


**#212**  
**How to Submit a Successful Informal Dispute Resolution (IDR)**

Wisconsin Health Care Association  
 April 12, 2018 3:30pm to 4:30pm

By: Leah Killian-Smith, BA, NHA, RHIA, HSE  
 Director of Quality & Government Services

Consulting | Talent | Training | Resources




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**Purpose**

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To provide facilities, under certain circumstances, an additional opportunity to informally dispute cited deficiencies through a process that is independent from the State survey agency or, in the case of Federal surveys, the CMS Regional Office



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**Objectives**

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- Identify the key regulatory differences between an IDR and an IIDR
- Identify the key components of preparing a complete organized case for review
- Understand the process for MPRO reviewers that utilize making a recommendation to a state agency



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**Informal Dispute Resolution Process** Consulting | Talent | Training | Resources

- The IDR process provides nursing homes a single, informal opportunity to dispute survey findings subsequent to the receipt of the official statement of deficiencies (aka SOD or 2567)
- Federal certification regulations 42 CFR §488.31, requires that CMS and the state offer facility representatives an informal opportunity, at their request to dispute survey findings subsequent to the receipt of the official statement of deficiencies (SOD or 2567)
- If successful, the finding should be removed or modified and a revised 2567 will be issued

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**What Is It?** Consulting | Talent | Training | Resources

- The IDR Process may address:
  - Scope and severity of non-standard quality of care or IJ deficiencies
  - Remedies
  - Requirements of the Survey Process
  - Inconsistency of the survey teams in citations
  - Inadequacy or inaccuracy of the IDR process
- Details found in the SOM Chapter7
- CMS is the ultimate authority for the survey findings and imposition of CMPs

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**What is the IDR Process?** Consulting | Talent | Training | Resources

- Every state handles the IDR process differently
- Panel of experts, 3-7 person committee or panel that may include representatives from the agency, a trade association, a nursing home administrator, and/or DON
- Designated individual from the state agency
- Choice of state agency or independent MPRO facility will pay MPRO for IDR review

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**Eligibility for IDR** Consulting | Talent | Training | Resources

Situation	Eligibility for Informal Dispute Resolution
Continuation of same deficiency at revisit	Yes
New deficiency (i.e., new or changed facts, new tag) at revisit or as a result of an informal dispute resolution	Yes
New <i>instance</i> of deficiency (i.e., new facts, same tag) at revisit or as a result of an informal dispute resolution.	Yes
Different tag but same facts at revisit or as a result of an informal dispute resolution	No, unless the new tag constitutes substandard quality of care

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**Required Elements of an IDR** Consulting | Talent | Training | Resources

- Upon receipt of the 2567 facilities must be offered an informal opportunity to dispute deficiencies with the entity that conducted the survey
- Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process including the:
  - Scope and severity assessments of deficiencies with the exception of scope and severity assessments that constitute substandard quality of care of immediate jeopardy;
  - Remedies enforced 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 and
  - Alleged inadequacy or inaccuracy of the informal dispute resolution process

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**Notification** Consulting | Talent | Training | Resources

Notification process should inform the facility:

- That it may request the opportunity for informal dispute resolution, and that if it requests the opportunity, 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;
- Of the name, address, and telephone number of the person the facility must contact to request informal dispute resolution;
- How informal dispute resolution may be accomplished in that State, e.g., by telephone, in writing, or in a face-to-face meeting;
- Of the name and/or the position title of the person who will be conducting the informal dispute resolution, if known.

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**Appeals** Consulting | Talent | Training | Resources

**Two Different Surveys That can be Appealed:**

1. State and/or Federal Survey (happens every 9-15 months)
2. Complaint Surveys



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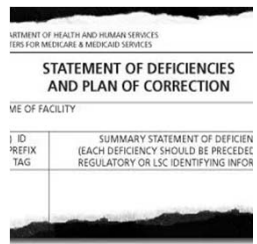
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**2567 Statement of Deficiencies** Consulting | Talent | Training | Resources

- State and Federal
- Enforcement
  - Deficiencies
  - Consequences
  - Remedies
- Plan of Correction
- Dispute and Appeal
  - Opportunity to defend practices
  - Offer evidence that may have been missed



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**New Survey Process** Consulting | Talent | Training | Resources

- Reform of Regulations – 11/28/17
- Renumbering of F-Tags
- Interpretive Guidance
- Responding During Survey
  - Communicate often to ensure surveyors have everything they need and have requested
  - Help locate information
  - Make copies – keep copies
- Immediate Action (Investigate and Document)

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### New Survey Process

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- Once the surveyors it is more difficult to eliminate deficiency or decrease scope and/or severity
- If brought to supervisor desk for clarification, they tend to lean toward higher scope and/or severity



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### Daily Check In & Exit

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- Check in daily during survey to obtain information and the pulse of the survey and the team
- Ask to meet with survey lead before formal exit so there are no surprises in front of residents and staff members



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### Surveyors Exit – Now What?

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- Start on POC immediately, don't wait for 2567
- Review Appendix PP, P, and Q for enforcement guidelines
  - What should we do?
  - Where did the deficiency come from?
- To offer more documentation/information
  - Call team lead, then supervisor
  - Provide written proof ASAP of your position

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## After 2567 Arrives

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- Review SOD thoroughly and include the IDT with SOM in hand for reference
- Copy previous submission and submit, things DO get lost
- Organize & highlight your documents as proof of care and services

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## Scope and Severity

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<b>Level 4</b> Immediate jeopardy to resident health or safety <small>*CMPs Required!</small>	<b>J</b> POC Category 1 Required Cat. 1 & 2 Optional	<b>K</b> POC Category 3 Required Cat. 1 & 2 Optional	<b>L</b> POC Category 3 Required Cat. 1 & 2 Optional
<b>Level 3</b> Actual harm that is not immediate	<b>G</b> POC Category 2 Required Cat. 1 Optional	<b>H</b> POC Category 2 Required Cat. 1 Optional	<b>I</b> POC Category 2 Required Cat. 1 & Temporary Management Optional
<b>Level 2</b> No actual harm with potential for more than minimal harm that is not immediate jeopardy	<b>D</b> POC Category 1 Required* Cat. 2 Optional	<b>E</b> POC Category 1 Required* Cat. 2 Optional	<b>F</b> POC Category 2 Required* Cat. 1 Optional
<b>Level 1</b> No actual harm with potential for minimal harm	<b>A</b> No POC No Remedies Not on 2567	<b>B</b> POC No Remedies	<b>C</b> POC No Remedies
	<b>Isolated</b>	<b>Pattern</b>	<b>Widespread</b>

\*Required only when imposing timely remedies instead of or in addition to termination  
   Substantial Compliance  
   SQC - Any deficiency in § 483.13, § 483.15, or § 483.25 that constitutes: immediate jeopardy; pattern or widespread actual harm that is not immediate jeopardy; or an actual harm with widespread potential for more than minimal harm that is not immediate jeopardy.

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## 10 Days to Appeal

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*Add a disclaimer to your POC*

**F000:**

- This plan of correction constitutes our written allegation of compliance for the deficiencies cited.
- Submission of this plan of correction is not an admission that the deficiency exists or that it is cited accurately. This plan of correction is submitted to meet state and federal requirements.

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**Remedies by Category** Consulting | Talent | Training | Resources

**Category 1**

- Directed Plan of Correction
- State Monitoring
- Directed In-Service Training



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**Remedies by Category** Consulting | Talent | Training | Resources

**Category 2**

- Denial of Payment – New Admissions
- Denial of Payment – All Individuals
- Imposed by CMS
- CMPs
  - ✓ \$50 - \$3,000/day
  - ✓ \$1,000 - \$10,000/instance



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**Remedies by Category** Consulting | Talent | Training | Resources

**Category 3**

- Temporary Management
- Termination of Certification
- Optional CMPs
  - ✓ \$3,050-\$10,000/day
  - ✓ \$1,000-\$10,000/instance



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**Appeal Issues** Consulting | Talent | Training | Resources

- Scope and Severity Matter in Appeals
- If you know there is obvious deficient practice and it will not be eliminated, ask for a decrease in scope and severity
- More successful



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**Plans of Correction** Consulting | Talent | Training | Resources

- EPOC
- Required
  - What do you do? We follow our policy
  - How did we correct for cited residents?
  - How do we identify other residents who may be affected?
  - How do we prevent recurrence?
  - How will we monitor for compliance?
  - Who is responsible?
  - Date of Correction?

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**Types of Appeals** Consulting | Talent | Training | Resources

- IDR – Informal Dispute Resolution
- IIDR – Independent Informal Dispute Resolution
- \*\*\*\*\*Must choose one or the other
- Formal Federal Appeal
- Facility State Complaint Division
  - Reconsideration & Appeal Hearings
  - \*\*\*Separate from IIDR & Federal Appeal
  - IDR for Complaint = Request for Reconsideration

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## How Do I Prepare?

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1. Review the citation
2. Review written documentation from state and/or federal surveyors
3. Review medical record of cited resident(s)
4. Organize records in a fashion all can read, find, and understand (Exhibit A, B, C, D, etc.)
5. Request clinician or practitioner involvement
6. Request to meet in person, not always granted but priceless if approved
7. Prepare staff and leaders for informal appeal

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## IDR

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### Informal Dispute Resolution

You may submit an informal appeal for deficiencies or correction orders that result from:

- State standard survey
- Federal survey
- Complaint investigation
- Follow-up survey or revisit
- VA Investigation



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## IDR Process

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- Timing
  - Within 10 days after 2567 is received
- Appeal to health department
  - Online, in writing, by telephone, or in person
  - Identify which tags are being appealed and why
- POC due within 10 days
- Who hears the appeal?
  - Another unit supervisor

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### IDR Process

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- Decision Process
  - Recommendations come from health department
  - Commissioner upholds or changes recommendation(s)
  - CMS has final decision



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### What is an IIDR?

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- Independent Informal Dispute Resolution
  - Reviewed by an Administrative Law Judge (ALJ)
  - Can be used to dispute any deficiency issued during standard survey or complaint
  - More formal – typically legal counsel is involved



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### IIDR Process

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- Appeal within 10 days of receiving the 2567
- Appeal in writing or online
  - What tags are you appealing and why?
- The 2567 is still due within 10 days even if you are appealing
  - Disclaimer is important to defend your practice

*Comment*



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## Who Hears Appeal?

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- Administrative Law Judge (ALJ)
  - Department of Health and provider present their cases
  - Submission in writing ahead of time is required
  - Exhibits, witnesses, opening and closing arguments are a part of process



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## Decision Process

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- Administrative Law Judge (ALJ) makes recommendations within ten days
- Commissioner upholds or changes the ALJ recommendations
- CMS always has final decision



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## Formal Federal Appeal

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- Timing – within 60 days after receipt of the 2567
  - If facility waives right to appeal within 60 days of CMS letter date (separate from 2567), CMPs may be reduced by up to 35%
  - Provider can still request IDR or IIDR
  - POC due within 10 days
  - Appeal to CMS
  - Federal law judge hears appeal
  - Decision is ALJ recommendation and then provider reimbursement review board makes final decision

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**Complaint Division Appeals** Consulting | Talent | Training | Resources

- Any complaint deficiency is subject to IDR or IIDR federal appeal process for F or K Tag cites
- For complaint division determination of maltreatment, neglect, abuse, or exploitation
  - Request within 15 days of report results
  - Appeal to division director
  - Director or Assistant Division Director/Manager of the health complaint division
  - Director makes decision to uphold or rescind findings or report after final hearing

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**Not Satisfied with Decision?** Consulting | Talent | Training | Resources

- Request a Fair Hearing
- Request within 30 days after
  - Receipt of decision of reconsideration
  - Denial of reconsideration request
  - Facility complaint division fails to act within 15 days
- Request to Commissioner of Human Services
  - Written request for hearing

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**Who Hears the Appeal?** Consulting | Talent | Training | Resources

- Department of Human Services Judge hears the appeal
- Decision Process
  - Determination is based on preponderance of evidence
  - Human Services Judge makes recommendation to health commissioner to either uphold or rescind findings or reconsideration hearing

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### Example

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**TO BE COMPLETED BY DQA STAFF**

Name - Facility: \_\_\_\_\_ Facility License No: \_\_\_\_\_

Mailing Address - Facility: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Event ID Number(s): \_\_\_\_\_

Was IU, SQC, Condition, or Request Standard cited?

Yes  No # If "Yes," list tag number(s): \_\_\_\_\_

DQA Regional Office Conducting the Survey

NEIRO (Green Bay)  NRO (Rhinelander)  SERO (Milwaukee)  SRO (Madison)  WRO (Eau Claire)

**TO BE COMPLETED BY PROVIDER**

Name - Contact Person: \_\_\_\_\_ Telephone No. - Contact Person: \_\_\_\_\_ Date SCO Received (MM/SS/yyyy): \_\_\_\_\_

Date Request Submitted (MM/SS/yyyy): \_\_\_\_\_ Type of Review Requested:  Telephone  Desk Review Will provider's legal counsel be involved in IDR process?  Yes  No

Enter the disputed federal and state tags or codes and the primary reason for requesting IDR (from the following list) in the space below. Enter only one reason for each tag / code. Facilities may not use the IDR process to challenge scope and severity assessments of deficiencies unless the scope and severity assessment constitutes Immediate Jeopardy (IJ) or Substandard Quality of Care (SQC).

01 Errors in Citation Details    02 Incorrect Scope (only if IU or SQC)    03 Incorrect Severity (only if IU or SQC)

04 Wrong Tag / Code    05 New Information Available    06 Code Interpretation

07 Other - Explain: \_\_\_\_\_

Tag / Code Scope and Severity	Reason for IDR	Tag / Code Scope and Severity	Reason for IDR

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### Citation

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- New Resident in past 8 hours
- Morbidly Obese
- Staff member double padded resident for night shift
- Resident put call bell on to be changed
- Staff member told resident they don't change people at night
- At 6am new CNA arrived
- Resident was tearful explaining how night staff member did not change her
- Facility cited with a G

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### Psychosocial Severity Guide

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**Severity Levels**

The following are *examples of severity* levels of negative psychosocial outcomes that *could have* developed, continued, or worsened as a result of a facility's noncompliance. This Guide is only to be used once the survey team has determined noncompliance at a regulatory requirement. The survey team must have established a connection between the noncompliance and a negative psychosocial outcome to the resident as evidenced by observations, record review, and/or interviews with residents, their representatives, and/or staff.

**Severity Level 4 Considerations: Immediate Jeopardy to Resident Health or Safety**

Immediate Jeopardy is a situation in which the facility'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*. Examples of negative psychosocial outcomes as a result of the facility's noncompliance *at severity level four* include, but are not limited to:

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**Level 4** Consulting | Talent | Training | Resources

- Suicidal ideation/thoughts and preoccupation (with a plan) or suicidal attempt (active or passive) such as trying to jump from a high place, throwing oneself down a flight of stairs, refusing to eat or drink in order to kill oneself.
- Engaging in self-injurious behavior that is likely to cause serious injury, harm, impairment, or death to the resident (e.g., banging head against wall).
- Sustained and intense crying, moaning, screaming, or combative behavior.
- Expressions (verbal and/or non-verbal) of severe, unrelenting, excruciating, and unrelieved pain; pain has become all-consuming and overwhelms the resident.
- Recurrent (i.e., more than isolated or fleeting) debilitating fear/anxiety that may be manifested as panic, immobilization, screaming, and/or extremely aggressive or agitated behavior(s) (e.g., trembling, cowering) in response to an identifiable situation (e.g., approach of a specific staff member).
- Ongoing, persistent expression of dehumanization or humiliation in response to an identifiable situation, that persists regardless of whether the precipitating event(s) has ceased and has resulted in a potentially life-threatening consequence.
- Expressions of anger at an intense and sustained level that has caused or is likely to cause serious injury, harm, impairment, or death to self or others.
- Extreme changes in social patterns, such as sustained isolation from staff, friends and family for a prolonged period of time.

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**Level 3** Consulting | Talent | Training | Resources

**Severity Level 3 Considerations: Actual Harm that is not Immediate Jeopardy**  
 Severity Level 3 indicates noncompliance that results in actual harm, and can include but may not be limited to clinical compromise, decline, or the resident's inability to maintain and/or reach his/her highest practicable well-being. Examples of negative psychosocial outcomes as a result of the facility's noncompliance at *severity level three* include, but are not limited to:

- Significant decline in former social patterns that does not rise to a level of immediate jeopardy.
- Persistent depressed mood that may be manifested by verbal and nonverbal symptoms such as:
  - Social withdrawal: *apathy*; irritability; anxiety; hopelessness; tearfulness; crying; moaning;
  - Loss of interest or ability to experience or feel pleasure nearly every day for much of the day;
  - Psychomotor agitation (e.g., inability to sit still, pacing, hand-wringing, or pulling or rubbing of the skin, clothing, or other objects), accompanied by a bothered or sad expression;
  - Psychomotor retardation (e.g., slowed speech, thinking, and body movements; increased pauses before answering);

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**Level 3** Consulting | Talent | Training | Resources

- Verbal agitation (e.g., repeated requests for help, groaning, sighing, or other repeated verbalizations), accompanied by sad facial expressions;
- Expressions of feelings of worthlessness or excessive guilt nearly every day (not merely self-reproach or guilt about being sick or needing care);
- Markedly diminished ability to think or concentrate;
- Recurrent thoughts of death (not just fear of dying) or statements without an intent to act (e.g., "I wish I were dead" or "my family would be better off without me").
- Expressions (verbal and/or non-verbal) of persistent pain or physical distress (e.g., itching, thirst) that has compromised the resident's functioning such as diminished level of participation in social interactions and/or ADLs, intermittent crying and moaning, weight loss and/or diminished appetite. Pain or physical distress has become a central focus of the resident's attention, but it is not all-consuming or overwhelming (as in Severity Level 4).

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**Level 3** Consulting | Talent | Training | Resources

- Chronic or recurrent fear/anxiety that has compromised the resident's well-being and that may be manifested as avoidance of the fear-inducing situation(s) or person(s); preoccupation with fear; resistance to care and/or social interaction; moderate aggressive or agitated behavior(s) related to fear; sleeplessness due to fear; and/or verbal expressions of fear. Expressions of fear/anxiety are not to the level of panic and immobilization (as in Severity Level 4).
- Ongoing, persistent feeling and/or expression of dehumanization or humiliation that persists regardless of whether the precipitating, dehumanizing event(s) or situation(s) has ceased. These feelings do not result in a life-threatening consequence.
- Sustained distress (e.g., agitation indicative of under stimulation as manifested by fidgeting; restlessness; repetitive verbalization of not knowing what to do, needing to go to work, and/or needing to find something).
- Anger that has caused aggression that could lead to injuring self or others. Verbal aggression can be manifested by threatening, screaming, or cursing; physical aggression can be manifested by self-directed responses or hitting, shoving, biting, and scratching others.

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**Level 2** Consulting | Talent | Training | Resources

**Severity Level 2 Considerations: No Actual Harm with Potential for More Than Minimal Harm that is Not Immediate Jeopardy**

Severity Level 2 indicates noncompliance that results in a resident outcome of no more than minimal discomfort and/or has the potential to compromise the resident's ability to maintain or reach his or her highest practicable level of well-being. The potential exists for greater harm to occur if interventions are not provided. Examples of negative psychosocial outcomes as a result of the facility's noncompliance *at severity level two* include but are not limited to:

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**Level 2** Consulting | Talent | Training | Resources

- Intermittent sadness, as reflected in facial expression and/or demeanor, tearfulness, crying, or verbal/vocal agitation (e.g., repeated requests for help, moaning, and sighing).
- Feelings and/or complaints of discomfort or moderate pain. The resident may be irritable and/or express discomfort.
- Fear/anxiety that may be manifested as expressions or signs of minimal discomfort (e.g., verbal expressions of fear/anxiety; pulling away from a feared object or situation) or has the potential, not yet realized, to compromise the resident's well-being.
- Feeling of shame or embarrassment without a loss of interest in the environment and the self.
- Complaints of boredom and/or reports that there is nothing to do, accompanied by expressions of periodic distress that do not result in maladaptive behaviors (e.g., verbal or physical aggression).
- Verbal or nonverbal expressions of anger that did not lead to harm to self or others.

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**Level 1** Consulting | Talent | Training | Resources

**Severity Level 1 Considerations: No Actual Harm with Potential for Minimal Harm**  
 Severity Level 1 is not an option because any facility practice that results in a reduction of psychosocial well-being diminishes the resident's quality of life. The deficiency is, therefore, at least a Severity Level 2 because it has the potential for more than minimal harm.

While the survey team may find negative psychosocial outcomes related to any of the regulations, the *following* areas may be more susceptible to a negative psychosocial outcome or contain a psychosocial element that may be greater in severity than the physical outcome.  
*Areas where the survey team may more likely see psychosocial outcomes when citing a particular deficiency include, but are not limited to:*

**483.10 Resident Rights**  
 F557, Respect, Dignity/Right to Have Personal Property;  
 F558, Reasonable Accommodation of Needs/Preferences;

**483.12 Freedom from Abuse, Neglect, and Exploitation**  
 F600 Free from Abuse and Neglect;  
 F602 Free from Misappropriation/Exploitation;

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According to CMS Pub. 100-7 State Operations Provider Certification, Appendix P Survey Protocols – Psychosocial Outcome Severity Guide it is apparent that our facility should not have been cited at an actual harm level. The information below will show. We believe a G level deficiency is a very serious citation and that this finding is not consistent with the information provided.

It is understood that Level 1 is not an option due to the nature of the complaint.

Looking at the Level 3 Considerations, which is actual harm that is not immediate jeopardy the findings are not consistent with the examples given for consideration.

- Actual harm is non-compliance that results in a negative outcome that has compromised the residents' ability to maintain and/or reach her practicable physical, mental, and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. This does not include a deficient practice that only could cause or has caused limited consequence to the resident.
- There is no evidence to support the finding that the resident experienced actual harm. The resident was in the building less than 24 hours so the ability to comprehensively assess the resident was not possible. The nursing assistant did not follow facility protocol and the nursing assistant was discharged from employment upon notification of the incident.

The considerations for citing actual harm are not consistent with the regulatory guidance:

- There is no evidence that there were verbal or nonverbal expressions of anger on the part of the staff member. There was evidence of not following the protocol and poor customer service.
- There is no evidence of a significant decline in former social patterns
- There is no evidence of a persistent depressed mood
- There is no evidence of expressions of persistent pain or physical distress
- There is no evidence of chronic or recurrent fear/anxiety that has compromised the resident

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- There is no evidence of ongoing, persistent feeling and/or expression of dehumanization or humiliation that persists
- There is no evidence of apathy and social disengagement
- There is no evidence of sustained distress
- There is no evidence of anger that has caused aggression that could lead to injuring self or others.

In reviewing the Level 2 Considerations: No actual harm with potential for minimal harm that is not immediate jeopardy it is apparent that the considerations are somewhat consistent with the findings in the 2567.

- There is no evidence that the resident had intermittent sadness. It is documented that the resident was tearful during her interview with the surveyor but not at any other time
- There is evidence of feelings and/or complaints of discomfort but not pain
- There is evidence of fear/anxiety by the verbal expression of the resident one time during the morning the nursing assistant talked to the resident about her needing incontinent assistance
- There is evidence of the resident being afraid to say something to the nursing assistant about her discomfort

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- There is no evidence of complaints of boredom, nothing to do, or expressions of periodic stress
- There is no evidence of verbal or non-verbal expressions of anger

Based on the information presented in the 2567 the evidence does not support a G level deficiency. The facility agrees that the nursing assistant did not follow protocol and that resulted in the resident not receiving the proper incontinence care.

Based on the evidence, the facility is requesting that the deficiency be reduced to a D level.

On the 2567 the resident stated the following:

"I am soaked from head to toe and need to be cleaned up"

"It was my first night here, so E3 worked nights, she put me to bed. She laid 4 or 5 incontinent pads on the bed and put two diapers on me." I said, "I don't need that many", "through the night I rang the bell and someone came in and turned it off around 2:30am. I fell back asleep. I had to really pee. I was woke up at 5:00am for a blood sugar testing. The nurse left. I put on the call light and no one came. I got myself up and sat at the foot of the bed. My bed was soaked, sheets and clothes. I'm on a water pill. I was trying to use the sheet to cover myself. I kept watching people go up and down the hall. E3 came in around 6am. I said, "I'm really wet and need to be changed."

"I was afraid to say something to her. She (E3) left and said she'd come back to clean me up."

"CNA's came in around 7am to clean me up, they came in together and said, "What's the matter?" I was afraid and starting crying. I felt safer then."

The above comments from the resident do not constitute harm. The staff members comments are not consistent with the findings and were opinions and not facts. The staff do require training on documentation and submitting facility reported incidents, as the facility staff member assumed the assumption and findings of the allegations and they were incorrect.

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**You Do Have Options!** Consulting | Talent | Training | Resources



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**Questions?** Consulting | Talent | Training | Resources

**Leah Killian-Smith, BA, NHA, RHIA, HSE**  
**Director of QA & Government Services**  
**Pathway Health, Inc.**  
**11240 Stillwater Blvd N. Lake Elmo, MN 55042**  
**651-407-8699**  
[Leah.smith@pathwayhealth.com](mailto:Leah.smith@pathwayhealth.com)

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**Resources/References** Consulting | Talent | Training | Resources

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