date on or prior to the survey exit date and cannot be a date when action is being taken by the facility.
    - The corrective action completion dates must be acceptable to the State.
  - If the plan of correction is unacceptable for any reason, the State will notify the facility •
  - If the plan of correction is acceptable, the State will notify the facility by phone, email, etc.
    - Facilities are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely (CMS SOM Chapter 7 7304.4 – Acceptable Plan of Correction, Rev 63).

POC: Choosing a Compliance Date

- A provider is generally expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies, but the SSA may recommend that additional time be granted.
- Allow time for re-survey and potential correction prior to sanctions
- Select date in which you can reasonably fix the problem

(42 CFR 488.28)

Initial POC Development

Areas for QAPI to consider addressing in developing an acceptable POC for abuse-related deficiencies:

- Care plan
- Training
- Personnel action
- Revised policies and procedures
- Monitoring
- Installation of new equipment
  - Note: These areas might also be helpful if there is a need to implement a past noncompliance.

POC Pitfalls

- Excluding language that would support and/or defend the facility's approach.
- Insufficient response to the basic federal deficiency.
- Stating an employee was "disciplined", which implies guilt, unless it cannot be avoided.
- Using specific staff/resident names.

Determining Substantial Compliance

- Onsite Visit – Based on Date of Correction identified in POC.
- Desk Review – An accurate, complete, and well written plan of correction with low level deficiencies may lead to a desk audit (desk review) for compliance. In such cases, surveyors will not return in person for the re-survey but will find the provider in compliance based on an acceptable plan of correction.

Plan Of Correction (POC)

- Admissibility.
  - **Scenario:**
    - Complaint survey initiated by SSA; not initiated through a Facility Reported Incident (FRI) intake. Allegation is that staff are "rough" when assisting residents with transfers and ambulation. SSA substantiates allegation and Facility is cited for deficiencies for (1) failure to report allegation of abuse; (2) failure to maintain abuse-free environment. The remedies imposed include POC, which requires the Facility to make written promises to improve which can be problematic from a civil or criminal defense perspective. Should the Facility challenge the deficiency, the process requires the submission of written factual assertions.
    - Freedom Of Information Act (FOIA).

Abuse: Past Noncompliance

To cite past non-compliance, all three (3) of the following criteria must apply:

1. The facility must have been out of the compliance with a regulatory requirement at the time the incident occurred.
2. The non-compliance must have occurred after the exit date of the last standard survey and before the current survey.
3. 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.

Abuse: Past Noncompliance

- Past compliance evidence must show that the facility identified the (alleged) deficiency, developed and implemented corrective action following the incident and a period of compliance must be evident.
  - Generally, at least 30 days of consistent, documented compliance and oversight.

Abuse: Past Noncompliance

1. Past Noncompliance that is not Immediate Jeopardy and for which a quality assurance program has corrected the noncompliance, will not be cited if the facility brings this to the attention of the surveyor. The facility must provide the evidence to the surveyor who will contact his/her manager to review the information and make a determination if the evidence meets the criteria for past noncompliance.
2. Past noncompliance identified as immediate jeopardy is entered on CMS 2567 under the specific deficiency tag, scope and severity with supporting documentation. Note: The generic citation F698 has been discontinued.
3. The CMS 2567 should include the appropriate F-tag, date of deficiency, the date of past noncompliance, the evidence of past noncompliance and implementation of a plan of correction so that the civil money penalty amount can be determined.

Regulatory Appeals: IDR & IIDR

- Admissibility.

IDR & Past Noncompliance

- If a past noncompliance is cited in a survey report, the facility can still appeal the deficiency to contest whether a deficiency occurred.
- An IDR may not take issue as to whether a deficiency should have been cited as is past noncompliance.

Example: IDR & Past Noncompliance

- Example: QAPI identifies a potential risk and employs a Performance Improvement Plan (PIP) to reduce any the risk of a possible negative outcome. During survey, the SSA inquires about a practice that a PIP thereafter effectively addressed. In order to avoid an “active” deficiency (requiring a POC), the facility provides the PIP to the SSA . The SSA accepts the PIP as effective past noncompliance and cites the deficiency as such. The facility can appeal whether there was any deficient practice.

Enforcement: Past Noncompliance

- Civil money penalty is required for immediate jeopardy. A per instance CMP may be imposed.
- Past noncompliance does not apply to State Nursing Home Rules and the Public Health Code. A State of Michigan-tag (M-tag) may be cited and a State civil penalty order issued.

IDR

- IDR process:
  - The request must be submitted in writing along with an explanation of the specific deficiencies that are being disputed.
  - The request must be made within the same 10-calendar day period the facility has for submitting an acceptable plan of correction to the surveying entity.

IDR

- IDR process may not be used to challenge any other aspect of the survey process, including:
  - Scope and severity assessments of deficiencies, with the exception of scope and severity assessments that constitute substandard quality of care or immediate jeopardy;
  - Remedy(ies) imposed by the enforcing agency;
  - Alleged failure of the survey team to comply with a requirement of the survey process;
  - Alleged inconsistency of the survey team in citing deficiencies among facilities; or the
  - Alleged inadequacy or inaccuracy of the IDR process.

IIDR

- Independent IDR process does not delay the imposition of any remedies, including a civil money penalty.
- During the Independent IDR process a facility may dispute the factual basis of the cited deficiencies for which it requested Independent IDR. However, again like the IDR process, a facility may not challenge other aspects of the survey process, such as:
  - Scope or severity classifications, with the exception of assessments that constitute substandard quality of care or immediate jeopardy;
  - Remedy(ies) imposed;
  - Alleged failure of the survey team to comply with a requirement of the survey process;
  - Alleged inconsistency of the survey team in citing deficiencies among other facilities;
  - Alleged inadequacy or inaccuracy of the IDR or Independent IDR process.

IIDR

- The facility must request an Independent IDR within 10 calendar days of receipt of the offer.
- The facility should submit its request in writing to the State survey agency, or the approved Independent IDR entity or person, as appropriate.
- The facility's request should also include copies of any documents, such as facility policies and procedures, resident medical record information that are redacted to protect confidentiality and all patient identifiable information, or other information on which it relies in disputing the survey findings.

Appeals: Helpful Hints

1. TIMING. Late IDR and IIDR requests will not be granted.
2. Ensure that the IDR/IIDR address the deficiencies disputed with information to support why, and not any of the aspects that cannot be disputed.
3. Prepare the IDR/IIDR as you would a legal case, in a logical order with the evidence to support how the facility met the regulatory requirement(s) labeled and set up as easy to follow exhibits
4. Remember that the IDR and IIDR processes are intended to be Informal and are not intended to be a formal or evidentiary hearing. Thus, the facility should discuss with their legal counsel if they want to consider the possibility of having an attorney present during the process.

Appeals: Helpful Hints

- In order to substantiate a deficiency, the SSA must provide evidence of both:
  - (A) **Deficient Practice** that caused or is likely to cause a
  - (B) **Negative Outcome**.

Appeals: Helpful Hints: Deficient Practice & Negative Outcome

- Deficient Practice Statement in 2567:
  - Specific action(s), error(s), or lack of action (deficient practice).
  - Outcome(s) relative to the deficient practice, when possible.
  - Description of the extent of the deficient practice or the number of deficient cases relative to the total number of such cases.
  - Identifier of the individuals or situations referenced in the extent of the deficient practice.
  - Source(s) of the information through which the evidence was obtained.

Appeals: Helpful Hints

Answer the questions:

- Who
- What
- Where
- When
- How (*not why*!)
  - Why is oftentimes too subjective.

Regulatory Appeals: Resources

- All published CMS Resources, including, but not limited to:
  - State Operations Manual
    - Includes Appendix PP, which sets forth the intent and purpose of the regulation & is relied upon by State Survey Teams in citing deficiencies.
  - Survey Pathway Documents
    - Particularly useful for regulatory compliance related to abuse.
  - Survey & Certification Clarifications
    - Procedural and interpretive guidance on regulatory purpose and/or intent.

Link:

Nursing Homes | CMS

Regulatory Appeals: Resources

- Appendix PP, State Operations Manual
  - Provides intent of the regulation.
  - Guides survey team to think about specific other potential deficiencies.
    - Example: Use the same facts to support more than one deficiency.
- Survey Pathway Documents
  - Golden ticket for all things abuse-related.
  - Excellent resource for training staff and maintaining regulatory compliance.
  - Irreplaceable for abuse-related QAPI activities.
  - Brand new with the implementation of new/revised regulations.


Thank you!