PREPARING FOR SUCCESS: BUILDING A CASE FOR PAST NONCOMPLIANCE AND INFORMAL DISPUTE RESOLUTION STRATEGIES

FRIENDS SERVICES ALLIANCE ANNUAL CONFERENCE

OCTOBER 8, 2025

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INTRODUCTION

This session focuses on the critical steps nursing homes can take to effectively develop a case of past compliance prior to survey inspections. We will explore strategies for gathering and presenting evidence that demonstrates regulatory compliance, with an emphasis on areas previously identified as noncompliant.

This session also covers Informal Dispute Resolution (IDR) strategies for contesting citations issued during surveys.

Through case studies and practical examples, participants will gain insights that empowered them to proactively manage compliance issues, promote a culture of continuous improvement, and enhance the overall quality of care within their community.

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WHAT IS PAST NON-COMPLIANCE

- Past noncompliance generally means a facility has *sufficient* evidence to show that it corrected a deficient practice before the survey
- The most effective way to support past non-compliance is with a well documented internal plan of correction

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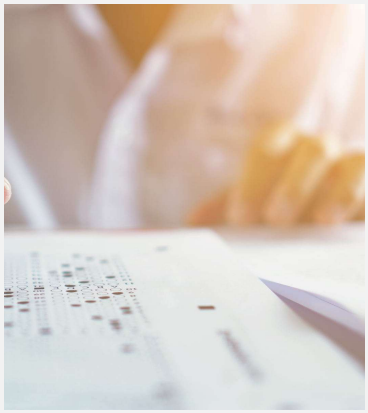
HOW DOES CMS DETERMINE PAST NONCOMPLIANCE?

Three criteria must be met for the survey team to consider past non-compliance:

1. The facility was not in compliance with the specific regulatory requirement specified by the 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/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 specific regulatory requirement as referenced by the specific F tag or K tag



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DETERMINING PAST NONCOMPLIANCE

- Deficiency identified during a current survey with a scope and severity at "G" or above or Substandard Quality of Care (SQC) findings at a scope and severity at "F" which meets all the following criteria: Not in compliance with the specific regulatory requirement(s) at the time the situation occurred
- Substandard Quality of Care=one or more deficiencies with scope and severity of an F or higher in the following areas:
  - (483.10) Resident Rights (F550, F558, F559, F565 or F584),
  - (483.12) Freedom from Abuse,
  - (483.24) Quality of Life,
  - (483.25) Quality of Care
  - (483.40) Behavioral Health (F742-745),
  - (483.45) Pharmacy Services (F757-F760),
  - (483.70) Administration (F850),
  - (483.80) Infection Control (F883)

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EXAMPLE

Nursing Home A had their last annual recertification survey on 3/13/25 and corrected all deficiencies and received notice that they were back in substantial compliance as of 5/15/25.

On 6/5/25 the Department of Health conducts an on site visit due to a facility reported incident of a fall with major injury which occurred on 6/3/25.

If the surveyors determine there is deficient practice, is the first criteria met for considering past non-compliance?

Did the non-compliance occur after the date of the recertification survey and before this survey?

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EXAMPLE (CONTINUED

Nursing Home A had their last annual recertification survey on 3/13/25 and corrected all deficiencies and received notice that they were back in substantial compliance as of 5/15/25.

On 6/5/25 the Department of Health conducts an on site visit due to a facility reported incident of a fall with major injury which occurred on 6/3/25.

If the surveyors determine there is deficient practice, is the first criteria met for considering past non-compliance?

Did the non-compliance occur after the date of the recertification survey and before this survey?

Does the facility have sufficient documentation that it corrected the noncompliance and is in substantial compliance during the survey?

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DOCUMENTING TO SUPPORT PAST NONCOMPLIANCE

RESPOND SWIFTLY AND DILLIGENTLY TO ALL SERIOUS EVENTS

- The key to meeting past noncompliance is to treat all serious incidents as one would respond to an immediate jeopardy situation (remember, there does not need to be harm for an IJ to be cited).
- Conduct a thorough investigation of the incident to identify the root cause and take corrective action for the resident that was affected.
- Identify other residents who could potentially be affected the same deficient practice.
- Identify system or process changes will occur as a result of the deficient practice
- Establish a date for completion of corrective actions
- How will you monitor to ensure that correction is sustained

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DOCUMENTING TO SUPPORT PAST NONCOMPLIANCE

You are essentially identifying your own deficient practice and writing a formal plan of correction.

- Document investigation findings to determine corrective action for the resident affected.
- Look for residents with similar characteristics or for evidence of how others could be affected in a similar situation. Complete assessments for those residents or ALL residents if the situation warrants and document that this was done, what the findings were and if you took any corrective action.
- Review your policies or procedures to ensure that they are clear and meet current professional standards of practice. Educate staff if there are changes to the policies or procedures. Also re-educate staff so that they understand how to prevent similar situations in the future.
- Establish a date by which you can realistically allege correction.
- Establish audits to monitor compliance and review the findings at the QAPI meeting.

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DOCUMENTING TO SUPPORT PAST NONCOMPLIANCE

Your internal plan of correction must be well documented and retained with all supporting documentation to show the effort you and your team have put into addressing the serious incident.

It is no different than the documentation that you would keep to show the DOH that you have corrected deficiencies that they cited on a 2567.

Take credit for your work!

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EXAMPLE

- Our resident in Nursing Home A, Mrs. Jones had a fall with major injury. A new nursing assistant was helping Mrs. Jones to the bathroom. She reviewed the care plan and saw that Mrs. Jones requires one assist for a stand/pivot transfer to the commode. When Mrs. Jones attempted to stand, her knees buckled, and she fell to the ground landing with her right leg behind her. Upon assessment by the RN, it was determined that Mrs. Jones needed to go out to the hospital for possible fracture.
- The RN began the investigation by asking the aide what happened to cause the fall. Upon hearing that the aide attempted to do a stand/pivot transfer, the nurse stated, "that was changed on her care plan yesterday because she was complaining of dizziness".

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EXAMPLE (CONTINUED)

- What would some of the next steps be to ensure that an appropriate plan of correction is implemented?
  - Address what you will do for this resident based on the findings of the investigation
  - Why was the information the aide accessed not current?
  - Keep delving into the reason WHY until you come up with all possible factors that played a role in the ultimate outcome for this resident.
  - Document what action you will take for this resident (assess her transfer status upon return and update the care plan accordingly?)
  - Determine if this could happen to any other residents and identify actions the facility will take to prevent it from happening to others (process for communication of care plan changes?) In this case, document whole house audit of care plans, etc.. to ensure proper transfer status is documented and that all staff are aware. Document any corrective action or if there was none.
  - Educate the IDT team on the process for communicating changes to care plan interventions. Retain copy of the educational material presented and staff signature sheets with dates/times of attendance.

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EXAMPLE (CONTINUED)

- What would be some of the next steps to ensure that an appropriate plan of correction for is implemented?
  - ✓ Establish/document a date by which you expect that this deficiency will be corrected
  - ✓ Determine who will be responsible for conducting routine audits to ensure that changes in care plans are properly documented and communicated
  - ✓ Assigned person for audits must complete the audits within the established time frames and address any identified issues if they are identified; what corrective action is taken when noncompliance is identified.
  - ✓ Audits are to analyzed by the person responsible to identify if there are trends or patterns. A summary of the findings are presented at QAPI for further review and or recommendation as necessary until compliance is achieved and sustained. (timeframes established in the POC, i.e. conduct audits for 3 months)

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EXAMPLE (CONTINUED)

- Retain all documentation of the formal internal POC and present when DOH comes in to conduct a survey.
- If you don't have the supporting documentation and cannot show that you achieved substantial compliance before surveyors, come in, you will not meet the criteria for Past Noncompliance.

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WHAT HAPPENS IF THERE *IS* A DETERMINATION OF PAST NONCOMPLIANCE?

The facility does not write a plan of correction!!!

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DOCUMENTATION ON THE 2567

- Past noncompliance is documented at the actual deficiency tag where the past noncompliance is identified. F tags for Health inspection and K tags for Life Safety. A scope and severity determination is assigned to a past noncompliance citation. (G or higher) Surveyors document the corrective action that was taken by the facility.
- The provider's plan of correction column on the CMS-2567 will print **"Past noncompliance-no plan of correction required"** for tags identified as past noncompliance.

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KEY ELEMENTS THAT YOU SHOULD KNOW

- Past noncompliance demonstrates that the facility addresses and corrects serious deficiencies before they are identified by the DOH. This is a GOOD thing!!

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KEY ELEMENTS TO KNOW (CONTINUED)

- A CMP may be imposed 42 CFR §488.30(b) for past noncompliance since the last standard survey. CMS strongly urges states to impose CMP for past noncompliance at level of IJ.
- The points for scope and severity still apply and are included in your star rating.
- If you have a Nurse Aide Training Program, the criteria for disapproval of the program still applies for findings of Past Noncompliance when a CMP of more than $5000 is assessed.

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UNDERSTANDING KEY PROCESSES IN HEALTHCARE SURVEY CORRECTIONS:

OVERVIEW OF INFORMAL DISPUTE RESOLUTIONS (IDRS) AND FORM CMS-2567 IN REGULATORY COMPLIANCE

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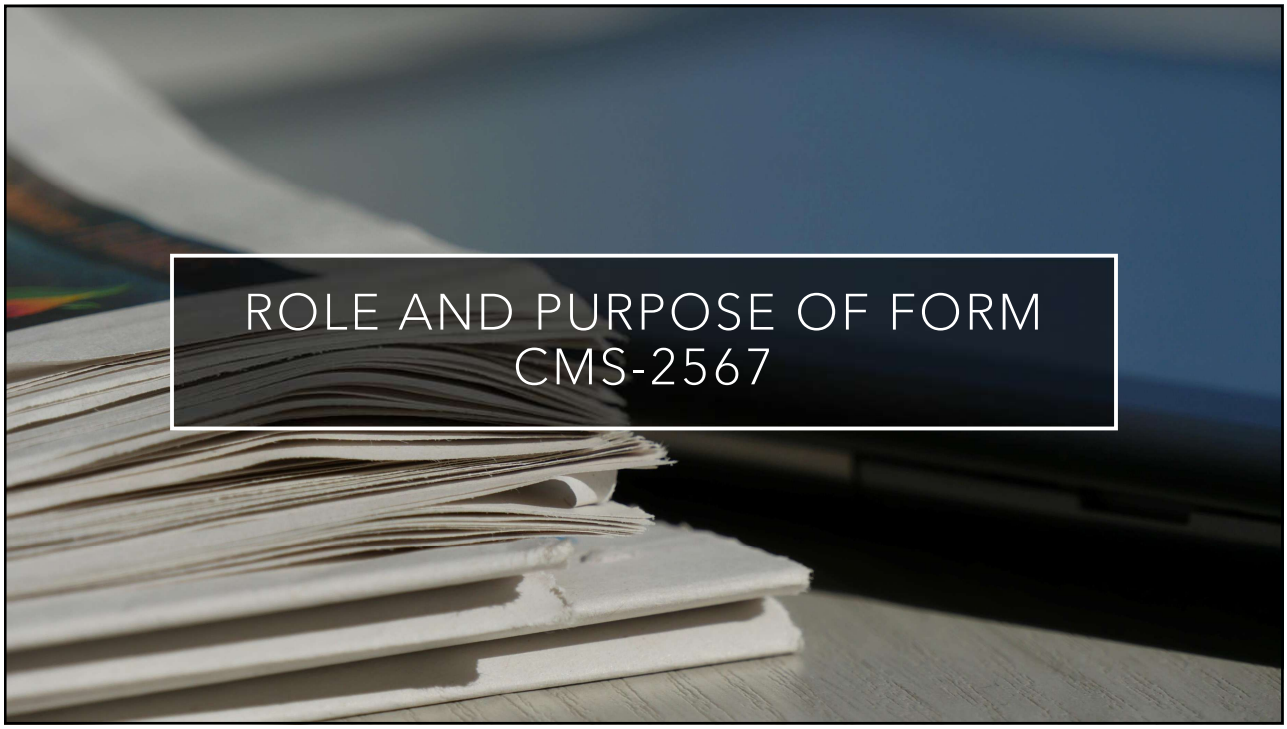

ROLE AND PURPOSE OF FORM CMS-2567

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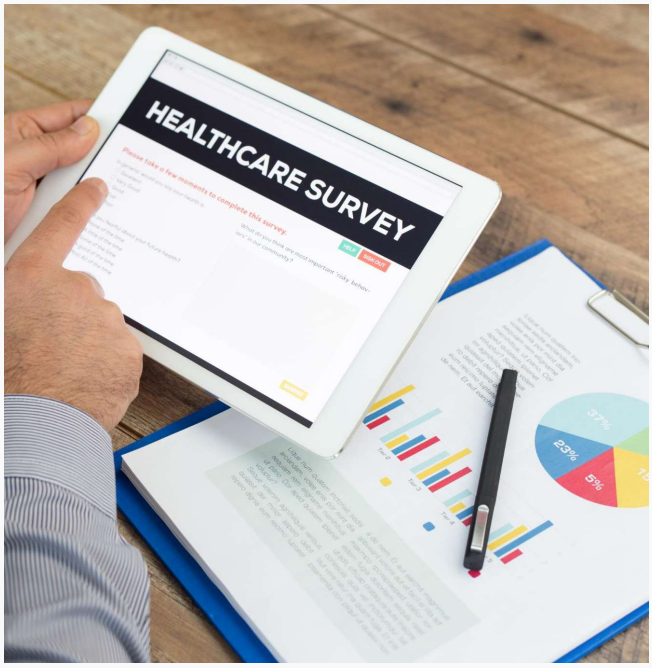

DEFINITION AND USE OF FORM CMS-2567 IN HEALTHCARE REGULATORY SURVEYS

Standardized Communication Tool

Form CMS-2567 is a standardized document used to communicate regulatory survey findings clearly and formally.

Healthcare Regulatory Surveys

The form summarizes results from surveys conducted at nursing homes, hospitals, and other Medicare and Medicaid providers.

Medicare and Medicaid Providers

It applies to facilities participating in Medicare and Medicaid, ensuring compliance with federal standards.

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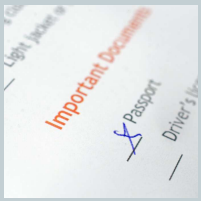
DOCUMENTATION OF DEFICIENCIES AND STRUCTURE OF THE FORM

Purpose of Documentation

The 2567 form provides written notice detailing deficiencies found during healthcare facility inspections.



Statement of Deficiencies (SOD)

SOD section records nature, regulatory citations, findings, and supporting evidence of each deficiency.

Plan of Correction (POC)

POC section outlines corrective actions, timelines, and compliance strategies to address deficiencies.

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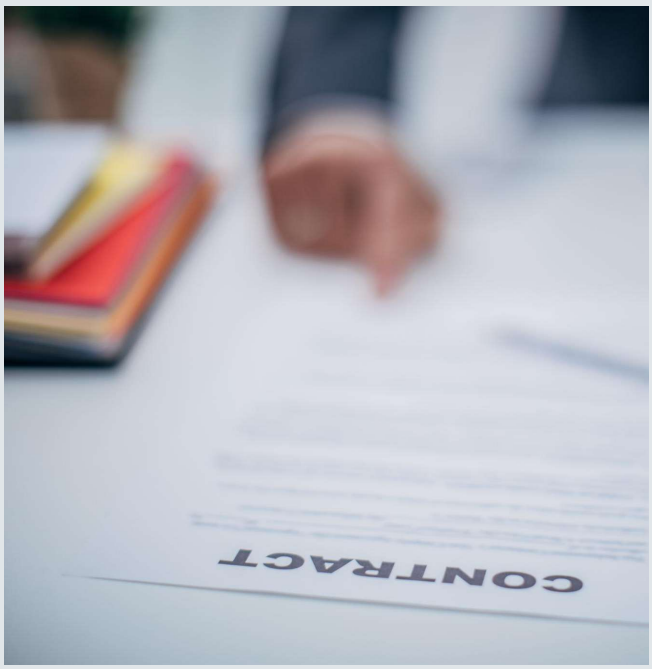

LEGAL STATUS AND PUBLIC ACCESSIBILITY OF THE COMPLETED FORM

Legal Document Status

The completed form 2567 is a legally binding document recognized by authorities.

Public Record Access

This form is part of the public record and accessible to residents, families, and stakeholders.

Quality and Compliance Transparency

The form provides transparency about facility quality and compliance for interested parties.

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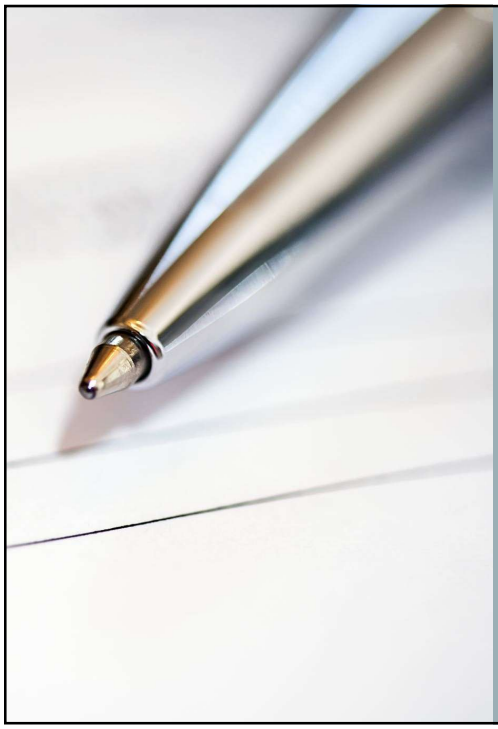

PROCESS INVOLVING FORM CMS-2567

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STEPS FOLLOWING A REGULATORY SURVEY AND DELIVERY OF THE 2567

Completion and Delivery of Form 2567

Surveyors complete the 2567 form documenting survey findings and deliver it to the facility promptly.

Facility Review and Response

The facility reviews the 2567 findings and prepares responses or plans addressing identified issues.

Compliance and Improvement Actions

Facilities implement corrective actions to meet regulatory standards and improve quality of care.

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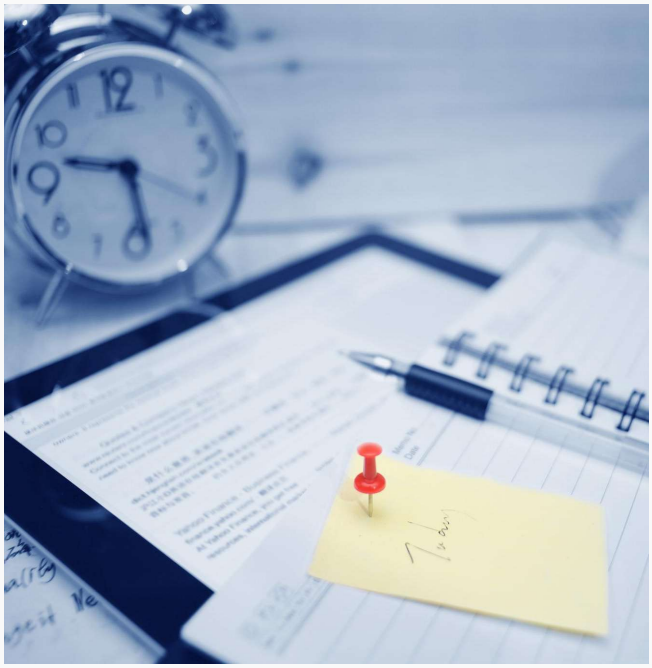

FACILITY RESPONSIBILITIES: REVIEWING FINDINGS, SUBMITTING CORRECTIONS, AND CHALLENGING DEFICIENCIES

Reviewing Findings

Facilities must carefully review all findings to understand deficiencies in detail.

Submitting Plan of Correction

An acceptable Plan of Correction must be submitted within a specific timeframe, typically 10 calendar days.

Challenging Deficiencies

Facilities may dispute deficiencies through an Informal Dispute Resolution (IDR) process if they disagree with findings.

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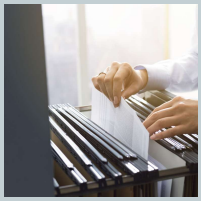
DEFINITION AND PURPOSE OF IDR IN CONTESTING DEFICIENCY FINDINGS

Meaning of IDR

Informal Dispute Resolution is a less formal administrative process used to contest deficiency findings.

Purpose of IDR

IDR provides an opportunity to present evidence and clarify misunderstandings about deficiencies.



Regulatory Challenge

Facilities can argue that a deficiency is unwarranted based on regulatory standards through IDR.

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KEY FEATURES: VOLUNTARY NATURE, SCOPE, EVIDENCE SUBMISSION, AND REVIEW PROCESS

Voluntary and Timely Initiation

Initiating an IDR is voluntary and must be requested within a short timeline, often 10 calendar days from receipt.

Limited Scope of IDR

IDR addresses only cited deficiencies and does not affect penalties or delay corrective actions unless specified.

Evidence Submission Process

Facilities may submit documentation or hold conferences to support their position during the IDR process.

Impartial Review and Outcome

An impartial reviewer examines submissions and may uphold, modify, or delete deficiencies, communicating findings in writing.

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BENEFITS AND LIMITATIONS OF THE IDR PROCESS

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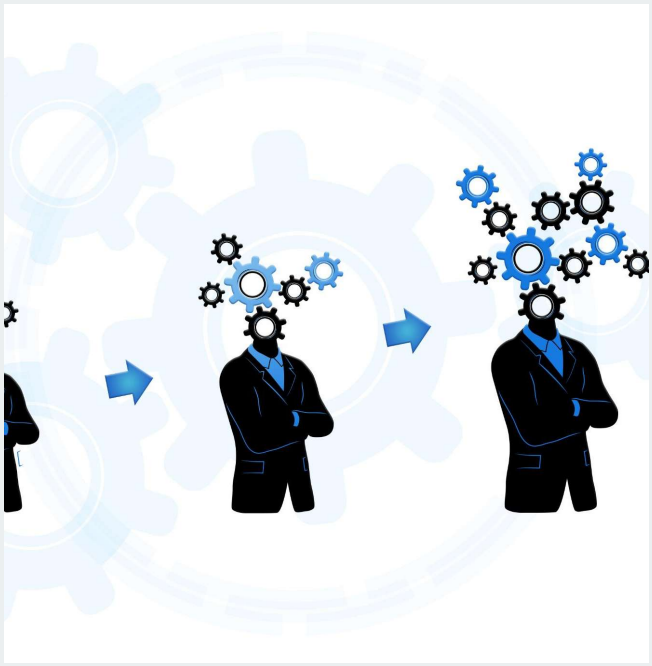

REQUIREMENT TO PROCEED WITH CORRECTIVE ACTIONS DURING IDR

No Delay in Enforcement

The IDR process does not delay enforcement or corrective actions required by the facility.

Plan of Correction Compliance

Facilities must continue implementing their Plan of Correction regardless of the IDR outcome unless deficiencies are resolved.

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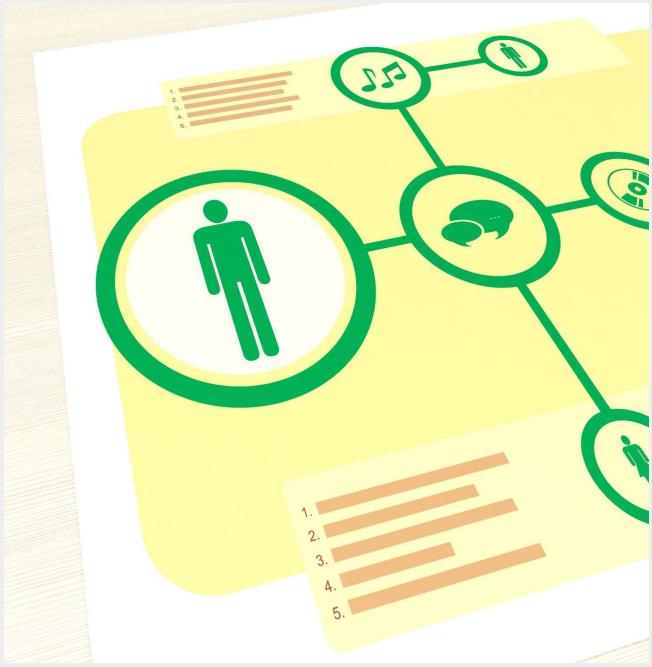

BENEFITS: FAIRNESS, POTENTIAL MODIFICATION OR REMOVAL OF DEFICIENCIES, AND REGULATORY INTEGRITY

Fair Contest Opportunity

Facilities receive a fair chance to contest survey findings and present their case effectively.

Modification or Removal of Deficiencies

Inaccurate or unsupported deficiencies may be removed or modified to ensure accuracy in evaluations.

Regulatory Integrity

Maintains the integrity and fairness of the regulatory process by addressing disputes transparently.

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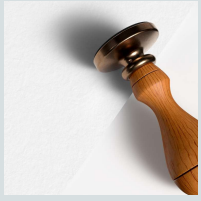
LIMITATIONS: SCOPE, ENFORCEMENT TIMELINES, AND FINALITY OF IDR OUTCOMES

Scope of IDR

IDR strictly covers survey findings and excludes penalties or civil monetary fines.

Enforcement Timelines

IDR does not delay enforcement timelines unless the identified deficiency is resolved.



Finality of Outcomes

IDR outcomes are final for survey cycles, but formal appeals may exist for enforcement actions.

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INTERRELATIONSHIP BETWEEN FORM CMS-2567 AND IDR

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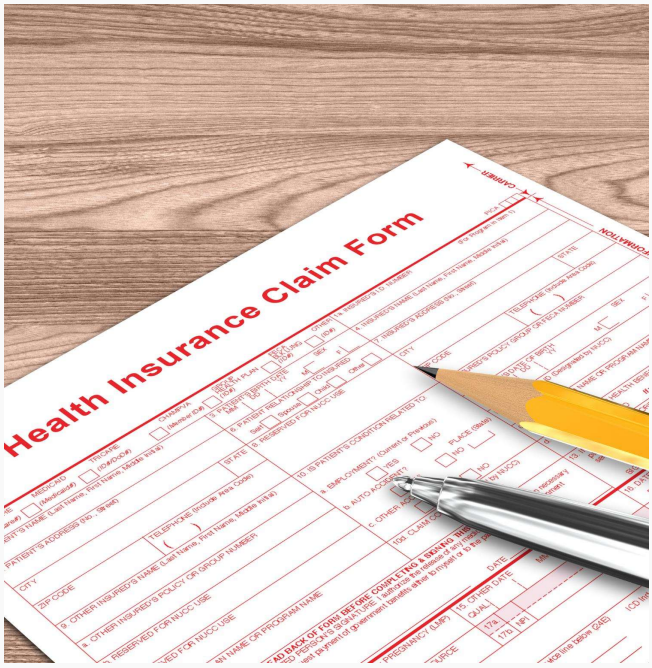

ELIGIBILITY OF DEFICIENCIES FOR IDR REVIEW AND FACILITY INITIATION

Deficiencies Eligible for IDR

All deficiencies listed on the 2567 form qualify for IDR review within regulatory scope and timeframe.

Facility Initiation of IDR

Facilities start the IDR process when they identify errors or lack of evidence in cited deficiencies.

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IMPACT OF IDR OUTCOMES ON THE OFFICIAL RECORD AND FACILITY COMPLIANCE STATUS

IDR Outcome Effects

IDR results can update the official record, changing the documented compliance details for a facility.

Facility Compliance Impact

Changes in the official record from IDR outcomes may alter the facility's compliance status and public profile.

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CONCLUSION

CMS-2567 Form Importance

CMS-2567 form documents survey findings critical for healthcare regulatory compliance and quality assurance.

Informal Dispute Resolution (IDR)

The IDR process provides facilities a formal way to dispute survey findings and improve compliance outcomes.

Navigating Surveys Successfully

Understanding CMS-2567 and IDR helps healthcare facilities effectively manage surveys and maintain quality care standards.

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SUMMARY

- All incidents should be taken seriously and quickly addressed
- Treat each incident as you would any immediate jeopardy situation.
- Conduct thorough investigations that will help you identify breakdowns in processes or systems and implement measures to correct them.
- Do formal internal plans of correction and retain documentation to show what corrections have been made.
- Keep a folder or binder for the state surveyors to show proof of meeting the criteria for past noncompliance.

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CONTACT INFORMATION

Sharon Eyster
Vice President of Operations/COO
717-303-1502
seyster@ucc-homes.org

Ann Patterson
Vice President of Health Services
443-587-8004
apatterson@broadmead.org

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REFERENCES

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- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter05-10.pdf

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