ENFORCEMENT ANALYSIS AND DETERMINATION CRITERIA ALS-03-007

DATE: March 17, 2003

ALS-03-007

TO: AL Regional Field Operations Supervisors
AL Licensing Specialists
AL Nurse Consultants
AL Regional Support Staff

FROM: Kevin Coughlin, Chief
Assisted Living Section

Ke Coughlin

SUBJECT: Enforcement Analysis and Determination Criteria

The Assisted Living Section enforcement specialist evaluates citations to determine which sanctions to impose, if any, and the amount of any forfeiture to be assessed. The enforcement specialist consults with the Office of Legal Counsel and administrative staff prior to revoking a license and as indicated depending on the scope and complexity of violations under review.

The enforcement analysis is based on the documentation and findings presented in the statement of deficiency.

The following factors are considered in determining whether enforcement action will occur, the sanction to be imposed, and the amount of any forfeiture.

1. The gravity of the violation, including the probability that death or serious physical or psychological harm to a resident will result or has resulted; the severity of the actual or potential harm; and the extent to which the provisions of the applicable statutes or rules were violated.

2. "Good faith" exercised by the licensee. Indications of good faith include, but are not limited to, awareness of the applicable statutes and regulation and reasonable diligence in complying with such requirements, prior accomplishments manifesting the licensee's desire to comply with the requirements, efforts to correct and any other mitigating factors in favor of the licensee.

3. Any previous violations committed by the licensee. Uncorrected and repeat violations.

4. The financial benefit to the facility of committing or continuing the violation.

5. Sanctions imposed for comparable violations in other facilities.

The enforcement analysis will take into account the extent and seriousness of the deficient practice. For example, the number of residents affected by the deficient practice and the degree of negative outcome or potential negative outcome, the period of time during which the violation occurred (hours, days, weeks), or the number of locations in which the deficient practice was identified.

Incidents "self-reported" by the licensee that result in violations represent "good faith" and are considered in the enforcement review.

APPEAL PROCESS

Assisted Living Section - Appeal Process

When enforcement action occurs as a result of violations issued in assisted living facilities, the facility is notified of the right to appeal as specified by Chapter 50, Wisconsin Statute. An explanation of the process for appealing a sanction must be included in the enforcement notice sent to the facility.

The facility must submit a written request for a hearing within ten days after receipt of the enforcement notification. The request for a hearing is sent to:

Division of Hearings and Appeals
P.O. Box 7875
Madison WI 53707-7875

The Department's Office of Legal Counsel (OLC) receives notification from the Division of Hearings and Appeals when a hearing has been requested. The research technician updates the enforcement database to include information regarding the status of an appeal. OLC notifies the Assisted Living research technician of hearing requests, stipulations, or hearing decisions. The research technician provides copies of all materials to the appropriate regional office.

Regional Office staff update the APIS assisted living database to include the status of appeals. The enforcement specialist sends a monthly enforcement report to Regional Field Operations Supervisors. The enforcement report includes current information about requests for appeals, hearing decisions, and settlements.

Generally, an OLC attorney will be assigned to represent the Department throughout the appeal process. The attorney will review the issued statement of deficiency (SOD) and other pertinent documents that were used as evidence of a violation. The attorney may consult with investigative staff, regional supervisors, and the enforcement specialist to prepare for hearing or discuss possible terms for settlement, if appropriate.

ENFORCEMENT RECORDS

Assisted Living Section – Enforcement Records
3/18/03

The following summarizes record maintenance/tracking for the Assisted Living Section enforcement review and decision-making processes.

Enforcement Specialist

- Summarizes deficiencies that result in enforcement action in *Enforcement Database (ACCESS).*

- Maintains a file of enforcement reviews and enforcement decisions for each provider.

  The file includes:

  - Written request for enforcement review (e-mail from regional office)
  - Copy of SOD
  - Summary of enforcement review and enforcement decision (e-mail to regional office)
  - other documents relating to the enforcement review, if any

- Publishes a monthly enforcement report

- Tracks timelines for review and completion of enforcement and submits a monthly report to Section Chief

Research Technician:

- Receives copies of all enforcement letters from the regional offices

- Compares enforcement action documented in enforcement letter to documentation entered in *Enforcement Database (ACCESS).* Ensures forfeiture amounts match. Maintains file of enforcement letters to track receipt of forfeiture payments, appeals, etc.

- Processes all forfeiture payments received to the State Treasurer. Documents forfeiture amount(s) received in *Enforcement Database.*

- Tracks timelines for forfeiture payments due and sends Notice of Overdue Forfeiture to facilities as appropriate. Provides regional office, Office of Legal Counsel and enforcement specialist with copies of all notices. If non-payment of forfeiture continues, notifies appropriate regional office and enforcement specialist to follow next steps identified in ALS memo #03-003.

ENFORCEMENT NOTIFICATION AND REFERRAL PROCEDURE ALS-03-009

CORRESPONDENCE/MEMORANDUM

Division of Supportive Livin

Bureau of Quality Assuranc

DATE: March 21, 2003

ALS-03-009

TO: AL Regional Field Operations Supervisors
AL Licensing Specialists
AL Nurse Consultants
AL Regional Support Staff

FROM: Kevin Coughlin, Chief
Assisted Living Section

SUBJECT: Enforcement Notification and Referral Procedure

The Bureau of Quality Assurance is committed to maintaining strong partnerships with other agencies representing individuals living in assisted living settings, such as program bureaus, county agencies, and advocates. The following describes a general procedure for notifying agency representatives about the status of regulatory activities in Community Based Residential Facilities (CBRF), Adult Family Homes (AFH), Residential Care Apartment Complexes (RCAC), and Adult Day Care Centers (ADC).

When citations are issued as a result of compliance surveys or complaint investigations, a Statement of Deficiency (SOD) is issued to providers by the regional office. Statements of Deficiency are sent by certified mail. When the regional office receives confirmation (via the certified mail green card) that the provider has received the SOD, a copy of the SOD, along with the letter of transmittal, is sent to the following interested parties:

- County Human Service Agency where the facility is located
- Resident's case manager (if county differs from the county in which the facility is located). Decisions to forward SODs to case managers are made by Regional Field Operations Supervisors based on survey findings.)
- Assistant Area Administrator, Office of Strategic Finance
- Care Management Organization (CMO) – Family Care Counties
- Ombudsman, if the facility serves individuals over age 60
- BQA - Health Services Section, certified AODA programs
- The program Bureau for the client population served
    - Bureau of Aging and Long Term Care Resources (BALTCR)
    - Bureau of Developmental Disability Services (BDDS)
    - Bureau of Community Mental Health (BCMH)/Bureau of Substance Abuse Services (BSAS)

On a monthly basis, the enforcement specialist produces and disseminates a current, quarterly enforcement report. The report is sent to several interested parties including:

- Division of Disability and Elder Services - Bureau Directors
- Assistant Area Administrators, Office of Strategic Finance
- Board on Aging and Long Term Care
- Community Integration Specialists

The enforcement specialist refers serious violations to the Medicaid Fraud Control Unit, Department of Justice, on a monthly basis.

TRAINING VIOLATIONS
ALS-03-002

CORRESPONDENCE/MEMORANDUM

Division of Supportive Livin

Bureau of Quality Assuranc

DATE: March 17, 2003

TO: AL Regional Field Operations Supervisors
AL Licensing Specialists
AL Nurse Consultants
AL Support Staff

ALS-03-002

FROM: Kevin Coughlin, Section Chief
Assisted Living Section

SUBJECT: Forfeiture Assessments for Violations of HFS Chapter 83 Staff Training Requirements

Staff training is essential to ensuring the health, safety, and welfare of residents in Community Based Residential Facilities (CBRFs). Statewide non-compliance with minimum training requirements has been a persistent problem in CBRFs and training violations are among the top citations issued over the past three years (2000-2002).

Forfeitures for training violations increased effective January 1, 2003 and a standard formula is applied. The standard formula provides general guidance; however, **forfeitures may vary depending on the scope of non-compliance and other factors documented in the statement of deficiency.**

Section HFS Chpt. 83.14 specifies the minimum training requirements for staff employed in CBRFs. When licensing specialists/nurse consultants determine that training requirements have not been met, a Statement of Deficiency (SOD) is issued. The citations are referred to the enforcement specialist for enforcement review.

Procedure

1. The licensing specialist/nurse consultant documents the training violation in ASPEN. For each untrained CBRF employee, the violation should include:
   - the employee's date of hire; and
   - evidence that the required training did not occur. If personnel records do not include training certificates, interview staff to verify that training requirements were not met.

(If training requirements for medication management or dietary services have not been met, include documentation to show that employees had responsibilities in these areas.)

2. The licensing specialist/nurse consultant or Regional Field Operations Supervisor refers the violation(s) for enforcement review to the enforcement specialist with the following information:
   - tags referred for forfeiture (e.g., 83.14(2));
   - Aspen survey report Event ID.

3. The enforcement specialist reviews the citation(s).
   - each training violation is assessed a forfeiture of $200 per untrained staff member identified;
   - second and subsequent citations are assessed at $400 per untrained staff member;
   - the maximum forfeiture per tag will be $1000.

Exception: Forfeiture assessments may vary depending on findings, resident outcomes, or other considerations.

SMOKE AND HEAT DETECTION SYSTEM
RCRS-02-01
DSL-BQA 02-001

CORRESPONDENCE/MEMORANDUM

Division of Supportive Living
Bureau of Quality Assurance

DATE: January 2, 2002

TO: Regional Field Operations Directors
Regional Field Operations Supervisor
Assistants to the Regional Field Operations Director
Licensing/Certification Specialists
Engineers

RCRS-02-01

FROM: La Vern Woodford, Chief
Resident Care Review Section
Bureau of Quality Assurance

SUBJECT: Interconnected Smoke and Heat Detection System Survey Procedure

Effective January 1, 2002, all Community Based Residential Facilities (CBRFs) shall have a fully interconnected smoke and heat detection system per NFPA, s. 50.035, Wis. Stats., and s. HFS 83.43, Wisconsin Administrative Code. Over the past several years, the department has received plans and fees for review of upgraded systems. Plans have been logged in and reviewed. In some cases, engineers have gone out to facilities and have done final inspections of the systems.

The engineers have developed a flow sheet that indicates the facility name, location, plan approval date, whether they have inspected the facility and whether the file is closed. If the file is closed, the plan review, letters, etc., will be transferred to the CBRF file.

Responsibility of the Licensing Specialists:

Offsite

- Review CBRF file and engineer flow sheet to determine what type of action to take at the facility during the survey.

Onsite:

1. **If the flow sheet indicates the engineer has inspected and the file is closed.**

    - Review inspection reports, if applicable, to determine if facility is in compliance with annual inspection, cleaning and testing (s. HFS 83.43(3)(b)1.); if the facility is in compliance for sensitivity testing (s. HFS 83.43(3)(b)2.); and if the facility is in compliance with quarterly testing (s. HFS 83.43(3)(a)).
    - Have facility staff in charge test the smoke detection system to verify that they know how the system works (s. HFS 83.42(3)(d)). Facility staff should inform the residents that it is only a test and they do not have to evacuate. Do not force the staff to try if they do not know how to test the equipment. Some systems are connected to the fire department or other monitoring facility and they would need to be informed first.

2. **The flow sheet indicates that there has been plan review and approval, but the engineer has not inspected or closed the file.**

- 83.43(3)(a)). Look at the inspection reports carefully to see if there are any comments about resident rooms with battery operated detectors, comments indicating problems, etc.
- Have facility staff in charge test the smoke detection system to verify that they know how the system works (s. HFS 83.42(3)(d)). Facility staff should inform the residents that it is only a test and they do nc have to evacuate. Do not force the staff to try if they do not know how to test the equipment. Some systems are connected to the fire department or other monitoring facility and they would need to be informed first. Pay special attention to those new areas that were required in January 1, 1997, i.e., bedrooms, rooms with lintels, heat detectors, etc.
- If the licensing specialist feels there is the probability that the system is not installed per Chapter HFS 83 or not updated at all, alert the RFOS or RFOD when onsite by telephone. The RFOD/RFOS will advise the licensing specialist on how to proceed and will inform the licensee.
- Give a copy of the Inspection/Testing form or NFPA 72 Inspection Certificate (see attached) and plan review letters, and any other documents related to inspection or installation of the system, to the engineer. The engineer will do the final inspection for compliance with Chapter HFS 83 and in accordance with plan review. Any problems noted by the engineer will be given to the licensing specialist and the licensing specialist will write up the deficiency and send to facility.

Decision Making/Enforcement:

- Issue deficiencies identified in any area related to the fire protection system.
- If the facility is not in compliance with the requirements concerning an interconnected smoke detection system as of January 1, 2002, issue a citation under s. HFS 83.43(4)(b)3. In addition, draft an enforcement letter indicating that we are assessing a per-day forfeiture from January 1, 2002, until the facility is in compliance with the smoke/heat detection system requirements. Forfeitures will range from $10 per day (facilities that are making good faith efforts to get into compliance) to $50 per day (facilities that have not done anything to get into compliance). Send the draft to Bob Huncosky for review and approval.

LW/KC/caa

cc: Sue Schroeder
Deb Bursinger
Jane Walters
Juan Flores
Jon Cechvala
Lynn Wallace
Jan Eakins
Lora Quinn
David Soens

Attachment

Information about Bureau of Quality Assurance (BQA)

BQA Web Pages

BQA Provider Training

BQA Numbered Memos

DHFS Forms

Wisconsin Nurse Aide Training and Registry Info

Caregiver Program/ Background Checks

Wisconsin Adult Programs Caregiver Misconduct Registry

If you have Complaints about Wisconsin Health Care

Applicable Codes Relating to Fire Protection Systems to Meet the January 1, 2002 Deadline

Introduction | Rules & Regulations | Forms | Providers | Contacts | What's Happening | Publications | Related Sites

Date: January 18, 2002 **DSL-BQA Memo 02-001**

To: Community Based Residential Facilities **CBRF 01**

From: La Vern Woodford, Chief, Resident Care Review Section

Via: Susan Schroeder, Director, Bureau of Quality Assurance

Introduction

This is the fifth in a series of BQA Memos that have been sent since 1996 regarding fire protection systems. (Previous memos: DSL-BQA Memo 00-036; DSL-BQA Memo 99-032; DSL-BQA Memo 97-033 (PDF); DSL-BQA Memo 96-044) By January 1, 2002, all Community Based Residential Facilities (CBRFs) must have an approved, fully interconnected, or radio-transmitting, fire protection system in all required locations.

This memorandum outlines fire protection system requirements for CBRFs that must be in place by January 1, 2002. Because these requirements are based on Wisconsin Statutes, Section 50.035, and on Wisconsin Administrative Code, Section HFS 83.43, no waivers or variances will be provided. CBRFs must be in compliance with the smoke detection, heat detection, and plan review submission described below by January 1, 2002. (Please note that the Chapter HFS 83 code references pertaining to these requirements have been in effect since November 1996.)

Smoke Detectors

1. Section HFS 83.43(4)(b)1. and 2. All CBRFs shall have at least one smoke detector in each of the following locations:

   a. At the head of every open stairway.

4. In an enclosed furnace room.
5. In an enclosed laundry room.

2) Section HFS 83.43(5)(b). CBRFs licensed before January 1, 1997, shall meet the requirements under par. (a) within five years after January, 1997, or when any smoke detector of the smoke detector system in the facility on January 1, 1997 needs replacement and new smoke detectors compatible with the smoke detection system currently in the CBRF are not available and a new smoke detection system needs to be installed, whichever comes first.

Interdepartmental Code

Please be advised that the Department of Health and Family Services, Wisconsin Administrative Code, Section HFS 83.42 and the Department of Commerce, Commercial Building Code COMM 51.24 **[updated to COMM 14]**, both have requirements concerning fire alarm system design, construction, inspection, testing, and maintenance referenced in the National Fire Protection Association (NFPA), Standard 72.

Plan Review

Section HFS 83.56(2). Plan Review. All construction plans for new CBRFs of any size and any additions to existing buildings shall be reviewed and approved by the Department before construction.

The Bureau considers the installation of new parts of the fire protection system to be an addition to the facility.

Any changes to the fire protection system require plan submittal and approval. For plan review assistance, please call (608) 267-1442 and reference forms DSL-2333 for CBRFs attached to health care facilities or DSL-2496 for freestanding CBRFs, or department web site at: http://www.dhfs.state.wi.us/rl_DSL/PlanReview/index.htm

Follow Sections HFS 83.56(2) and (3) for plan review submission and fee requirements.

Compliance with This Requirement

The department expects all CBRFs to have an approved, fully interconnected, or radio-transmitting, fire protection system in all required locations by January 1, 2002. Any facility found not to be in compliance will be cited and issued a statement of deficiency. In accordance with Wis. Stat., sec. 50.03(5g)(c)1, a *daily* forfeiture will be assessed from January 1, 2002, until the facility is in compliance. Forfeitures will range from $10 *per day* (facilities that are making good faith efforts to get into compliance) to $50 *per day* (facilities that have not done anything to get into compliance)

HOT WATER TEMPERATURES
DSL-BQA 98-020
DSL-BQA 97-047
DSL-BQA 98-021

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Hot-Water Temperatures - Update

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Date: June 3, 1998 **DSL-BQA 98-020**

To: Community Based Residential Facilities **CBRF-06 Updates DSL-BQA-97-047**

From: Judy Fryback, Director, Bureau of Quality Assurance

In November 1997, we mailed DSL-BQA-97-047 advising all community-based residential facilities of the requirements for hot-water temperatures found in section HFS 83.41(5)(d)2, Wis. Administrative Code. This code states,

"The temperature of water at fixtures in showers and tubs used by residents shall be automatically regulated by valves and may not exceed 110 degrees Fahrenheit, except for Community Based Residential Facilities (CBRFs) exclusively serving residents recovering from alcohol or drug dependency or clients of a governmental corrections agency."

In addition, we noted that similar temperatures should be found at sinks used by residents, pursuant to the requirements in sec. HFS 83.21(4)(w), Wis. Admin. Code. This code requires the CBRF to provide a

"safe environment…The CBRF shall safe-guard residents who cannot fully guard themselves from an environmental hazard to which it is likely that they would be exposed, including both conditions which would be hazardous to anyone, and conditions which are hazardous to the resident because of the resident's condition or handicap."

From March through May 1998, the Bureau of Quality Assurance cited and assessed forfeitures against 33 CBRFs for hot water temperatures that ranged between 130-160 degrees F. At these temperatures, severe, full-thickness scalding that causes irreversible second and third-degree burns can occur in 1 to 30 seconds. At 140 degrees, first-degree burns can occur in less than 2 seconds. Too-hot water may be particularly dangerous for the elderly and handicapped who may have

2. Install a shower valve at each shower used by residents that complies with the intent of the "fail safe" system. The Department of Commerce has currently approved one such valve – the Chicago 2500 TempShield Tub and Shower faucet valve. This valve controls water temperatures at the tub and shower and shuts off the water if the temperature exceeds 110 degrees. It does not control water temperatures at the sinks and there is not an approved counterpart for installation at the sink. Another method will be required to control water temperatures at the sinks.

3. Install a faucet with an adjustable hot-limit safety stop at each sink used by residents. Safety stops keep water at the faucets at a pre-set temperature by blending the amount of cold and hot water. If the water heater malfunctions, however, and heats the water even higher than where it had been set, a safety stop will still continue blending the same amount of hot and cold water. As a result, water temperatures at the faucet will be hotter than what is expected and burns could occur.

4. Install, at each sink, shower, and tub used by residents, a temperature-actuated flow reduction valve. Depending on the faucet, these valves cost between $6 and $30 and can be easily retrofitted onto each shower, tub, and sink fixture. These valves reduce the flow of water to a trickle when the water temperature is approximately 115 degrees F. or above. We cannot recommend brand names; however, such valves are available at local plumbing or hardware stores. Because we do not have experience with the reliability of these valves, we suggest that you monitor the temperature of water coming from faucets on which these devices have been installed. In addition, these devices only limit the hot-water temperature to approximately 115 degrees F. Facilities using this option on tubs and showers will need to request a waiver of the 110-degree hot water requirement for tubs and showers.

To maintain compliance with HFS 83.41(5)(d) 2 and HFS 83.21(4)(w), Wis. Administrative Code, we ask that you:

- Routinely check the temperature of water at various fixtures used by residents;
- Take appropriate responsive action if the temperature is above 110 degrees; and
- Regularly clean the mixing valve(s) because liming from the mineral deposits found in water may eventually cause mixing valves to malfunction.

If you have questions, please contact the Regional Field Operations Director to whom your facility is assigned. Their names and phone numbers are [via Regional Offices]:

DATE: November 17, 1997 DSL-BQA-97-047

TO: Community Based Residential Facilities CBRF 18

FROM: Judy Fryback, Director
Bureau of Quality Assurance

Water Temperatures

This memorandum serves to alert you to the dangers of hot water temperatures and to remind you of the HFS 83 requirements for water temperatures.

Section HFS 83.41(5)(d)2., Wisconsin Administrative Code, states: "The temperature of water at fixtures in showers and tubs used by residents shall be automatically regulated by valves and may not exceed 110 degrees Fahrenheit, except for Community Based Residential Facilities (CBRFs) exclusively serving residents recovering from alcohol or drug dependency or clients of a governmental corrections agency."

It has come to our attention that in many CBRFs, the water temperatures at tubs and showers are consistently found to be above the required 110 degrees Fahrenheit. This appears to be due to the fact that mixing valves have not been routinely installed on the domestic water heaters that are being used. Facilities that have mixing valves, but which are located in areas where the water is hard, may be experiencing a lime build-up on the valves. In these cases, continuous maintenance is needed to keep the valves functioning properly.

Water that is too hot may scald individuals who are exposed to it. This danger is particularly great for the elderly and handicapped, who can have circulatory or other neurological disabilities that prevent the instantaneous recoil from too-hot water. Full-thickness scalding causes irreversible second and third degree burns in which the skin blisters and swells; it does not return to normal but forms scar tissue on healing. Full-thickness scalding occurs at the following rates at the following temperatures on normal skin, and even faster on skin that has been compromised:

110 degrees Fahrenheit	13 minutes
120 degrees Fahrenheit	10 minutes
125 degrees Fahrenheit	2 minutes
127 degrees Fahrenheit	1 minute
130 degrees Fahrenheit	30 seconds
140 degrees Fahrenheit	6 seconds
158 degrees Fahrenheit	1 second

Although the temperature at tubs and showers is to be 110 degrees Fahrenheit, section HFS 83.41(5)(d)2. requires the water temperature at the water heater to be at least 125 degrees but no more than 130 degrees. Temperatures in this range are required to prevent the growth of Legionella Bacteria, which causes Legionnaire's disease.

The temperature setting of other water heaters, such as those connected to dishwashers and clothes washing machines may exceed these temperatures. Facilities that are served entirely by one water heater may need to install a booster heater at the dishwasher or washing machine to have water that is hot enough at these points.

Licensing specialists will be checking hot water temperatures at showers and tubs to verify that they do not exceed 110 degrees Fahrenheit. They will also check the temperature at the water heater itself to verify that the water at the heater is between 125 and 130 degrees Fahrenheit. If either of these requirements are not met, they will issue a citation under section HFS 83.41(5)(d)2.

Additionally, if the water temperature at any sink that is accessible to residents is found to exceed 110 degrees Fahrenheit, a citation may be issued under section HFS 83.21(4)(w). This code states that each resident has the right

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Hot-Water Temperatures

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DATE: June 5, 1998 **DSL-BQA 98-021**

TO: Adult Family Homes **AFH 03**

FROM: Judy Fryback, Director, Bureau of Quality Assurance

HFS 88.10(3)(L), Wisconsin Administrative Code, states that persons residing in adult family homes have the right to

"...a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or handicap."

One of the dangers to which residents might be exposed is water that is too hot. The elderly and individuals with mental and physical handicaps may have neurological conditions that prevent instant recoil from hot water. Because they do not instantly react to water that is too hot, they are particularly at

120 is obtained. The down side of this option is that a water temperature of 140 degrees F. **at the hot water heater** is recommended to kill any Legionella bacteria that are in the water system.

- Installing a thermostatic mixing valve on the cold and hot water lines that lead from the water heater to the fixtures. A thermostatic mixing valve tempers the water such that water temperature will not exceed the temperature at which the thermostat is set. The mixing valve will control the water temperature at sinks, tubs, and showers served by the water line.

  Because a thermostatic valve will allow hot or cold water to continue flowing if it fails, adult family homes may, in addition, choose to install a "fail safe" valve between the mixing valve and the faucets to which the water line is leading. Generally, these are solenoid-actuated valves that shut down the hot water supply to the shower or tub (or sink) if the water exceeds 110 degrees. Although these valves are generally quite expensive, they are they only way to guarantee that unsafe water will not reach any of the faucets served by the water line. However, neither HFS 88, Wis. Administrative Code, nor the state plumbing code requires this type of valve in a non-health care facility.

  The size of your piping and the manufacturer model design both affect the cost of a thermostatic mixing valve and a fail-safe valve. If you purchase a thermostatic mixing valve or a thermostatic mixing valve and a fail-safe valve, we urge you to shop around. We have heard that estimates may vary greatly.

a trickle when the water temperature is approximately 115 degrees F. or above. We cannot recommend brand names; however, such valves are available at local plumbing or hardware stores. Because we do not have experience with the reliability of these valves, we suggest that you monitor the temperature of water coming from faucets on which these devices have been installed.

If you have questions, please contact the Regional Field Operations Director assigned to your home. Their names and phone numbers are [in Regional Offices].

Last Revised: *February 12, 2003*

ISSUING THE NOTICE OF ENFORCEMENT
ALS-03-010

CORRESPONDENCE/MEMORANDUM

Division of Supportive Living

Bureau of Quality Assurance

DRAFT

DATE: March 18, 2003

TO: AL Regional Field Operations Supervisors
AL Licensing Specialists
AL Nurse Consultants
AL Support Staff

ALS-03-010

FROM: Kevin Coughlin, Chief
Assisted Living Section

SUBJECT: Issuing Enforcement Notices

This memorandum outlines procedures for issuing enforcement notices to Adult Family Homes (AFH) and Community Based Residential Facilities (CBRF).

1. Based on deficiencies referred by regional office staff, the enforcement specialist notifies the Regional Field Operations Supervisor (RFOS) of enforcement determinations within 14 days.

2. Regional Office staff complete the appropriate enforcement notice (samples attached.).

3. As a general practice, enforcement notices are sent to providers, by certified mail, with the original related Statement of Deficiency (SOD).

4. The regional office maintains a copy of the enforcement notice and transmits a copy of the notice to central office (research technician).

5. The enforcement specialist and/or the Office of Legal Counsel may be contacted to review enforcement notices for serious violations, such as those resulting in revocation or conditions to a license.

6. Enforcement notices for overdue forfeitures are completed by the central office research technician. Refer to ALS memo #03-003.

KC/LT/caa

cc: Susan Schroeder
Otis Woods
Atty. Jesse Garza, OLC
Laurie Arkens

Attachments:
- CBRF Enforcement Notice (template)
- AFH Enforcement Notice (template)

OVERDUE FORFEITURE PAYMENTS
ALS-03-003

CORRESPONDENCE/MEMORANDUM

Division of Supportive Living
Bureau of Quality Assurance

DATE: March 17, 2003

TO: AL Regional Field Operations Supervisors
AL Licensing Specialists
AL Nurse Consultants
AL Support Staff

ALS-03-003

FROM: Kevin Coughlin, Chief
Assisted Living Section

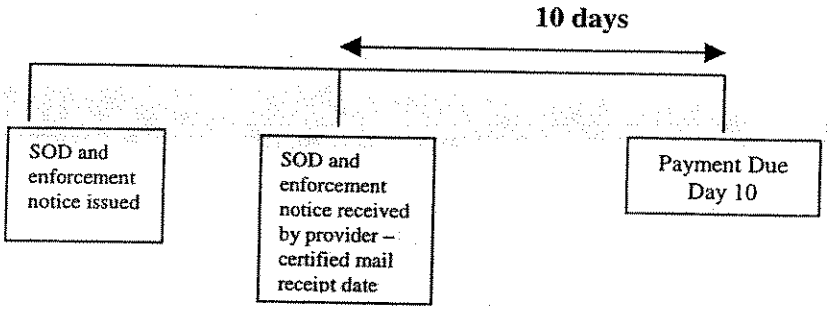
SUBJECT: Overdue Forfeiture Payment

This memorandum outlines the procedure for assessing fines for Community Based Residential Facilities (CBRFs) with overdue forfeiture payments.

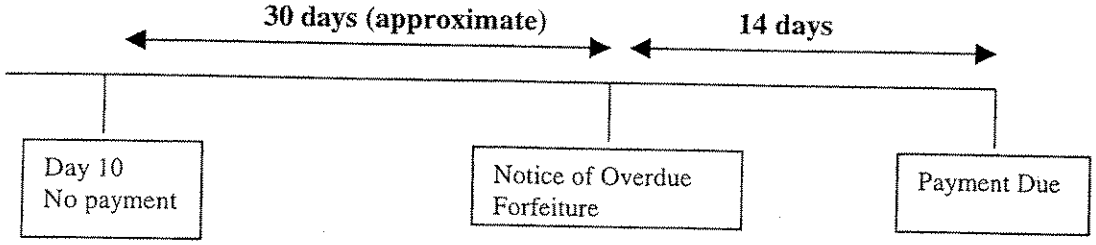
Section 50.03(5g)(c)1.c., Wis. Stats., requires that CBRFs submit forfeiture payments within 10 days after receiving notice of a forfeiture assessment or, if the forfeiture is appealed, within 10 days of the final appeal decision.

Procedure:

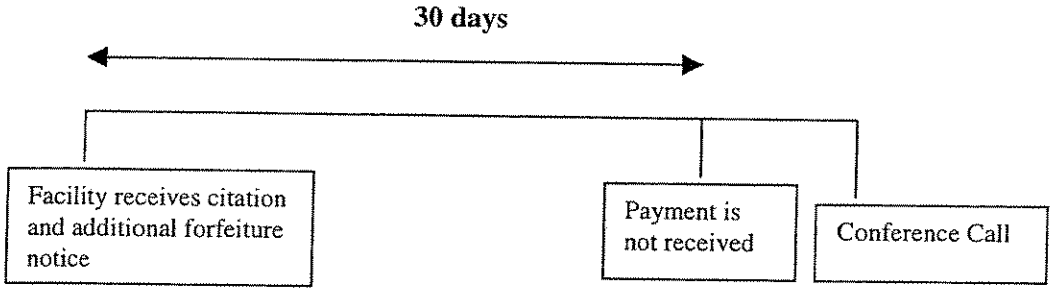
1. An initial notice of forfeiture is sent to the CBRF licensee from the regional office (RO), by certified mail, with the Statement of Deficiency (SOD).



2. If a forfeiture payment is overdue and has not been appealed, a "Notice of Overdue Forfeiture" is sent to the licensee from the Bureau of Quality Assurance (BQA) central office via certified mail. The "Notice of Overdue Forfeiture" is sent within approximately 30 days of the forfeiture payment due date. See attached sample notice, "Notice of Overdue Forfeiture." The overdue notice provides the facility with a specific date to pay the outstanding forfeiture. [14 calendar days from the date of the "Notice of Overdue Forfeiture".]



5. If the facility does not pay the initial and overdue forfeitures within 30 days of receipt of the citation, a conference call will be scheduled with the forfeiture specialist and office of legal counsel to discuss recourse, such as referral to collections, license revocation, or other action.



Attachments: Sample "Notice of Overdue Forfeiture"
Sample "Notice of Forfeiture"
Sample Citation
Flowchart

cc: Susan Schroeder
Otis Woods
Jesse Garza
Laurie Arkens

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin
Department of Health and Family Services

DIVISION OF SUPPORTIVE LIVING

BUREAU OF QUALITY ASSURANCE
1 WEST WILSON STREET
P O BOX 2969
MADISON WI 53701-2969

Telephone: 608-266-8481
FAX: 608-267-0352
TTY: 608-266-7376
www.dhfs.state.wi.us

February 24, 2003

Marla Costello
2711 W. Howard Street
Chicago IL 60645-1303

NOTICE OF OVERDUE FORFEITURE
Certified Mail #7001 2510 0005 8620 9846

Re: Hampton Supportive Care

S A M P L E

Dear Ms. Costello:

On October 14 2002, the Department of Health and Family Services assessed a forfeiture of **$5760** against Hampton Supportive Care for violation of §§ HFS 83.15(1)(a), HFS 83.41(2)(c) and HFS 83.43(1), Wis. Administrative Code. This action was taken pursuant to sub. 50.03(5g)(c)1, Wisconsin Statutes. At that time, we advised you that you had ten days to either appeal the forfeiture assessment or to pay it. On November 4, 2002, we received check number 7078 in the amount of $1530 along with correspondence from you indicating you were appealing § HFS 83.15(1)(a) and the corresponding $4230 forfeiture. However, according to our records, and the records at the Division of Hearings and Appeals, Hampton Supportive Care did not appeal the remaining $4230 forfeiture assessment. As a result, payment of the forfeiture is overdue.

Please remit payment of this **$4230** forfeiture by sending a check to:

Colette Anderson
DHFS/DDES/BQA/Assisted Living
P.O. Box 2969
Madison WI 53701-2969

The check should be made out to "Department of Health and Family Services" (for deposit in the state School Fund). If we do not receive payment of this forfeiture **by March 10, 2003,** we may take one or more of the following action(s):

- Issue a citation for failing to comply with § 50.03(5g)(c)1.c., Wis. Stats., for failing to pay or appeal a notice of forfeiture within 10 days as required by statute. Along with this citation, we have the legal authority to assess a forfeiture of $10/day for each day your facility fails to pay its overdue forfeiture and remains out of compliance with § 50.03(5g)(c)1.c., Wis. Stats.
- Refer collection of the forfeiture to a collection agency and/or to the Office of the Attorney General.
- Refuse to renew or to revoke your license for violating the law or administrative rules governing community based residential facilities.

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF SUPPORTIVE LIVING

BUREAU OF QUALITY ASSURANCE
1 WEST WILSON STREET
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Telephone: 608-266-8481
FAX: 608-267-0352
TTY: 608-266-7376
www.dhfs.state.wi.us

CERTIFIED MAIL
Cert. Card #
SOD #

NOTICE OF FORFEITURE

Dear :

On , a file review of your facility was conducted by the Division of Disability and Elder Services (DDES), Bureau of Quality Assurance, to determine if your facility was in compliance with Chapter HFS 83, the Wisconsin Administrative Code governing community based residential facilities (CBRFs).

Your Statement of Deficiency is enclosed. Sign and date the **original** Statement of Deficiency and return within ten days of receipt of this letter to:

Please note that §HFS 83.07(14)(a) requires that the facility shall immediately post (next to the CBRF license) any citation of deficiency, notice of revocation, notice of non-renewal and any other notice of enforcement action initiated by the Department on forms and in correspondence received from the Department. Citations of deficiencies shall remain posted for 30 days following receipt by the facility, or until compliance is achieved, whichever is longer. Notices of revocation, non-renewal, and other notices of enforcement action shall remain posted until a final determination is made.

The Department has determined that you violated §50.03(5g)(c)1.c., as outlined in the enclosed Statement of Deficiency (SOD #). Therefore, pursuant to the authority of §50.03(5g), Wis. Stats., **IT IS HEREBY ORDERED** that you are assessed a forfeiture, for the violations set forth herein, in the amount of $, based on the forfeiture totals listed below.

Chapter HFS 83 Code	Forfeiture Amount
	$. Original forfeiture assessed for SOD #
	$. Non-payment of forfeiture assessed at $10/day from to . **This forfeiture will continue to accrue at $10/day until the date of postmark on your payment envelope.**
TOTAL FORFEITURE TO DATE	$

Sample Citation Text – Attachment ALS-03-003

Text for Citation: 50.03(5g)(c)1.c. Cite under 9999 – ASPEN. Enter as a new survey.

50.03(5g)(c)1.c. All forfeitures shall be paid to the department within 10 days after receipt of notice of assessment or, if the forfeiture is contested under par. (f), within 10 days after receipt of the final decision after exhaustion of administrative review, unless the final decision is appealed and the order is stayed by court order under s. 50.03(11). The department shall remit all forfeitures paid under this subdivision to the state treasurer for deposit in the school fund.

This requirement was NOT MET as evidenced by:

Based on record review, the facility did not pay forfeitures to the department within 10 days after receipt of the notice of assessment. On [date], the facility was assessed a forfeiture in the amount of [forfeiture amount]. As of [date], the licensee has not paid the forfeiture and the payment is [000] days overdue.

Findings include:

On [date] a licensing visit was conducted by licensing specialist [number]. Violations were identified and a statement of deficiency [SOD number] was issued on [date]. Forfeitures were assessed for the following violations:

[chapter 83 code]	[forfeiture amount]
[repeat]	[repeat]

A notice of assessed forfeitures was sent to the facility on [date] by certified mail indicating that payment was due in 10 days.

On [date], the Bureau of Quality Assurance sent the licensee a notice that the forfeiture payment was overdue and payment was to be remitted no later than [date].

As of [date of this violation], the licensee has not paid the forfeiture.

[Note: if there was an appeal, that information and relevant dates should be included. Any other pertinent details should also be included, such as dates of phone calls to the licensee, if any.]

LICENSE RENEWAL LATE FEES
ALS-03-004

CORRESPONDENCE/MEMORANDUM

Division of Supportive Living

Bureau of Quality Assurance

DATE: March 17, 2003

TO: AL Regional Field Operations Supervisors
AL Licensing Specialists
AL Nurse Consultants
AL Support Staff

ALS-03-004

FROM: Kevin Coughlin, Chief
Assisted Living Section

SUBJECT: CBRF License Renewal Late Fees

This memorandum outlines a procedure for issuing license continuation late fees for Community Based Residential Facilities (CBRF).

Procedure:

1. The **license continuation fee and biennial license report** are due 30 days prior to the expiration of the biennial licensing period. The regional office sends a notice to the CBRF 60 days in advance of the license continuation date indicating the date payment is due (see attached sample "License Continuation" notice). Refer to Wis. Stats. 50.037(2)(c).

2. If the license continuation fee and application form are not received by the **end of the licensing period**, the regional office sends the licensee a late fee notice. The notice informs the licensee that revocation may occur within 30 days if license fees and late fees are not paid immediately. (see sample attached "Warning-Past Due Fee Payment and/or Application".)

Note: The issuance of a late fee is required by Section 50.037(2)(c), Wis. Stats., which states that facilities "shall pay an additional fee of $10 per day for every day after the deadline that the facility does not pay the fee." The late fee is not a forfeiture and is not subject to appeal. Payment is made to the Division of Supportive Living, not to the State Treasurer for deposit in the school fund.

3. The late fee is $10 per day from the **payment due date** to the date of the postmark on the payment envelope.

Example:

Licensure period:	September 1, 2001 to September 1, 2003
License Continuation notice is sent by region:	July 1, 2003
Payment due date:	August 1, 2003 (day zero)
Late fee (sent after September 1, 2003):	$10/day from August 2, 2003 (August 1 is "day zero") to the postmark date on the payment envelope. (The facility must calculate the total late payment based on the mailing date of the payment envelope.)
Total Due:	**License continuation fee and late fee.**

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin
Department of Health and Family Services

Division of Disability and Elder Services
SOUTHEASTERN REGIONAL OFFICE

819 North 6th Street
Room 210
Milwaukee, WI 53203
Fax: (414) 227-3903
Phone: (414) 227-2005

Facility ID
Facility Type
Facility Class
Licensor
Facility County

TO: Facility Contact
Facility Address
City, State, Zip

FROM: Regional Field Operations Supervisor
Division of Disability and Elder Services
Bureau of Quality Assurance

RE: **LICENSE CONTINUATION**

According to our records, your license is scheduled for review by the license continuation date listed below. Please complete the enclosed application according to the instructions. **Completed biennial applications and biennial license fees must be submitted to the Regional Office no later than the payment due date listed below.**

Pursuant to Wis. Stat. s.50.037(2)(c), a late fee of $10 per day will be assessed for every day after the payment due date that we have not received your fee payment. The postmark on the envelope in which your fee payment is submitted will determine the amount of your late fee, if any.

Facility Name
Facility Address
City, State, Zip
License Continuation Date:
Payment Due Date:

Based on your present capacity of X
your fee is $X

Please make your check in the amount of $XXX payable to "Division of Disability and Elder Services" and return it along with this page to the Regional Office at the address shown in the letterhead above. Thank you.

If you do not wish to continue your license, please notify the Regional Office in writing immediately.

Attach to ALS-03-004

CERTIFIED MAIL
Certified Mail Card #

Re: Warning – Application and/or Past Due Fee Payment and Late Fees

Facility:

Dear :

A review of your license must be completed every two years or when a probationary period expires. By letter dated , you were notified that your biennial fee payment and/or application form were due to this office by . To date, we have not received your license fee payment and/or application.

Based on your current licensed capacity of , your fee should be , plus late fees due. A late fee of $10.00 per day will be assessed for every day after the deadline date established above that we have not received your fee payment and application form. The postmark on the envelope in which the fee payment and/or application form are received will determine the amount of your late fee.

Please send a check or money order in the appropriate amount made payable to the "Division of Disability and Elder Services." This amount should be the biennial fee payment of **plus late fee of $10.00 per day calculated from to the date of postmark on your payment envelope.** Please send the fee and/or application to:

Division of Disability and Elder Services
Bureau of Quality Assurance

If we do not receive your biennial fee payment and late fee payment immediately, we may revoke your license for violating the law or administrative rules governing community based residential facilities pursuant to § 50.03(4)(c)1, Wis. Stat.

Sincerely,

Regional Field Operations Supervisor

cc:

Appendix A
Principles of Documentation

Principles of Documentation

FOR

THE STATEMENT OF DEFICIENCIES

HCFA - 2567

PRINCIPLES OF DOCUMENTATION - 2000
FOR THE STATEMENT OF DEFICIENCIES (HCFA-2567)

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JUNE 26, 2000

INTRODUCTION

This manual provides guidance on how to structure a deficiency statement on the HCFA Form 2567 after all the necessary information and evidence have been gathered. These guidelines include a general discussion of the legal aspects of the Statements of Deficiencies and identify and explain the principles considered in the citation of deficiencies to be documented on the HCFA-2567. The principles are generic and apply to the documentation of survey results regardless of the particular program (Medicare, Medicaid or the Clinical Laboratory Improvement Amendments) or the particular provider or supplier type.

This guide does not replace or supersede the law, regulations, or State Operations Manual (SOM). Rather, this manual is intended to provide guidance for documenting citations. Therefore, this manual does not create additional substantive or procedural requirements that must be present to sustain a valid citation.

The HCFA-2567 is the record of the survey where the survey team documents and justifies its determination of compliance and informs the provider or supplier of its state of compliance with the requirements for participation in the Federal programs. This information will serve as the basis for the facility to analyze its deficient practices or system failures and to develop plans of correction. The HCFA-2567 may also document deficient practices identified by means other than an on-site survey, e.g., a review of compliance with the requirements to transmit comprehensive assessments to the State Agency.

Each principle is discussed in depth and includes an example of that principle. Each example is identified as being effective and is included to illustrate a particular documentation principle and may not represent a complete citation. In each case, there may be other language that may be as effective. The adequacy of any citation can be evaluated only in the context of the particular type and source of evidence, the extent and consequence of deficiency, and other relevant factors.

DEFINITIONS

Listed below are definitions that will be used throughout these materials.

COP: an abbreviation that commonly refers to a •condition of participation.• COP also is used throughout this manual to refer to a •condition for coverage• relevant to suppliers. The Conditions of Participation are requirements with which an entity must comply in order to participate in the programs.

Deficiency Citation: an entry made on the HCFA-2567 that includes: 1) the alpha prefix and data tag number, 2) the Code of Federal Regulations (CFR), or Life Safety Code (LSC) reference, 3) the language from that reference which pinpoints the aspect(s) of the requirement with which the entity failed to comply, 4) an explicit statement that the requirement was •NOT MET• and 5) the evidence (the deficient entity practice statement and relevant individual findings or facts) to support the decision of noncompliance (see Exhibit 0-1).

Deficient Practice: the action(s), error(s), or lack of action on the part of the entity relative to a requirement (and to the extent possible, the resulting outcome). (•practice• and •entity practice• are used interchangeably throughout this manual.)

Deficient Practice Statement: a statement at the beginning of the evidence that sets out why the entity was not in compliance with a regulation.

Entity: a generic term used to describe providers and suppliers under the Social Security Act or laboratories that participate in the CLIA program.

Evidence: an integral part of the citation that begins with a description of the deficient entity practice and identifies the relevant individual findings and facts that substantiate the failure of the entity to comply with the regulation.

Extent of deficient practice: the prevalence or frequency of a deficient entity practice.

Finding: a generic term used to describe each discrete item of information observed or discovered during the survey about practices of an entity relative to the specific requirement being cited as being not met.

Fact: an event known to have actually happened. A truth known by actual experience or observation.

LEGAL ASPECTS OF THE STATEMENT OF DEFICIENCIES

The survey and certification of an entity that participates in Medicare, Medicaid or the Clinical Laboratory Improvement Amendments (CLIA) of the Public Health Service Act, is a process that must adhere to legal requirements. These programs are administered under extensive laws, regulations, operation manuals and other guidelines. Surveys and the documentation from surveys become an important part of subsequent legal proceedings arising out of the certification process.

This section is a brief overview of the legal aspects of surveying and the importance of surveyor documentation to the decision making and appeals process. It is not intended to provide complete and detailed information on the mechanics of the process. Please refer to the State Operations Manual (SOM) for more detailed information.

The survey process determines, and the documentation records, the compliance or noncompliance of providers, suppliers, and CLIA laboratories. The surveyor provides the reasons justifying any resulting enforcement action and the record on which to defend that action in the appeals process. Consistent and accurate documentation is imperative in the entire certification process as it forms the basis for the record and the certification decision. Moreover, the documentation may also be reviewed in any subsequent appeal, i.e., reconsideration, hearing before an Administrative Law Judge (ALJ) of the Departmental Appeals Board (DAB), review by the Board's Appellate Division, and judicial review.

A certification of compliance or noncompliance with the applicable requirements by the State agency or the Federal Government is an official finding and determines whether or not the provider or supplier may participate in the Medicare or Medicaid program or whether a laboratory is issued a certificate to operate under CLIA. It also determines whether any of these entities are subject to other sanctions. The decision-making process and subsequent certifications are based on the documentation of the survey in the Statement of Deficiencies (HCFA 2567), as well as, other documentation such as surveyor worksheets or notes.

A prospective provider, supplier or clinical laboratory may request a reconsideration of a determination that it does not qualify to participate in the Medicare/Medicaid program. A formal reconsideration is a thorough, independent review of the prior decision and the entire body of evidence. If the reconsideration determination upholds the initial decision, the entity may request an evidentiary hearing before an ALJ.

If an entity is determined to no longer meet the requirements and is subject to termination or alternate remedies/sanctions, the actual or projected termination or remedy may be appealed through an evidentiary hearing before an ALJ. If a laboratory's certificate is subject to limitation, suspension, revocation, or is actually limited, suspended, or revoked, the actual or projected limitation, suspension or revocation may be appealed through an evidentiary hearing before an ALJ. During a hearing, the government has the responsibility to show why a provider or supplier should be terminated or be subject to alternate remedies, and/or a laboratory's certificate should be limited, suspended or revoked.

The evidence must provide the underlying reason, basis or rationale for the findings of noncompliance

OVERVIEW

Listed immediately below for easy reference are the principles considered in the development and completion of the HCFA-2567. Following this listing, each principle is explained in detail in a separate section.

Principle #1: Entity Compliance and Noncompliance
When an entity complies with the requirements applicable to the survey conducted, the HCFA-2567 should consist of an explicit statement that the entity is in compliance. If an entity does not comply with one or more applicable requirements, the HCFA-2567 includes corresponding citations of noncompliance.

Principle #2: Using Plain Language
The deficiency citation is written clearly, objectively and in a manner that is easily understood. The deficiency citation does not include consultation, advice, comments or direction aimed at the surveyed entity.

Principle #3: Components of a Deficiency Citation
A deficiency citation consists of (A) a regulatory reference, (B) a deficient practice statement and (C) relevant findings.

A. Regulatory Reference:
A Regulatory Reference includes the following components:
1) a survey data tag number,
2) the CFR or LSC reference,
3) the language from that reference which specifies the aspect(s) of the requirement with which the entity was noncompliant
4) an explicit statement that the requirement was •NOT MET•.

B. Deficient Practice Statement
The statement of deficient practice is one component of the evidence. It includes:
1) the specific action(s), error(s), or lack of action (deficient practice),
2) outcome(s) relative to the deficient practice, when possible
3) a description of the extent of the deficient practice or the number of deficient cases relative to the total number of such cases,
4) the identifier of the individuals or situations referenced in the extent of the deficient practice, and
5) the source(s) of the information through which the evidence was obtained.

C. Relevant Facts and Findings
The facts and findings relevant to the deficient practice, answer the questions: who, what, where, when, and how. They illustrate the entity•s noncompliance with the requirement or regulation.

Principle #4: Relevance of Onsite Correction of Findings

Principle #1: Entity Compliance and Noncompliance

When an entity complies with the requirements applicable to the survey conducted, the HCFA-2567 should consist of an explicit statement that the entity is in compliance for that particular survey. If an entity does not comply with one or more applicable requirements, the HCFA-2567 includes corresponding citations of noncompliance. The statutes and implementing regulations are the legal authority for determining an entity•s compliance with Federal requirements for participation or coverage in Medicare, Medicaid, and CLIA.

The HCFA-2567 is the official document that communicates the determination of compliance or noncompliance with the Federal requirements. Also, it is the form that an entity uses to submit a plan to achieve compliance. It is an official record and is available to the public on request.

Exhibit 1-1 illustrates how to give official notice to the provider or any other interested parties of the compliance status of the entity when the surveyor has identified no deficiencies. The specific requirements with which the entity must comply, as contained in Title 42 of the Code of Federal Regulations (CFR), are included.

Exhibit 1-1: **Effective** Documentation for Principle #1

TAG	SUMMARY STATEMENT OF DEFICIENCIES
G000	The [Name] Home Health Agency is in compliance with 42 CFR Part 484, Requirements for Home Health Agencies.

If a nursing home has no deficiencies identified at the time of the survey, the entry on the HCFA-2567 would read that the NH is in compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities.

For SNF/NF, if the provider•s noncompliance is isolated and does not pose a risk of more than minimal harm (S/S=A), the deficiency is documented on the •A• Form- Statement of Isolated Deficiencies Which Cause No Harm With Only A Potential For Minimal Harm For SNFs and NFs. (See Appendix C) In addition, the documentation on the HCFA-2567L would state the SNF/NF is in substantial compliance.

Best practice is to:

- Put all relevant facts in chronological order.
- Keep sentences short.
- Use simple sentence structure.
- Use the active voice (e.g. •The DON reprimanded the CNA• not •the CNA was reprimanded by the DON•.).
- Avoid undefined abbreviations, initials and technical jargon.
- Write in laymanŒs terms.
- Write to inform, not impress.
- Avoid unnecessary words.
- Avoid vague terminology (such as, seems, appears, did not always).
- Avoid words that imply or state conclusions without including the facts to support them (e.g., •only•, •just•, •unsatisfactory•, •unnecessary•, or •inadequate•).
- Ensure the accuracy of quoted material.

According to Strunk and White, •When you become hopelessly mired in a sentence, it is best to start fresh; do not try to fight your way through against the terrible odds of syntax. Usually what is wrong is that the construction has become too involved at some point; the sentence needs to be broken apart and replaced by two or more shorter sentences[2].•

Principle #3: Components of a Deficiency Citation

A deficiency citation consists of (a) a regulatory reference, (b) a statement of deficient practice, and (c) relevant findings. (For SNFs and NFs, the scope and severity decision is documented in the left column under the survey data tag number.). Since all relevant information demonstrating non-compliance have been provided in the deficiency citation, conclusionary and or summary remarks at the end of the deficiency citation are not necessary and should be avoided.

This principle addresses **all** of the components of a complete citation.

Regulatory Reference

When the entityŒs practice violates a regulation or requirement, determine the regulation that the entity may have violated. Examine the language of the regulation under which a deficiency could be cited. Determine if the requirement addresses the entityŒs policies and procedures, actions, or inaction.

A regulatory reference is composed of: 1) a survey data tag number, 2) the CFR or LSC reference, 3) the language from that reference which specifies the aspect(s) of the requirement with which the entity was noncompliant, and 4) an explicit statement that the requirement was •NOT MET•.

Regardless of the computer software used to produce the HCFA-2567, essential components of the citation: survey data tag; CFR or LSC reference, language of the requirement for that reference and an explicit statement that the requirement was not met are generated automatically on the HCFA-2567. Each handwritten citation should include all of those components. These components are then followed by the deficient entity practice statement and the relevant findings.

Requirements

Federal requirements for participation or coverage can be categorized as follows:

! **structure-requirements** that specify the initial conditions that must be present for an entity to be certified to participate and that, in general, are expected to remain as is unless there is a need for major renovation, reorganization or expansion of services. Some examples of structure requirements include:

The agency has by-laws that **or** Each bedroom measures

! **process--requirements** that specify the ongoing manner in which an entity must operate. They do not allow the entity discretion to vary from what is specified. Examples of process requirements include:

The plan of care must be reviewed by **or** The physical examination is conducted on an annual basis

! **outcome-requirements** that specify the results that must be obtained or events that must occur or not occur following an act. Generally, these requirements are stated in terms of the recipient=s response to receipt of needed services or conditions that must result from, or are prevented by, implementing one or more processes. Example of outcome requirements include:

The facility must ensure that a resident maintains acceptable parameters of...

F-314. Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual=s clinical condition demonstrates they are unavoidable.

The findings document the outcomes that occurred or failed to occur or failure to assist the individual(s) to achieve optimal improvement in overall functioning or to prevent avoidable regression or loss of function. The citation documents sufficient facts to illustrate the level of harm that has occurred or may occur.

Deficient Practice Statement

The statement of deficient practice must be written in terms specific enough to allow a reasonably knowledgeable person to understand the aspect(s) of the requirement that is (are) not met. They are also used to identify the levels of scope and severity of the deficiency. It includes what the entity did or did not do which caused the noncompliance.

The statement of deficient practice must not repeat the regulation, but should state what the facility did that was wrong or failed to do, to let the reader know what to look for in the findings. The statement of deficient practice presents the specific action(s), error(s), or lack of action(s) relative to the requirement.

The evidence for a citation begins with a statement of deficient practice that summarizes the issues

Only those patients on anti-coagulant therapy would be affected by the deficient practice. Therefore, the universe would be the total number of patients with orders for anti-coagulants.

The surveyor then determines the number of individuals within the sample or expanded sample on anti-coagulant therapy who were harmed or could be harmed by the failed practice. Did the ESRD center fail to monitor all of those patients on anti-coagulant therapy? If not, how many were not monitored? The total number of patients affected by the failed practice divided by the total number of patients that could have been affected by the failed practice provides a numerical quantification in percent of the extent of the failed practice.

The extent of deficient practice will depend upon whether:
(1) the requirement related to all cases or individuals served by the entity
(2) surveyors had knowledge of all cases to which the requirement applied
(3) the requirement related to a subset of all the cases or individuals served by the entity or only a sample of applicable situations or cases
(4) the deficient practice was determined through only random opportunities for discovery.

Based on observation, the facility failed to maintain appropriate lighting standards for 7 of 12 emergency exits and failed to test pressure back flows on 2 of 2 water lines. In this example, there are 3 separate expressions of extent: the deficient practice created a potential hazard/ impact on the entire recipient population, there were 12 exits and the lighting was insufficient at 7 of those 12, and 2 of 2 water lines were deficient.

! Knowledge of all cases or situations

When the deficiency is based on knowledge obtained about all applicable cases or situations, both this total and the number of cases/situations that evidenced deficiency should be recorded within the body of the citation. The following phrases illustrate a variety of acceptable measures:

In an interview with the pharmacist at 2:00 p.m. on 5/29/XX he stated that of 98 residents at the facility for whom Haldol had been prescribed, 74 had individual program plans that had not been developed with the participation of...

The hospital's pharmacy committee minutes dated 01/11/XX confirmed that of the 86 patients to whom medications are administered, 45 (approximately 53%) were identified as being unable to...

Nineteen of the 20 residential living units were observed to need the following repairs:

Each of the 5 seclusion rooms used by the facility

! Sample of applicable situations

When the requirement is not applicable to all of the cases or individuals served by an entity, the extent would be developed by using only the cases or individuals with a negative outcome as a result of the deficient practice divided by the total number of cases or individuals in the sample that

was breached by a hole measuring 5 inches....

During tour on unit on XX/XX/XX at 2:15 p.m., RS #1 was observed to be mechanically restrained to his bed in locked leather cuffs while he was asleep.@

Identifiers

An individual=s name must not appear in the HCFA 2567. The identity of the recipients of deficient practice or any persons, including surveyors, who will be referred to in the report, must remain confidential. They are included in the report by indicating their identifiers, which can be letters, numbers, or a combination or both. These identifiers also appear in the statement of deficient practice and in the findings.

When the person referred to in the report is an entity staff member, the person(s) may be addressed by their position, discipline, or job title, or be assigned an identifier.

Identification of each case found to be deficient provides the entity with information necessary to evaluate the context of the problem. When the evidence refers to individual recipients, the statement of deficient entity practice should reference by identifiers.

The coding system used to indicate the recipients should be decipherable by the entity, and retrievable by the RO or SA. Whenever possible, if a revisit or follow-up survey finds noncompliance for the same individual as in the standard survey, reassign the same identifier code. If it is not possible to use the same identifier, use a different set of numbers for revisits so that in the event of a hearing, the same identifier is not used for two different recipients. Every effort should be made to protect a recipient=s privacy especially regarding information gathered during an in-depth interview. Do not identify recipients or family members without their permission. If the interviewee does not wish the entity to know the source of the information provided to you, that information may be recorded on the HCFA-2567 without an identifier. The HCFA-2567 would state, ADuring a confidential interview ....@ However, the interviewee must be told that there is no guarantee this information will remain confidential as a court may require that confidential information be disclosed. If the interviewee=s identity is not disclosed to the entity, the HCFA-2567 must contain sufficient information for the entity to correct the deficient practice, and to contest the deficiency, if it desires.

When the deficient entity practice references personnel files or staff training, a separate coding system should be developed to identify the staff affected by the deficient entity practice without using their names.

When random observations or recipients/cases/records beyond the original sample(s) are included in a citation, an identifier should be given to the individual so that the entity may evaluate the extent

Observations

Observation is the process by which a surveyor gathers information in accordance with the requirements, based on input obtained from the five senses. It is what the surveyor sees, hears, touches, smells or tastes during the survey that evidences an entity•s deficiency. It must answer the who, what, where, when, and how questions. A surveyor may observe if the actions or outcomes described in a clinical or administrative record actually occur in the daily operation of the entity. Actions or outcomes that are described in a clinical or administrative record and observed are also recorded as an observation.

The surveyor must note the specific date and time the observations were made and describe the observation.

Detailed documentation of observations of deficient practice assists the provider in identifying when and where the deficient practice occurred. Time includes the number of observations in which the deficient practice was observed and, as appropriate, the duration of each observation. For example, a series of observations that identify the failure to deliver service from 4:00 P.M. to 6:00 P.M., may help the entity to identify staffing or supervisory concerns, such as, inadequate supervision or sufficient staffing on a particular shift. Terms such as •throughout the survey•, •during observation on the second day of the survey•, etc. are vague, too general and should be avoided. Exhibit 3-3 illustrates an appropriate manner to document the evidence that was obtained through observation.

Interviews

The interview process largely consists of talking to individuals (e.g., patients, clients, residents, family, visitors, staff, physicians, ombudsman) to collect information in accordance with requirements about the entity practices. Information obtained through interviews can provide evidence to support a deficiency.

For example: surveyors talk with recipients to determine whether the entity fulfills the commitments it has made in records; staff are interviewed to determine their knowledge of the needs of the recipient and of entity polices and procedures. To the greatest extent possible, the surveyor verifies the information obtained from interview through observation or record review. In the absence of other objective validation of information, information may also be confirmed/verified through multiple interview sources.

Exhibit 3-4: **Effective** Documentation of **interview** based on findings

TAG	SUMMARY OF STATEMENT OF DEFICIENCIES
F252	42 CFR 483.15 (h) (1) The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This requirement was NOT MET as evidenced by: Based on observation and interview, the facility failed to provide a homelike environment for 2 of 15 sampled residents (# 5, #6) whose rooms lacked individual decorations and any personal belongings. Findings include: 1. Observations made during the tour at 10 AM on xx/xx/xx, noted that Resident 5•s room was barren of any individualized decorations and personal belongings. During an interview on XX/XX/XX at 3:00 p.m., Resident #5 stated, •I miss my pictures; they are all I have left. I want them with me but no one will get them for me. I want my own toiletries too!• 2. At 10 AM on xx/xx/xx, Resident #6•s room was observed to be barren of any individualized decorations and personal belongings. During an interview on XX/XX/XX at 11:00 a.m., a family member of Resident #6 stated,• My (Resident #6) would like to have a rocking chair. I asked the nurse if I could bring it in and she said she would check on it and let me know. This was about three weeks ago and she has not yet told me if it was acceptable or not.• During an interview with the director of nursing (DON) on XX/XX/XX at 1:00 p.m., the DON revealed that the facility was aware of the residents• requests for personal belongings but had tried to discourage displays of any personal items to reduce theft in the facility.

Exhibit 3-5 **Effective** documentation of **record review** based findings

TAG	SUMMARY STATEMENT OF DEFICIENCIES
V 321	405.2137(b)(4) STANDARD: PATIENT CARE PLAN The care plan for patients whose medical conditions has not stabilized is reviewed at least monthly by the professional patient care team described in paragraph (b)(2) of this section. For patients whose condition has become stabilized, the care plan is reviewed every 6 months. The care plan is revised as necessary to insure that it provides for the patients ongoing needs. This STANDARD is not met as evidenced by: Based on record review, the provider failed to address changes in therapies on the Patient Care Plan (PCP) for 2 of 7 patients (#1, #4). 1) Review of the admission progress note dated 4/10/XX showed that Patient #1 started receiving peritoneal dialysis (in the home) on 4/1/XX. Per the 10/2/XX Social Services note, Patient #1 was switched (at the request of the patient) from peritoneal to hemodialysis (in the dialysis center) on 9/11/XX. Review of the most current PCP dated 12/2/XX revealed that this change in treatment modality was not addressed in the PCP. 2)Patient #4 started hemodialysis (in the dialysis center) on 2/11//xx per the admission assessment. The 9/8/XX Physicians Progress note indicated that Patient #4 received a transplanted kidney on 4/5/XX, but restarted hemodialysis again on 8/1/XX after the transplant was rejected. Review of the PCP dated 12/2/XX revealed that the patient's changes in status were not addressed in the PCP.

Exhibit 3-7. This example reports the evidence in a way that the entity can understand that the requirement was not met and how the survey team determined that the requirement was not met. The facts are stated clearly, the deficient practice is apparent, and there is no extraneous information within the citation that might cause confusion. All of the components of a complete citation are included.

Exhibit 3-7: **Effective** Documentation of Principle #3

TAG	SUMMARY STATEMENT OF DEFICIENCIES
L 210	418.94 (a) Standard: Supervision A registered nurse visits the home site at least every two weeks when aide services are being provided, and the visit includes an assessment of the aide services. This STANDARD is NOT MET as evidenced by: Based on review of 4 of 12 medical records (# 5,3,9,12) and interviews in 2 of 4 home visits (# 5, 12), it was determined that the registered nurse visit did not include an assessment of whether the aide provided grooming services (shampoo and shower) to the patients. The findings include: 1. Review of medical records for Patient #5 revealed that: between 10/20/XX to 12/20/XX, the records did not contain documentation that any of the registered nurse visits to the home site included an assessment of the aide services. The son of Patient #5 said, during an interview on 12/28/XX, •The aide never shampoos my Mom•s hair and the nurse said that she is supposed to be doing that.• During an interview at 10AM on 12/29 with the nurse caring for the patient, the nurse acknowledged that the family member had mentioned the shampoos, the plan of care did indicate the patient was to receive shampoos, but she had not followed up with the aide about not doing them, nor had she verified what was reflected on the aide assignment sheet or what the aide had recorded. 2. Review of medical records for Patient #12 revealed that: between 10/28/XX to 12/28/XX, the records did not contain documentation that any of the registered nurse visits to the home site included an assessment of the aide services. The family member of Patient #12 said, during an interview on 12/28/XX, •The aide did not give (my family member) a shower; instead the aide gave (my family member) a very quick bath in bed. I don•t know why but the aide always comes late and leaves early.• 3. The same lack of documentation regarding registered nurse visits to the home site to assess aide services was found in medical records for Patients #3 for review period 03/10/XX to 05/07/XX; and #9 for review period 02/11/XX to 03/29/XX.

Each of the three sources may not be necessary to confirm a deficiency. Regardless of the particular avenue(s) through which information about an entity•s compliance with requirements is gathered, the