SURVEY GUIDE
LONG-TERM CARE FACILITIES

Nursing Homes, Skilled Nursing Facilities,
Nursing Facilities

STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES

Division of Quality Assurance
Bureau of Nursing Home Resident Care

P-62014 (07/2025)

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Introduction

The Division of Quality Assurance (DQA) conducts unannounced surveys in Wisconsin nursing homes to ensure that each facility meets the necessary requirements for state licensure and, if applicable, for federal Medicare and/or Medicaid certification. Surveys are outcome-oriented with a focus on current conditions at the facility. This does not mean that harm must occur in order to issue a citation or that process regulations will not be cited if resident outcome has not occurred.

The following information is intended to guide staff of Wisconsin nursing homes through the survey process.

This guide is a general reference for informational purposes. In the event of any conflict between information provided in this guide and the applicable legal requirements for nursing homes, a nursing home should rely on the applicable legal requirements.

I. Survey process

A. Overview

The survey team includes a registered nurse, a health services specialist, and an engineer. A dietitian or pharmacist may participate on selected surveys. Surveyors evaluate nursing home performance and compliance with applicable laws and standards in the areas of:

- § 483.10 Resident Rights
- § 483.12 Freedom from Abuse, Neglect, and Exploitation
- § 483.15 Admission, Transfer, and Discharge Rights
- § 483.20 Resident Assessment
- § 483.21 Comprehensive Person-Centered Care Planning
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- § 483.55 Dental Services
- § 483.60 Food and Nutrition Services
- § 483.65 Specialized Rehabilitative Services
- § 483.70 Administration
- § 483.75 Quality Assurance and Performance Improvement
- § 483.80 Infection Control
- § 483.85 Compliance and Ethics Program
- § 483.90 Physical Environment
- § 483.95 Training Requirements

During a recertification survey, surveyors will conduct an in-depth review of about 20% of the facility's residents. These residents are considered the "sample."

B. Survey Tasks

Offsite Preparation

For recertification surveys, the software for the long-term care survey process will generate a list of residents to be reviewed as part of the survey sample. This list will comprise 70% of the residents to be included in the final sample.

As part of offsite preparation, each surveyor will review the residents selected offsite and facility rates for specific Minimum Data Set (MDS) indicators to get a sense of how many residents and which MDS indicators are potential areas of concern. Additionally, the team coordinator will review:

- The CASPER 3 report to identify patterns of repeat deficiencies
- Results of the last standard survey
- Complaints since the last survey, including active complaints
- Facility reported incidents (FRIs)
- Facility variance/waivers

As part of the offsite preparation, the team coordinator will assign team members to specific units using last year's floor plan and to mandatory facility task assignments. (See "Other Activities" below.)

Once the team coordinator completes the offsite preparation, each team member will independently review the information. There is no required offsite preparation team meeting.

Facility Entrance

The team coordinator conducts a brief entrance conference with the administrator and, then, goes to his/her assigned unit. The surveyor assigned the kitchen conducts a brief visit to the kitchen and, then, goes to his/her assigned unit. All other surveyors go immediately to their assigned areas.

The team coordinator will ask the administrator for the following information:

Information Needed Immediately Upon Entrance

1. Census number
2. Complete matrix for new admissions in the last 30 days who are still residing in facility
3. List of residents who smoke, designated smoking times, and locations

Information Needed Within One Hour of Entrance

1. Schedule of meal times, locations of dining rooms, copies of all current menus including therapeutic menus that will be served for the duration of the survey and the policy for food brought in by visitors
2. Schedule of medication administration times
3. Number and location of med storage rooms and med carts
4. Actual working schedules for licensed and registered nursing staff for the survey time period
5. List of key personnel, location, and phone numbers
6. Names of staff and residents in the paid feeding assistant program

Information Needed Within Four Hours of Entrance

1. Complete matrix for all other residents
2. Admission packet
3. Dialysis contract(s), agreement(s), arrangement(s), and policies and procedures, if applicable
4. List of qualified staff providing hemodialysis or assistance for peritoneal dialysis treatments, if applicable
5. Agreement(s) or policies and procedures for transport to and from dialysis treatments, if applicable
6. Whether or not the facility has an onsite, separately certified ESRD unit
7. Hospice agreement and policies and procedures for each hospice used [name of facility designee(s) who coordinate(s) services with hospice providers]
8. Infection prevention and control program standards, policies and procedures, and antibiotic stewardship program
9. Influenza / pneumococcal immunization policy and procedures
10. QAA committee information
11. QAPI plan
12. Abuse prohibition policy and procedures
13. Description of any experimental research occurring in the facility

14. Facility assessment
15. Nurse staffing waivers
16. List of rooms meeting any one of the following conditions that require a variance:
    - Less than the required square footage
    - More than four residents
    - Below ground level
    - No window to the outside
    - No direct access to an exit corridor

Information Needed by the End of the First Day of the Survey

1. Surveyor access to all resident electronic health records and specific information on how surveyors can access the EHRs outside of the conference room.

Information Needed Within 24 Hours of Entrance

1. Completed *LTC Facility Application for Medicare and Medicaid* (CMS-671)
2. Completed *Resident Census and Condition of Residents* (CMS-672)
3. Completed *Beneficiary Notice – Residents Discharged Within the Last Six Months*

The team coordinator will ask the facility to complete a matrix that will include each resident and identify each of the following components about the resident. These include:

- Residents admitted within the past 30 days
- Alzheimer's / Dementia
- Mental illness, developmental disability, or intellectual disability, and no PASARR level II
- Medications – certain medications such as insulin, anticoagulants
- Facility acquired pressure ulcers at any stage
- Worsened pressure ulcer(s) at any stage
- Excessive weight loss
- Tube feeding
- Dehydration
- Physical restraints
- Fall(s)
- Indwelling urinary catheter
- Dialysis
- Hospice
- End of life / comfort care / palliative care
- Tracheostomy
- Ventilator
- Transmission-based precautions
- Central venous line / intravenous therapy
- Infections

Initial Pool Process

Once surveyors get to their units, they will ask the nurse for a list of new admissions to the unit within the last 30 days. They will then go room-to-room **without staff** to identify residents to include in the initial pool. The initial pool will be the subset of residents from which the final sample will be drawn.

The initial pool will be comprised of:

- Residents selected offsite (approximately 70% of the final sample)

- Vulnerable residents who are dependent on staff (This is a subgroup because these residents are at a high risk for care concerns.)
- New admissions within the last 30 days (This is a subgroup since new admissions are typically excluded from the resident listing because they have not yet had an MDS submitted and have unique needs.)
- Active complaints or FRIs
- Any other resident who has a significant concern that does not fall into any of the other subgroups

Surveyors will screen residents by briefly observing and interviewing them to determine if they should be included in the initial pool of residents. When the surveyor has identified at least eight residents for the pool from the unit, the surveyor will begin conducting longer interviews, observations, and limited record review of their pool residents. If a resident is interviewable, surveyors will complete a full interview for the resident, which takes about 20 minutes. Questions will revolve around the care areas of quality of life, resident rights, and quality of care with the purpose of identifying any unaddressed concerns of the resident. If a resident is non-interviewable, surveyors will attempt to interview a representative or family member who is familiar with the resident's care.

On the first day of survey, in addition to observing and interviewing his/her initial pool residents, surveyor(s) will observe the first scheduled full meal to identify potential concerns.

The pool process is expected to take eight to ten hours. Surveyors will briefly meet together at the end of the day to discuss their progress. There will not be an exit conference with the facility the first day unless the survey team has identified immediate jeopardy.

Sample Selection

Once the initial pool process is finished, surveyors will meet as a team for about an hour to select the sample. The team will select the sample based on facility census. As indicated earlier, approximately 70% of residents in the final sample will have been identified offsite. The remaining 30% will come from information that was gathered during the pool selection process. Information that has been entered into the computer software during the pool selection process, as well as MDS information that is already in the system, will help the team identify a subset of residents that should be included in the sample, such as any resident who had an abuse concern. The software will also assist the survey team in ensuring that care area concerns are represented. The system will select five residents for an "unnecessary medication review" based on information entered by the surveyor during interviews, observations, record review, and information from the MDS.

Generally, the sample size is about 20% of the facility census with a cap of 35 residents for larger facilities.

Investigation

Information gathered during this portion of the survey process will follow up on concerns identified during the initial pool process to determine whether appropriate care and services are provided in accordance with the care plan and in a manner that enhances each resident's quality of life. During this portion of the survey, surveyors will spend the majority of their time on the floor observing and interviewing the residents and staff. Surveyors will only use the record to corroborate what they are seeing and hearing. Surveyors will use critical element (CE) pathways to help guide their investigation. The pathways include observation, interview, and record review investigative probes for a number of care areas, including pressure ulcers and dialysis. Surveyors will use the guidance and protocols in Appendix PP for care areas that do not have a pathway, such as dignity and personal property. The CEs are critical components of care; they cover provision of care and services, as well as the facility assessment and care planning.

Ongoing and Other Survey Activities

- ***Closed Record Review***

  Surveyors will review up to three closed records. For the death review, the system will select a resident who was not on hospice and died in the last 90 days. For the hospitalization review, the system will select a resident who went to the hospital and has not returned in the last 90 days. For the community discharge review, the system will select a resident who was discharged back to the community in the last 90 days.

- ***Mandatory Facility Tasks***
  - ***Dining*** (completed only if the team identified concerns during the first meal observation)
  - **Infection control** (includes a review of laundry; must include at least one resident on transmission-based precautions) The purpose is to ensure facility is consistently implementing an infection prevention and control program across all departments.
  - ***SNF beneficiary protection notification review*** (includes a review of the notices that were given to three residents who were discharged from Medicare Part A)
  - ***Kitchen*** (includes observations and interviews to determine that food is prepared, stored, and served in a manner that prevents food-borne illness)
  - ***Medication administration*** (includes observations of 25 medication opportunities over different routes, units, and shifts)
  - ***Medication storage*** (includes review of half of medication units and half of medication carts on the units that were not observed)
  - ***Resident council meeting*** (includes interviews of active council members to identify concerns and to determine if suggestions / recommendations are acted upon)
  - ***Sufficient and competent nurse staffing*** (includes a review of staffing and competency of staff and whether these are contributing to complaints or to quality of life or quality of care concerns)
  - ***QAA / QAPI*** (includes a review of facility systems for identifying concerns and acting upon them to improve quality of care and quality of life)
- ***Triggered Facility Tasks*** (Investigated only if surveyors have identified concerns during observations, interviews, and record reviews)
  - ***Personal funds*** (includes a review of resident access to funds and handling of resident funds)
  - ***Environment*** (includes a more in-depth review of the environment if concerns have been identified)

Decision-Making / Potential Citations

After individual compliance decisions are made, the team will make a compliance and scope / severity determination for all potential deficiencies that came forward from each surveyor.

Throughout the survey, the survey team reviews and analyzes all information to determine whether the facility has complied with all applicable federal and state requirements. Decision-making is an ongoing process that continues after the survey is completed.

A ***deficiency*** exists when a facility fails to comply with a federal regulation. A ***violation*** exists when a facility fails to comply with a state statute or administrative rule. All citations are written on the CMS-2567 Statement of Deficiencies (SOD) or the CMS "A" form.

Certified nursing homes must meet ***resident-centered*** federal regulations for each resident. These are regulations that refer to ***each resident*** or ***the resident.*** Regardless of severity, one example of non compliance with a resident-centered federal regulation shows that a deficient practice exists. Examples of such regulations are:

- *"**The resident** has the right to be free from any physical or chemical restraints …"* [F604, 42 CFR 483.10(e)(1)]
- *"The facility must provide … an ongoing program … of activities … designed to meet the interests of and support the physical, mental, and psychosocial well-being of **each resident**."* [F679, 42 CFR 483.24(c)(1)]

Facility-centered federal regulations refer to systems or processes that facilities must have in place. One example of non compliance with a facility-centered federal regulation does not necessarily mean a deficiency exists. Citations of facility-centered regulations are based on evidence that a system or process was not functioning. For example, one instance of a non-sterile dressing change would not necessarily mean that the facility had failed to comply with the requirement at F880 (42 CFR 483.80) to "maintain an infection prevention and control program …"

In certain cases, a deficient practice may lead to non compliance with more than one regulation. When determining potential citations, DQA will look at the applicable outcome regulations and the

process regulations that may have led to the outcome or potential outcome. The Centers for Medicare and Medicaid Services (CMS) has instructed states to look at and to cite all independent but associated regulations for which non compliance exists.

DQA will not cite a violation of state regulations if surveyors are citing the same deficient practice under a federal regulation.

Exit Conference

Although not required, the survey coordinator, as a courtesy to facilities, will usually meet with facility administration at the end of the day to alert administration of its findings and the areas in which deficient practices exist. The survey team will ***not*** discuss concerns that do not immediately jeopardize residents if the team is still gathering information to determine whether a violation exists or is still gathering information to establish the extent of the problem. When the team brings concerns to the facility's attention, we encourage the facility to provide any documentation or other information that might clarify or modify the team's perception of the situation.

When the survey team has concluded its on-site survey, the team coordinator conducts an exit conference with the facility administrator or designee. The administrator can determine which staff, board members, etc. may attend the exit conference. Administrative staff should encourage residents to attend and should make necessary accommodations so that residents can attend. Facilities should understand that the information presented at the exit conference is preliminary and may change following supervisory review.

During the exit conference, the coordinator summarizes the team's conclusions and, when applicable, presents the findings that substantiate non compliance. Providers are encouraged to use the exit conference to supply additional information that may clarify or refute findings. Because of the ongoing dialog that has occurred, there should be few instances where the facility is not aware of surveyors' concerns prior to the exit conference. Typically, the only "surprises" at the exit conference should be those situations that have just occurred or situations where the survey team has needed ongoing monitoring to determine if a deficient practice exists or to determine scope or severity.

The exit conference for the Life Safety Code survey may or may not be held with the health surveyors, depending upon the timing of the Life Safety Code survey.

The facility may have an attorney present, but we request that you give advance notice of this to the survey coordinator. A court reporter may not attend the exit conference. If a facility makes an audio or video tape recording of the exit conference, the facility must make a simultaneous recording and give it to the survey team.

When deficiencies or violations are found, DQA will, in most cases, mail the Statement of Deficiencies to the facility or to the Chapter 50 designee within ten working days of completion of the health survey. Similarly, in most cases, DQA will also mail the SOD with Life Safety Code deficiencies to the facility or to the Chapter 50 designee within ten working days of completion of the Life Safety Code survey. During the period of time in which the SOD is being written and reviewed, the nursing home may submit additional information to the regional office that will refute the decision that had been made to cite or that will modify scope or severity.

Occasionally, during the period in which the SOD is being written and reviewed, supervisory and quality assurance review of the findings may lead to dropping a citation, citing a deficiency that had not been discussed with the facility at the survey, or to changing the level of scope and severity. If this occurs, DQA staff will notify the facility by phone. This gives the facility an opportunity to respond before DQA writes and mails the SOD.

II. Explanation of citations

Federal deficiencies are cited separately from state violations. DQA assigns a federal severity/ scope category to each federal citation and a state classification to each state citation.

C. Classification of Violations of Wis. Admin. Code Ch. DHS 132 or Wis. Stat. Ch. 50

All state code violations are classified according to their level of severity and according to the probability of harm occurring.

1. **Class A.** This is a violation that creates a condition or occurrence relating to the operation and maintenance of a nursing home which presents a substantial probability for resident death or serious mental or physical harm. A facility must immediately correct a Class A violation unless DQA sets a fixed period of time while reviewing the plan of correction. DQA may assess forfeitures of up to $10,000 per day of violation. [Wis. Stat. § 50.04(5)(a)1]. *(For computer purposes only, Class A violations show a scope/severity rating of "F" in the left-hand column of the SOD.)*

2. **Class B.** This is a violation that creates a condition or occurrence relating to the operation and maintenance of a nursing home which directly threatens the health, safety, or welfare of a resident. Class B violations are subject to a forfeiture of up to $5,000 per day of violation [Wis. Stat. § 50.04(5)(a)2]. *(For computer purposes only, class B violations show a scope/severity rating of "B" in the left-hand column of the SOD.)*

   For computer purposes only, a state code violation that has an example(s) at the level of a Class A and an example(s) at the level of a Class B will have a scope/severity rating of "G" in the left-hand column of the SOD.

3. **Class C.** This is a violation that creates a condition or occurrence relating to the operation and maintenance of a nursing home which does not directly threaten the health, safety, or welfare of a resident. A Class C level violation may be issued as:

   - ***Class C*** when the licensee violated the same statute or rule during the previous two (2) years or when a nursing home fails to correct a correction order by the date specified. Class C violations are subject to a forfeiture of up to $500 per day of violation [Wis. Stat. § 50.04(5)(a)3]. *(For computer purposes only, Class C violations show a scope/severity rating of "C" in the left-hand column of the SOD.)*
   - ***Correction Order*** when the licensee has not violated the same state statute or administrative rule in the previous two (2) years. *(For computer purposes only, Class C violations show a scope/severity rating of "D" in the left-hand column of the SOD.)*
   - ***Notation*** when the licensee did not violate the same state statute or administrative rule in the previous two years and is able to correct the violation by the end of the onsite survey. *(For computer purposes only, Class C violations show a scope/severity rating of "E" in the left-hand column of the SOD.)*

D. Federal Deficiencies

Each federal deficiency is categorized by severity and scope, using the following guidelines.

Severity / Harm Level (Resident Outcome)

- ***Level 4 (Immediate Jeopardy).*** Immediate jeopardy exists when a deficient practice has caused or is likely to cause serious injury, serious harm, impairment or death to a resident receiving care in the facility. Immediate corrective action is or was needed at the time of the deficient practice to prevent death or serious harm from occurring. Immediate jeopardy is not removed as long as facility practice establishes a reasonable degree of predictability of similar actions, situations, practices, or incidents occurring in the future.
- ***Level 3.*** Severity Level 3 exists when a deficient practice causes a negative outcome that compromises the resident's ability to maintain and/or reach his or her highest practicable physical, mental, and/or psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.
- ***Level 2.*** Severity Level 2 exists when a deficient practice causes minimal physical, mental, and/or psychosocial harm (discomfort) to the resident. Harm at level 2 also exists when a deficient practice has the potential to compromise the resident's ability to maintain and/or reach his or her

highest practicable physical, mental, and/or psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.

- ***Level 1.*** Severity Level 1 exists when a situation has the potential for causing no more than minor negative impact on residents.

If a federal deficiency has multiple examples at different levels, the most serious level determines the category, along with the frequency associated with that particular level.

Frequency Classification (or Scope)

- **Isolated (Scope 1).** If a situation affects or involves a very limited number of residents (generally three or less) and/or one or a very limited number of staff and/or the situation occurs only occasionally or in a very limited number of locations, then the deficiency is classified as "isolated."
- **Pattern (Scope 2).** If a situation involves or affects, or could involve or affect, more than a very limited number of residents and/or involves more than a limited number of staff and/or the situation occurs in several locations, then the deficiency is classified as "pattern." A pattern also exists if a deficient practice is widespread within a small subset of all residents in the facility (e.g., residents with gastrostomy tubes).
- **Widespread (Scope 3).** If a situation is pervasive throughout the facility or represents a systemic failure that affects or has the potential to affect a large portion of the facility's residents, then the deficiency is classified as "widespread."

Past Non Compliance

A ***federal*** deficiency will not be issued for deficient practices that occurred between the last recertification survey and the current survey, if the following conditions are met:

- The facility identified the deficient practice at the time it occurred.
- The facility took appropriate measures to correct the deficient practice and to prevent it from reoccurring (i.e., facility took all measures that BNHRC would have expected in a plan of correction).
- The deficient practice has not reoccurred and the facility is currently in compliance with the regulation.
- The deficient practice was at a Severity Level 3 or below. If at the immediate jeopardy level (Severity Level 4), serious resident harm did not occur.

III. Extended/partial extended surveys

A. Extended Survey

DQA will conduct an extended survey within two weeks of completion of the standard survey whenever a facility has **substandard quality of care**, for example:

- Resident Rights – F550, f558, F559, F561, F565, F584
- Pharmacy Services – F757-760
- Behavioral Health Services – F742-F745
- Infection Control – F883
- Freedom from Abuse, Neglect, and Exploitation – F600-F610
- Quality of Life – F675-F680
- Quality of Care – F684-F700
- Administration – F850

…that have a scope/severity level of:

- Immediate Jeopardy (Severity Level 4),
- Pattern or Widespread (Severity Level 3), or
- Widespread (Severity Level 2)

During an extended survey, surveyors add to the sample of resident reviews, review policies and procedures pertinent to the areas of deficiencies, and review staffing, in-service training, and contracts with consultants, if appropriate.

B. Partial Extended Survey

DQA conducts a partial extended survey within two weeks of completion of an abbreviated survey (e.g., complaint or revisit) after identifying substandard quality of care. Depending upon its findings during a partial extended survey, the survey team may expand the scope of its review to include a more comprehensive evaluation of compliance with the requirements under which substandard quality of care was found.

C. Loss of Nurse Aide Training and Competency Evaluation Program (NATCEP)

Facilities that are subject to an extended or partial extended survey because of the finding of substandard quality of care or which pay a civil money penalty of $5,000 or more are prohibited from offering or conducting a Nurse Aide Training and Competency Evaluation Program for a two-year period. This prohibition cannot be appealed. Facilities can request and may be granted a waiver of this prohibition if certain criteria are met.

IV. Plans of correction (POC)

A. Requirements for Submitting a Plan of Correction

A facility must submit a POC for:

- All state violations, except correction orders and notations, and
- All federal deficiencies that are not at Severity Level 1, Isolated

Nursing homes must complete and mail plans of correction to the appropriate DQA regional office by the **10th calendar day** following receipt of the SOD.

For state violations, DQA may extend the time frame for submitting plans of correction up to 30 calendar days if the plans involve substantial capital improvements. A facility must submit a written request for an extension to the Licensing and Regulatory Support Services Section of DQA prior to the **10th day** following receipt of the SOD to obtain the extension. DQA will send written notice of approval or denial of the extension to the facility.

B. Content of the Plan of Correction

The POC must:

- Identify ***what*** measures will be implemented for those residents found to have been affected by the deficient practice;
- Identify ***how*** the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- Identify ***what*** measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur;
- Identify ***how*** the facility will monitor its performance to ensure that the deficient practice is corrected and does not reoccur (e.g., monitoring by its quality assessment and assurance committee); and
- Identify a date by which substantial compliance will be achieved. In most cases, DQA expects facilities to be in substantial compliance within **30-45 days** following the survey exit.

A representative of the facility must sign and date plans of correction.

The POC must describe the corrective action that the facility will take to address the cited violation or deficiency, as described above. Although a facility may include in its POC a statement that it disagrees with the survey findings, a facility may not use the POC to malign the survey team or an individual surveyor.

DQA will not approve a POC that does not meet these standards. In such a case, DQA will identify why the POC was not acceptable, return it, and request that an acceptable plan be submitted within **five (5)** calendar days. A facility that fails to submit an acceptable POC is subject to the actions described in item IV. D. below.

If you have questions while drafting a POC, you may contact the surveyor or the Regional Field Operations Director or Supervisor.

C. Report of Correction

A facility that corrects a ***state*** violation prior to submitting a plan of correction may submit a notarized statement attesting to correction in lieu of submitting a POC.

D. Failure to Submit an Acceptable Plan of Correction

If a facility that participates in the Medicare or Medicaid program fails to submit a timely POC, DQA may immediately implement alternative federal enforcement remedies or initiate action to terminate the facility from the program. DQA may impose a POC if a facility fails to submit an acceptable POC.

E. Extended Time Period for Correction

A facility that cannot correct a state violation by the established completion date may request an extension by writing the regional office at least five calendar days prior to the correction date. DQA will determine whether the extended correction time is reasonable and will notify the facility of its decision.

F. Verification of Correction

DQA will verify correction of all state violations and federal deficiencies after the established completion dates have passed. Verification of correction may be done through an onsite revisit or through a desk review of the POC depending upon the nature of the citations, the regulatory groupings in which they fell, and their scope/severity level.

G. Failure to Correct State Violations or to Achieve Substantial Compliance with Federal Deficiencies

State Violations

Failure to correct a state violation by the date specified in the POC may result in one or more of the following:

- A forfeiture, or an increased forfeiture, on state Class A, B, and C violations.
- Suspension or revocation of the facility's license or issuance of a conditional license.
- Injunction for uncorrected Class A violations.
- Appointment of a state monitor or receiver if the Department of Health Services determines that the facility cannot protect the health, safety, and welfare of residents.
- Suspension of admissions if a Class A or Class B violation is not corrected within 90 days after receiving the violation. This applies to facilities that received one Class A or three Class B violations in a 12-month period during the three years preceding the first 12-month period.

Federal Deficiencies

Failure to achieve substantial compliance with federal requirements may result in the following adverse actions:

- For facilities with an opportunity to correct, a recommendation to CMS or the State Medicaid Agency to proceed with implementation of federal enforcement remedies. These remedies are associated with the deficiency have the highest scope and severity at the revisit.
- For facilities without an opportunity to correct (where enforcement remedies were implemented immediately following the survey), a continuation or modification of the remedy already implemented.

- Denial of payment for new admissions if the facility is not in substantial compliance with all federal nursing home regulations within three (3) months from the survey exit date or by the date specified in the letter that accompanied the Statement of Deficiency.
- Termination of the federal provider agreement for facilities participating in Medicare or Medicaid if the facility is not in substantial compliance within 180 days from the survey exit date or by the date specified in the letter that accompanied the Statement of Deficiency.. Termination of the federal provider agreement may also occur if a facility does not remove an immediate jeopardy situation within 23 days from the date the facility was verbally put on notice that immediate jeopardy exists.

V. Informal dispute resolution (IDR)

Facilities that disagree with all or part of a federal or state SOD may request informal dispute resolution (IDR) with two exceptions:

- IDR does not apply to a re-cited citation where (1) the re-cited facts are identical to the facts on the original citation and (b) where the original citation has already gone through IDR.
- IDR cannot, in general, be used solely to challenge the scope and severity assigned to a particular citation without challenging underlying facts and examples.

Maximus, through contact with DQA, conducts all facility IDR cases. The procedures for submitting an IDR request will be explained in the letter you receive that accompanies a Statement of Deficiencies.

Beginning April 2012, facilities may also request Independent Informal Dispute Resolution. Independent IDR will only apply to standard and/or complaint surveys that initiate an enforcement action for which a civil money penalty (CMP) is imposed and subject to being placed in escrow.

Case Conference

Pursuant to Wis. Stat. § 50.053, a facility may request an informal case conference to discuss and attempt to resolve, prior to hearing, any contested action initiated under subchapter I of Wis. Stat. ch. 50 (e.g., state violations and forfeitures). However, in order to preserve your rights to a hearing, an appeal must be filed within sixty (60) days of receipt of your SOD or forfeiture invoice. Scheduling IDR or a case conference does not constitute an appeal of the Department action. (See below.)

VI. Appeals

In addition to requesting informal dispute resolution, a facility may appeal certain Department actions related to federal or state citations.

A. Appeals of State Violations, Imposed Plans of Correction, Forfeitures, and Suspensions of Admissions

If a facility desires to contest the issuance of state Class A, B, or C violations, notations, plans of correction imposed on state violations, state forfeitures, or suspensions of admissions, it must send a written request for a hearing within 60 days of receipt of the SOD or other Department action, with a description of the action being contested, to:

Division of Hearings and Appeals
5005 University Avenue, Suite 201
Madison, WI 53705-5400

A facility must submit its appeal within 60 calendar days of receipt of notice of the Department action. The appeal must include a concise statement of the reason for objecting to the action.

Every state Class A, Class B, and Class C violation is reviewed to determine the appropriateness of a forfeiture or other state enforcement action. This review is conducted after IDR is completed. If the facility feels that there are extenuating circumstances or that they have information that would mitigate the circumstances of the violation as written, additional information can be sent to:

DQA / Bureau of Nursing Home Resident Care
P.O. Box 2969
Madison, WI 53701-2969

The additional information could include post-survey information, including but not limited to:

- Systems changes
- Cost of enhancements to systems to assure maintenance of compliance
- New programs
- Possible hiring of consultants
- Purchase of equipment

A facility that does not appeal a state violation and the forfeiture assessed on the violation will receive an automatic 35% reduction of the forfeiture if the forfeiture is paid within 10 days after receipt of the assessment notice.

B. Appeals of Federal Deficiencies that Result in the Imposition of a Remedy

A facility may appeal a certification of non compliance leading to an enforcement remedy [42 CFR 488.408(g)(1)] within 60 calendar days of receipt of the notice that imposes a federal remedy. Enforcement remedies may include civil money penalties, denial of payment for new admissions, temporary manager, a directed plan of correction, or directed in-service training. A facility may not appeal the choice of remedy [42 CFR 488.408(g)(2)]. Medicare certified facilities (SNFs) and dually certified facilities (SNFs/NFs) should mail their appeals to:

U.S. Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
ATTN: Theodore J. Kim, Director
330 Independence Ave. SW
Cohen Building, Rm. G-644
Washington, DC 20201

Facilities are asked to send a copy of their request to:

Center for Medicare and Medicaid Services
ATTN: Jan Suzuki
233 N. Michigan Ave., Suite 600
Chicago, IL 60601-5519

C. Medicaid Termination and Informal Reconsideration

Medicaid-only facilities wishing to contest the termination of Medicaid certification must send a written request, including a coy of the notice of the action being contested, to:

Division of Hearings and Appeals
5005 University Avenue, Suite 201
Madison, WI 53705-5400

A facility must submit its request for a hearing on termination or non renewal of Medicaid certification within 60 calendar days after receiving notice of the action.

In addition to filing an appeal, a Medicaid-certified facility also may request an informal reconsideration conference. To do so, it must submit a written request for informal reconsideration. The request may include any information that refutes the findings on which the termination is based. The request must be postmarked within 10 calendar days of receipt of a termination notice and be submitted to:

Administrator
Division of Long Term Care
P.O. Box 7851
Madison, WI 53707-7851

D. Medicare Termination

To appeal Medicare termination, Medicare-certified facilities (SNFs) and dually certified facilities (SNFs/NFs) must request a hearing before an administrative law judge of the Social Security Administration, Office of Hearings and Appeals. The facility must file an appeal within 60 calendar days of receipt of notice of the termination decision from The Centers for Medicare & Medicaid Services (CMS) [42 CFR 498.40(a)(1) and (2); 42 CFR 431.153(g)].

Pursuant to 42 CFR 498.22(b)(3), the date of receipt is presumed to be five days after the date on the notice, unless evidence shows that it was, in fact, received earlier or later.

This appeal should be mailed to either:

Jean Ay
Branch Manager
Long-Term Care Certification and Enforcement Branch
The Centers for Medicare & Medicaid Services
233 N. Michigan Ave., Suite 600
Chicago, IL 60601

or

U.S. Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
ATTN: Theodore J. Kim, Director
330 Independence Ave. SW
Cohen Building, Rm. G-644
Washington, DC 20201

Dually certified facilities must file any appeal of termination with the Centers for Medicare and Medicaid Services.

E. License Revocation, Suspension, or Denial of a Regular License

A facility must submit its request for a hearing on the revocation or suspension of a license or the denial of a regular license within 10 calendar days of receipt of the notice of the Department's action. The request must be submitted to:

Division of Hearings and Appeals
5005 University Avenue, Suite 201
Madison, WI 53705-5400

F. Denial of State Waiver or Variance Request

A facility may appeal the denial of a request for a state waiver or variance by writing:

Division of Hearings and Appeals
5005 University Avenue, Suite 201
Madison, WI 53705-5400

The facility has the burden of proving that the denial of a waiver or variance was unreasonable.

G. Care Level Determinations

A resident may appeal a care level determination within 45 calendar days of the date of the notice. The appeal must be filed with:

Division of Hearings and Appeals
5005 University Avenue, Suite 201
Madison, WI 53705-5400

An administrative law judge will hold a hearing within 90 calendar days from the date of the request for a hearing [42 CFR 431.244(f)]. Reimbursement for care and services will continue pending the decision for residents who appeal a change in the care level determination prior to the effective date of the care level change. The Department may recoup the cost of excess payments made on the resident's behalf if the Department's care level determination is upheld [42 CFR 431.230(b)].

VII. Waivers and variances

DQA may grant state waivers or variances for violations of state codes. All waivers and variances are reviewed annually.

A. State Code Waiver of Variance

A ***waiver*** grants an exemption from a requirement of Wis. Admin. Code ch. DHS 132.

A ***variance*** grants an alternate requirement in lieu of a requirement of Wis. Admin. Code ch. DHS 132.

1. Submitting a Waiver or Variance Request

a. Waiver or variance requests may be submitted at any time by writing to the Director of the Bureau of Nursing Home Resident Care of DQA. The request should include:
   - The rule from which the waiver or variance is requested
   - The time period for which the waiver or variance is requested
   - The reason for the request
   - The alternative actions proposed if a variance is requested, or the specific residents or rooms affected if a variance or waiver is requested
   - Documentation of assurance that resident health, safety, or welfare will not be adversely affected
   - Why compliance with the rule would result in unreasonable hardship or why the proposed alternative to the rule is in the interests of better care or management.

b. The Department will grant or deny a request, in writing, within 60 calendar days of receipt of a complete request. Notice of denials shall contain the reason for denial. If DQA does not issue a notice of denial within 60 calendar days, the waiver or variance is automatically granted.

c. The Department may, in consultation with the facility, modify the terms of the waiver or variance, impose conditions on the waiver or variance, or limit the duration of any waiver or variance.

d. A facility may appeal the denial of a state waiver or variance as noted in item VI. F.

2. Revoking a Waiver or Variance

The Department may revoke a waiver or variance if:

a. It determines that continuance of the waiver or variance adversely affects the health, safety, or welfare of a resident;

b. The facility fails to comply with the conditions imposed on the waiver or variance;

c. Revocation is required by a change in law; or

d. the licensee notifies the Department, in writing, that it wishes to relinquish the waiver or variance.

3. Approval for Admission of a Minor

A facility may not admit a person under the age of 18 years of age unless the Department approves the admission. A facility must follow the process outlined in Wis. Admin. Code § DHS 132.51(2)(f) to request approval to admit an individual under the age of 18. A facility should send a request, in writing, with:

a. A statement from the referring physician stating the medical, nursing, rehabilitation, and special services required by the minor;

b. A statement from the administrator certifying that the required services can be provided;

c. A statement from the attending physician certifying that the physician will be providing medical care; and

d. A statement from the persons or agencies assuming financial responsibility.

A facility may mail or fax this information to:

DHS / Division of Quality Assurance
Bureau of Nursing Home Resident Care
P.O. Box 2969
Madison, WI 53701-2969
Fax: 608-264-9889

B. Federal Regulation Waivers

1. Waivers of federal regulations may be granted only for:
   - Life Safety Code
   - Nurse Staffing 42 CFR 483.35(b)(1) and (2)
   - Resident Room Size 42 CFR 483.90(e)(1)(ii)

   A facility must send each federal waiver request to the following address or include it as part of a plan of correction. The DQA will forward certain federal waiver requests to the Centers for Medicare and Medicaid Services (CMS).

   DHS / Division of Quality Assurance
   Bureau of Nursing Home Resident Care
   P.O. Box 2969
   Madison, WI 53701-2969

2. The Center for Medicare and Medicaid Services will grant a federal waiver only if:
   - A facility demonstrates that approval of the waiver will not adversely affect resident health, safety, or welfare; or
   - Denial of a Life Safety Code waiver request creates an unreasonable hardship.

3. Facilities that have lost approval to offer or to conduct a Nurse Aide Training and Competency Evaluation Program may request a waiver by writing to:

   DHS / Division of Quality Assurance
   Office of Caregiver Quality
   P.O. Box 2969
   Madison, WI 53701-2969

VIII. Conclusion

The Division of Quality Assurance is committed to fair, consistent, and professional enforcement of state and federal requirements. If you have a concern, write to:

Administrator
DHS / Division of Quality Assurance
P.O. Box 2969
Madison, WI 53701-2969

We also encourage nursing homes to use *DQA Post-Survey Questionnaire* to provide feedback on the survey and on any deficiencies that were written. The questionnaire is available online at https://survey.alchemer.com/s3/7754814/DQA-Post-Survey-Questionnaire.

IX. DQA / Bureau of Nursing Home Resident Care Contact List

The Division of Quality Assurance (DQA), Bureau of Nursing Home Resident Care (BNHRC) central office and regional offices contact information are listed online at:

Division of Quality Assurance: Bureau of Nursing Home Resident Care Regional Offices | Wisconsin Department of Health Services

Topical BNHRC contacts can be found online under the Additional contacts dropdown listing at:

Nursing Homes | Wisconsin Department of Health Services