

V. Program Background & Responsibilities

Introduction:

This section of the guide explains the basic role of certification in ensuring that health care entities, such as nursing homes, meet the Medicare/Medicaid requirements. It outlines the functions and responsibilities of state agencies and, lastly, covers the role of the Centers for Medicare & Medicaid Services (CMS) in the process.

What you'll learn:

- Foundation for state agency activities
- Functions and responsibilities of state agencies
- Authority of the CMS Locations (aka Regional Offices)

Introduction – The Expectations of Nursing Homes & Oversight Agencies [SOM §7000]

The nursing home reform regulation establishes several expectations. The **first expectation** is that providers remain in [substantial compliance](#) with Medicare/Medicaid program requirements as well as state law. The regulation emphasizes the need for continued, rather than cyclical compliance. The enforcement process mandates that policies and procedures be established to remedy deficient practices and to ensure that correction is lasting; specifically, that facilities take the initiative and responsibility for continuously monitoring their own performance to sustain compliance. Measures such as the requirements for an acceptable plan of correction emphasize the ability to achieve and maintain compliance leading to improved quality of care.

Substantial compliance means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

- [CFR §488.301](#)

The **second expectation** is that all deficiencies will be addressed promptly. The standard for program participation mandated by the regulation is substantial compliance. The state and the regional office will take steps to bring about compliance quickly. In accordance with [§7304](#), remedies such as civil money penalties, temporary managers, directed plans of correction, in-service training, denial of payment for new admissions, and state monitoring can be imposed before a facility has an opportunity to correct its deficiencies.

The **third expectation** is that residents will receive the care and services they need to meet their highest practicable level of functioning. The process detailed in these sections provides incentives for the continued compliance needed to enable residents to reach these goals.

Basis for State Agency (SA) Activities [SOM §1002]

[The Social Security Act \(the Act\), Section 1864\(a\)](#), directs the Secretary of the Department of Health and Human Services (the Secretary) to use the help of state health agencies or other appropriate agencies when determining whether health care entities meet federal standards. This helping function is termed “**certification**.”

Certification Significance [SOM §1012A]

Certification is when the SA officially recommends its findings regarding whether health care entities meet the Act’s provider or supplier definitions, and whether the entities comply with standards required by federal regulations. **SAs do not have Medicare determination-making functions or authorities; those authorities are delegated to CMS’s Regional Offices (ROs)**. SA certifications are the crucial evidence relied upon by regional offices in approving healthcare entities to participate in Medicare. (See also [SOM §2000](#).)

Providers are parties who care for patients awaiting, receiving, or recuperating from treatment by intervening practitioners.

Suppliers includes those who furnish goods and services used in care and treatment.

- [SOM §2002](#)

SA Certification [SOM §1010]

The functions that the state SAs perform are referred to collectively as the certification process. This includes, but is not limited to:

- Identifying potential participants;
- Conducting investigations and fact-finding surveys;
- Explaining requirements and conducting periodic education programs for staff and residents, and their representatives, in order to present current regulations, procedures, and policies;
- Data entry of survey information into CMS data systems; and
- Maintaining survey, certification, statistical, or other records.

SA Administrative Responsibilities [SOM §4003]

The SA is responsible for:

- Establishing and maintaining organizational relationships with other state and local government groups as necessary for attaining program or related program goals;
- Keeping CMS advised of program needs and trends, and of responsive actions taken;
- Providing the material, equipment, and the training and support of personnel to perform the above functions; and
- Furnishing necessary records and accounting to provide justification for costs claimed for payment by the Secretary.

SA Staff Training and Development [SOM §4003.2]

All health facility surveyors employed in the Medicare and/or Medicaid programs must successfully complete the Basic Health Facility Surveyor Training Course *within the first year of employment*.

Each state is responsible for providing continuing education to its surveyors. Each SA provides the appropriate training through in-service education, state, regional, and/or national conferences, seminars and workshops, and related courses as needed and appropriate. The SAs are to assure that surveyors are trained to survey for all regulatory requirements and have the necessary skills to perform the survey.

The Basic Health Facility Surveyor Training Course provides training to federal and state surveyors on a wide variety of topics related to the survey and certification process. Subjects include regulatory, procedural, and issue-based information as well as practical skills, knowledge, and application.

In-Agency Training [SOM §4003.2B]

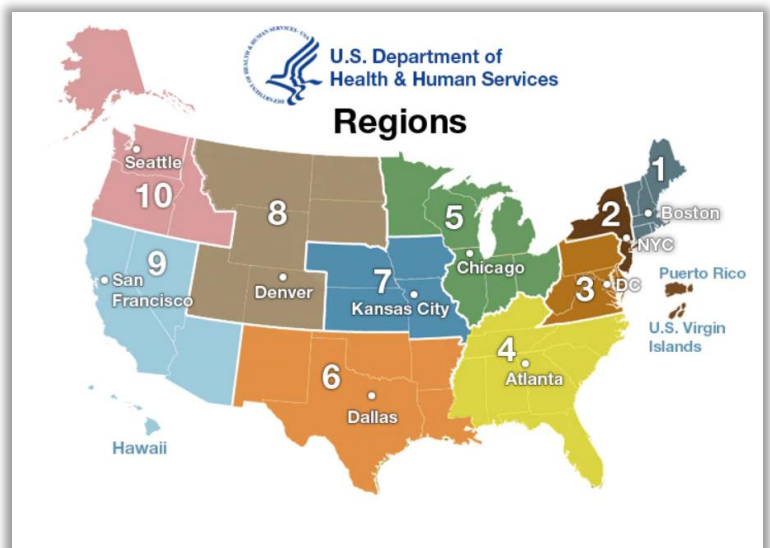
Each SA must have its own program of staff development that responds to the needs of new employees for orientation and basic training, and to the needs of experienced employees for continuing development and education.

CMS's Role [SOM §1006]

The primary mission of CMS is to administer the Medicare program and related provisions of the Social Security Act in a manner which:

- Promotes the timely and economic delivery of appropriate quality of care to eligible beneficiaries;
- Promotes beneficiary awareness of the services for which they are eligible; and
- Promotes efficiency and quality within the total health care delivery system.

CMS carries out its mission through a central office (CO) in Baltimore, which promulgates policies and provides monitoring, surveillance, and overall administrative control of the certification process (including its financial and surveyor training aspects), and 10 Regional Offices (ROs) which are responsible for assuring that health care providers meet applicable federal requirements. In relation to the responsibilities and activities of the state agencies (SAs), ROs are responsible for:



- Evaluating the performance of SAs;
- Providing liaison, direction, and technical assistance to SAs;
- Allocating SA funds for conducting certification activities; and
- Conducting surveillance and assessments of SA operations; reviewing SA certification actions; and providing feedback to states.

Surveyors must express deficiencies clearly and concisely with a regulatory citation for each.

Note: In 2020, CMS renamed the Regional Offices “Locations.” However, both names continue to appear on the [federal website](#) and CMS documents.

Approval and Correction of Deficiencies [SOM §1016]

Nursing homes are required to operate in compliance with a set of requirements known as the Requirements for Participation. This section of the SOM describes the fundamental activities of the SA in this role.

The SA ascertains, by a survey conducted by qualified health professionals, whether and how each standard is met. While an institution may fail to comply with one or more of the subsidiary standards during any given survey, it cannot participate in Medicare unless it... attains substantial compliance with requirements.

“The essence of what the SA certifies to CMS is a finding of whether an institution... substantially meets each requirement....”

The SA prepares its certification for the RO, sends the institution a [“Statement of Deficiencies,” \[SoD\] Form CMS-2567](#). The institution is given 10 calendar days in which to respond with a Plan of Correction (PoC) for each cited deficiency and enters this response on the form containing the statement of deficiencies.

If the institution has not come into compliance with all... Requirements... within the time period accepted as reasonable, the SA certifies noncompliance notwithstanding a PoC.

Statement of Deficiencies and Plan of Correction [SOM §2728]

The survey report form, [Statement of Deficiencies and Plan of Correction Form CMS-2567](#), is the federal form that must be used by the state to document inspections and surveys. It serves several important functions:

- It is the basic document disclosed to the public about the entity’s deficiencies and what is being done to remedy them;
- It documents the specific deficiencies cited;
- It documents any promises made by the provider/supplier, i.e., plans for correction and timeframes; and
- It provides an opportunity for the provider to refute survey findings and furnish documentation that requirements are met.

Statement of Deficiencies [SOM §2728A]

The surveyor prepares Form CMS-2567, and for each requirement not met, the surveyor makes a citation that includes the following:

- The prefix and data tag number ([see Appendix 1 of this guide](#));
- The deficiency that contains the [Code of Federal Regulations \(CFR\)](#) reference, the requirement that is not met, and an explicit statement to that effect; and
- The evidence to support the deficiency.

Sample → Statement of Deficiencies and Plan of Correction, Form CMS-2567:

Department of Health & Human Services Centers for Medicare & Medicaid Services		Printed: 01/20/2021 Form Approved OMB No. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355125	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER Augusta Place, a Prospera Community		STREET ADDRESS, CITY, STATE, ZIP CODE 301 Lorrain Drive Bismarck, ND 58503	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure each resident received adequate supervision and/or assistive devices to prevent accidents for 1 of 1 sampled resident (Resident #22) with a current bed alarm. Failure to reassess the effectiveness of current interventions and need for additional interventions when necessary may result in falls. Findings include: Review of the facility policy titled Alarms: Bed, Chair, and Door occurred on 02/26/20. This policy, revised December 2019, stated, . Purpose: To ensure that use of alarms is dignified and appropriate based on the resident's condition. Review of the resident's condition will determine if the resident will benefit from the use of an alarm. The use of alarms will be reviewed on a regular basis but not less than quarterly by the interdisciplinary team. Review of Resident #22's medical record occurred on all days of survey. The current care plan stated, . The resident is at risk for falls R/T (related to) hx (history) of falls, Dx (diagnosis): [MEDICAL CONDITION], impaired mobility. Cognitive loss, poor safety awareness. falls risk score=16. Bed alarm in place for resident safety due to HX of self transferring and falls. Date Initiated: 05/15/2016. Revision on: 06/18/2018. Observation on 02/24/20 at 10:08 a.m., identified a bed alarm on Resident #22's bed. During an interview on 02/26/20 at 4:00 p.m., an administrative nurse (#1) stated she was unable to find documentation the bed alarm had been re-evaluated. The facility failed to reassess the effectiveness of and need for Resident #22's bed alarm.		
Level of Harm - Minimal harm or potential for actual harm			
Residents Affected - Few			

Prefix Tag

Data Tag

CFR Reference

Evidence to Support the Deficiency

PoC Review [SOM §2728C]

The SA reviews the PoC for appropriateness, legibility, and completeness. If it is not properly completed or if there is a question about it, the SA contacts the facility representative to obtain clarification or an appropriate modification of the plan.

PoC Modifications [SOM §2728D]

The facility may submit evidence of correction or a modified PoC to the SA at any time. The SA retains a copy of the material and forwards the original to the regional office or state Medicaid office, as appropriate.

PoC Rejections [SOM §2728E]

If the SA finds that a PoC is unacceptable, it rejects it and seeks an acceptable PoC from the provider. Generally, changes must be made by the provider, but if adjustments required are minor, the SA may contact the provider by telephone, make the necessary adjustments, and submit the change to the provider. Changes to a PoC must be signed by the provider.

To certify a SNF to receive payment under Medicare and/or Medicaid, surveyors must complete at least:

- A life safety code survey; and
- A standard survey

Surveyors are to follow the procedures in [Appendix P](#) of the SOM for conducting all surveys of SNFs.