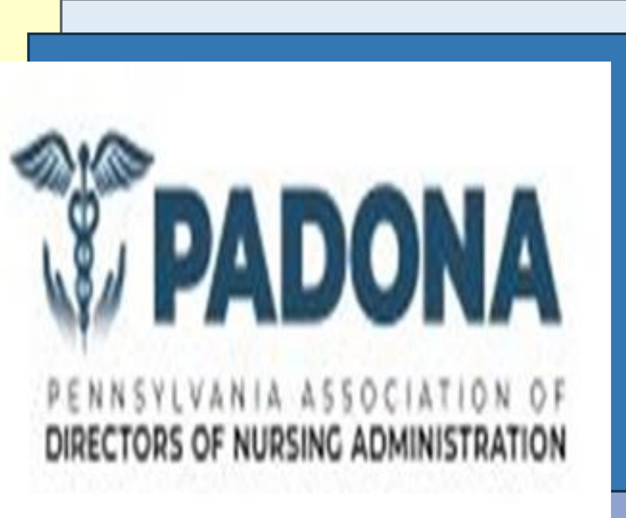
2026 Annual PADONA Conference

A Roadmap for Success To Establishing Past Non-Compliance



About Angela

An accomplished author and speaker with 36+ years of RN experience in post-acute care, Angela brings her extensive knowledge and skill on regulatory compliance, risk management, policy development, quality assurance, and survey preparedness.

Expertise & Role

As a Compliance Specialist, Angela provides educational training, support and mentoring to Post Acute care leaders on Long Term care regulatory compliance and provides guidance on risk management and risk mitigation to the communities that she serves. Angela holds certifications in wound care, infection prevention, healthcare compliance and completed certification thru Mitchell Hamline School of Law on Elder Law and Chronic Care.

Achievements & Affiliations

A PADONA member since 1993, Angela currently serves as Secretary on the PADONA Board of Directors. She was a 2024 Finalist for the Community RN Nightingale award and recently received the 2026 APACAN IMPACT award.

Objectives

1. Recognize and Identify deficient practice and systemic compliance issues
2. Understand the CMS guidelines for determination of past noncompliance
3. Clearly and objectively document past non-compliance to support organizational accountability and promote sustained compliance

Compliance with Regulatory Requirements

- CMS has regulatory requirements that must be followed in the **State Operations Manual (SOM)**

- Each state may have additional requirements that must be followed. **We must follow the most strict.**

- When you become aware that the facility is not meeting a regulatory requirement...

What is Past Non-Compliance?

Past non-compliance occurs when noncompliance previously existed, but the facility has already corrected the deficiency and is in substantial compliance at the time of a current survey (CMS, 2024)

corrected

Defined by **3 criteria** that **must be met**

Past Non Compliance Criteria

PER CMS - Past noncompliance means a deficiency citation of an F-tag or K-tag that meets all of the following three criteria:

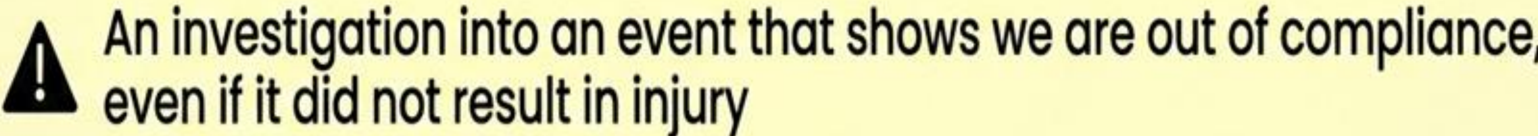
1. The facility was not in compliance with the specific regulatory requirement(s) (as referenced by the specific F-tag or K-tag) at the time the situation occurred;
2. The noncompliance occurred after the exit date of the last standard (recertification) survey and before the survey (standard, complaint, or revisit) currently being conducted;
3. There is sufficient evidence that the facility corrected the noncompliance and is in substantial compliance at the time of the current survey for the specific regulatory requirement(s), as referenced by the specific F-tag or K-tag.

Benefits of Establishing Past Non-Compliance (PNC)

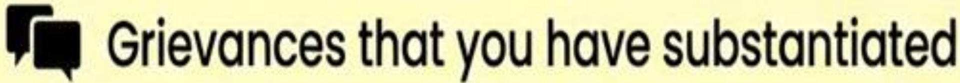
- Demonstrates facility has systems in place to identify and address adverse events- ***good faith effort***
- A nursing home does not provide a plan of correction for a deficiency cited as past noncompliance
- If noncompliance is at a level of immediate jeopardy- shortens the length of potential CMP that may be applied and/ or per incident CMP

When Do We Implement a Past Non Compliance

- An investigation for a facility reported incident (FRI) is substantiated



- An investigation into an event that shows we are out of compliance, even if it did not result in injury
  a. A fall where a staff member failed to follow the plan of care
  b. A facility acquired pressure injury where we did not have interventions in place
  c. Medication errors



- Grievances that you have substantiated
- Reading 24-hour clinical notes you identify a concern that was not otherwise reported that would get you a citation
- Process gaps identified thru routine auditing

Trigger Events

Immediate Jeopardy Triggers

Abuse

Resident Outcome/Experience:

- Unexplained head trauma/bruising, resident fear

Staff/Facility Action:

- Failure to investigate, staff treatment of residents

QOC/QOL & Infection Control

QOC/QOL:
Resident outcome/Experience:

- Sudden/unexpected COC
- Repeat falls, Pressure injuries

QOC/QOL:
Staff/Facility Action:

- Inappropriate use of mechanical lifts, untrained staff
- Medication Errors

Infection Control:
Resident outcome/Experience:

- Uncontrolled spread of infection

Infection Control:
Staff/Facility Action: Using same needle for more than one resident

Environmental & Safety

Environmental/Structural:
Resident Outcome/Experience:

- Burns
- Side rail entrapment

Environmental/Structural:
Staff/Facility Action:

- Lack of Emergency Preparation

Safety:

- Elopement
- Smoking
- Hot Beverage
- Fx due to lack of footrest

Why Is This SO Important?

Patient Focus & Responsibility

Patient Care may be affected - YOU must keep them safe

You are responsible for enforcing regulatory requirements and ensuring appropriate care of your residents

Consequences of Citations

State may identify this at their next visit and give you a citation

Citations =

- **LOTS of WORK** writing plans of corrections with tight deadlines

- Potential fines with Civil Money Penalties that can get quite high depending on their level of deficiency

- Decrease in Star Rating as points are added to your Health Inspection Score

- Often citations reflect where your quality ratings are struggling

What Surveyors review to issue PNC

LTC Survey Pathway (observations, interviews and record reviews)

- The facility's review, revision, or development of policies and/or procedures to address the areas of concerns

- The provision and use of new equipment, as necessary

- Provision of staff training required to assure ongoing compliance for the implementation and use of new and/or revised policies, procedures, and/or equipment, especially with new and/or temporary staff;

- Necessary modifications to plans of care, notification

- Provision of additional staffing, changes in assignments or deployment of staff,

- Provision of a monitoring mechanism to assure that the changes made are being supervised, evaluated, and reinforced by responsible facility staff

Possible Outcomes

They may accept it and not cite you at all. This is our goal for doing these!

They may cite you, but accept your Past Non-Compliance effective the date they exit. Then you don't have to do any further Plan of Correction (POC) when the 2567 comes.

Or, if we did not cover everything they thought we should, or we never finished the PNC before they came in, we may still get cited.

important to have many people review if possible. Many minds with different perspectives can really help make a solid product.

Past Non-Compliance on a 2567

- Citation given and will have the G points added to their survey score, however, they will not review 689 on revisit and do not need to submit a POC.
- (Revisits = Increased risk for additional citations, not clearing)

F689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) 483.25(d) Accidents. The facility must ensure that - 483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and 483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F689	Past noncompliance: no plan of correction required

POC NOT FINAL

What Triggers an Immediate Plan of Correction?

- Incident Reporting System
- Compliance Line
- Grievance Process
- Rounding
- Internal Auditing
- Reportable Event
- Mock Survey Findings

FOUR POINT PLAN

1. What corrective actions will be accomplished for those residents who have been affected by the incident
2. How will you identify other residents with the potential to be affected by a similar incident
3. What measures will be put into place or what system changes will you make to ensure that an incident does not reoccur
4. How will the preventative measures be monitored and who will be responsible

Date when the preventative measures will be implemented and evaluated

Let’s Start

- You will write a Past Non-Compliance (PNC)

  Some surveyors will not accept these as “past non-compliance”. However, they often will accept corrective actions as QAPI projects – therefore we will refer to them as an Ad Hoc QAPI in those states when needed to address an identified issue

1. Investigate why the problem occurred – take the time to do a **root cause**.
2. Identify which **F-tag(s)** may be affected and read what all the requirements are so you are familiar and ensure you include what is needed in your **PNC**.

Templates and Past Non-Compliance examples can be found at APACAN and in conference handouts

Give Yourself a Citation!

Write a Plan of Correction – AKA Past Non-Compliance

- Submit your plan into your QAPI committee through an Ad Hoc QAPI

You cannot change the fact that the non-compliance has occurred

You can and SHOULD correct the problem going forward

- Surveyors want to see that you have a system in place to monitor your facility compliance and self-identify when you are not following regulations
- But they also want to see that you took action to address it
- **You must be back in compliance at the time the surveyors walk in the door**

Investigation and Root Cause Analysis

First Things First:

- Notify the Medical Director
- Complete thorough investigation
- Convene IDT and QAPI Committee to review findings, draw conclusions and perform Root Cause Analysis
- Corrective action cannot or should not begin, including education, until likely system failures and causal factors are identified
- Work as a team to develop comprehensive plan to protect residents, educate staff and monitor the education and intervenitons for success

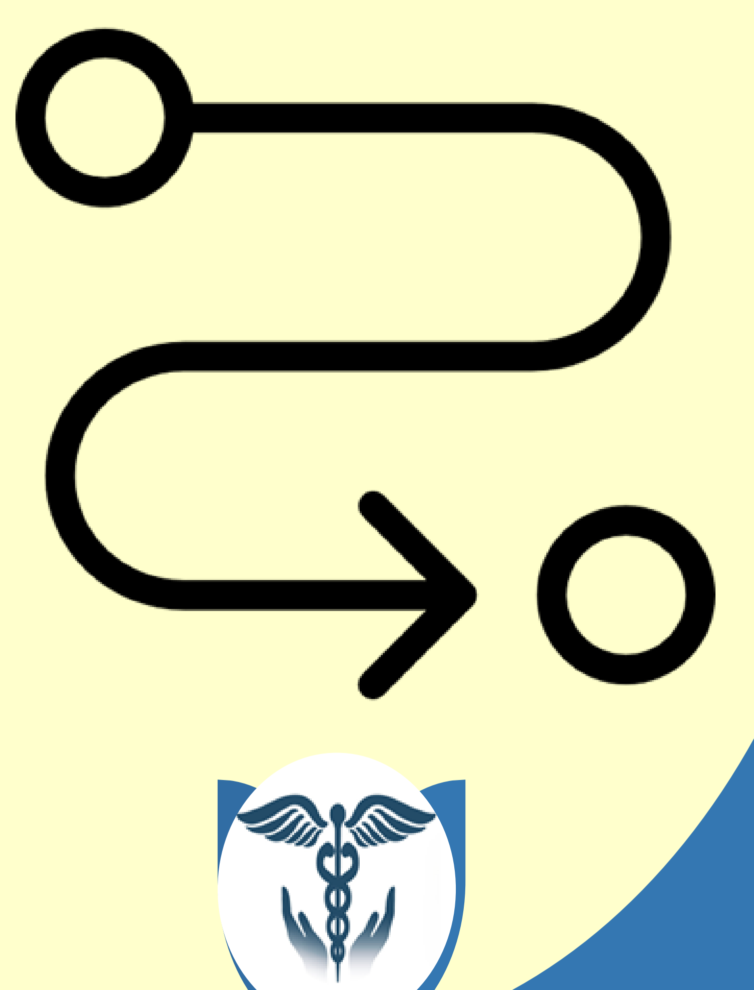
Example Situation

- Resident is being pushed in her wheelchair out to the nurses station to wait for transportation to an appointment.
- As she is being pushed, her foot drops to the floor but the aide does not realize this and continues to push her in her w/c.
- Her foot catches on the carpet, rolls under the wheelchair and falls out of the chair face first.
- She reports pain in her leg and is sent to the ER where she is found to have a femur fracture requiring surgery
- The next day you get a call from her daughter who is upset she was never notified her mom was sent to the hospital with a fracture

To Demonstrate PNC

Self- Report if applicable

Initiate an immediate investigation



Step One - Investigate and Complete a Root Cause Analysis

the team must analyze the root cause to understand the true depth and breadth of the problem. **The facility must identify the cause(s) of the problem or underperformance before implementing any intervention. Initiating solutions without knowing the root cause(s) is a bit like washing a car and hoping it will fix the radio.**

Use investigative questions to discover underlying causes:

- Which systems, processes, or practices were directly involved with the incident?
- What are the specific steps involved in each process or practice?
- Were any steps interrupted, inadequate, or omitted from the system, process, or practice? Could that have contributed to the events?
- Why did the system, process, or practice not function as anticipated?
- What quality improvements must the team make to the system, process, or practice to ensure high-quality care and avoid recurrence?

The facility can ascertain root cause(s) through an objective review of the system or process. The investigator should ask two questions:

1. **Would the event have occurred if this cause had not been present?**
2. **Will the problem reoccur if the cause is corrected or eliminated?**

Root Cause Analysis

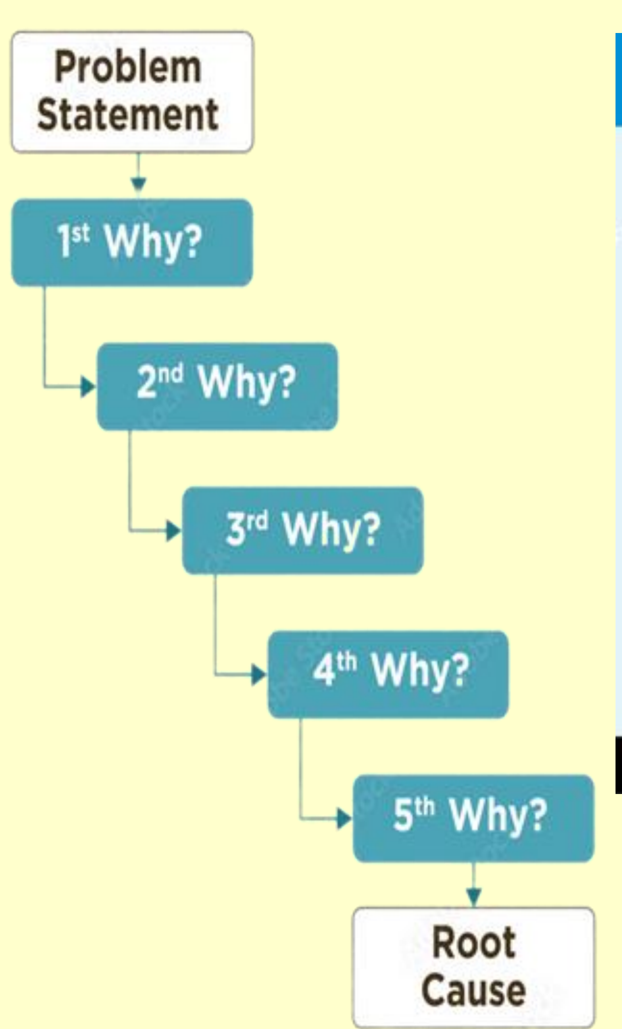
Failure Mode Effects & Analysis

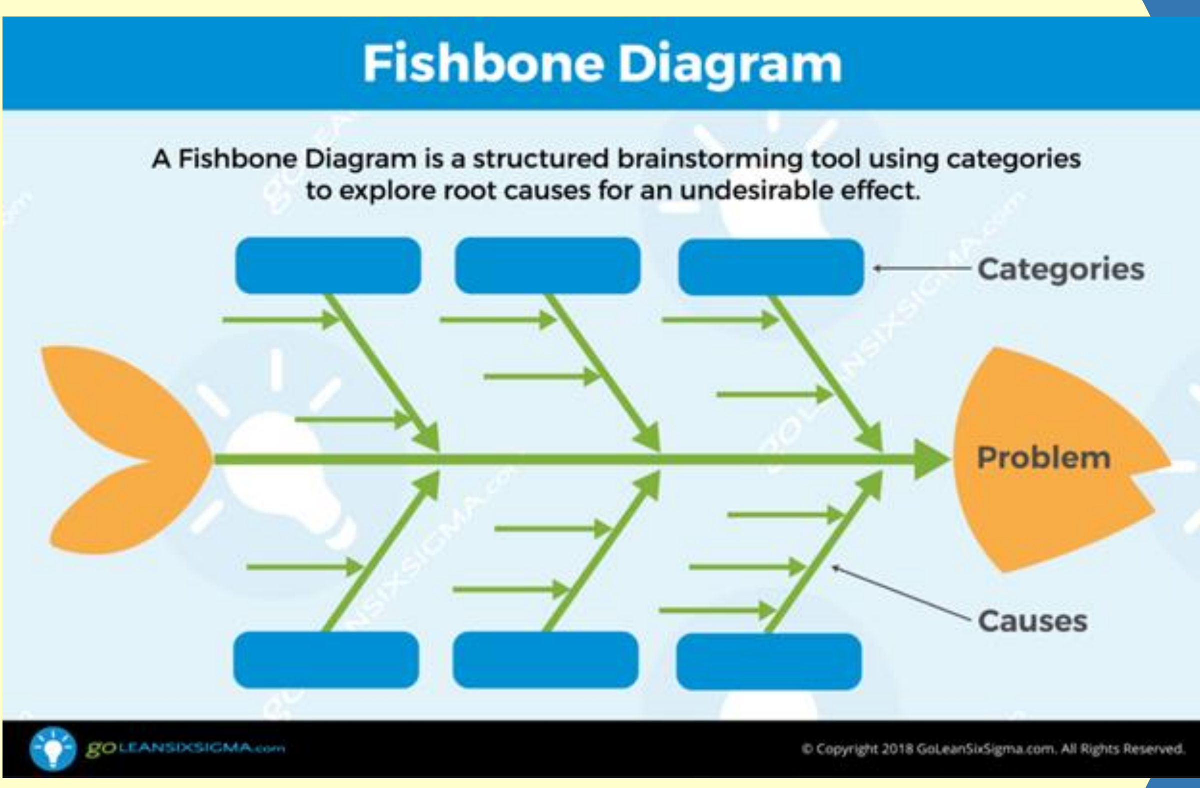
Structured proactive method to identify potential failures is products, process or systems and assess their consequences to prioritize risk mitigation

Specific way in which a component, process or system might fail.

Identifying failure modes helps anticipate problems before they occur and focuses on prevention rather than reaction

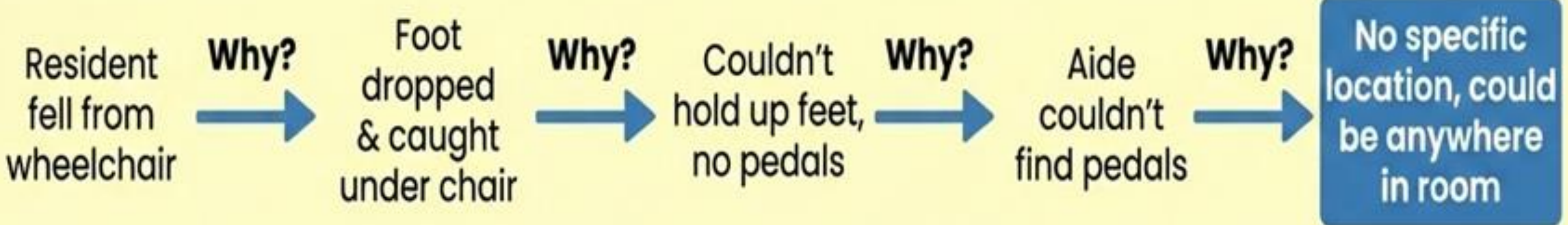
Root Cause Analysis





Investigation and Root Cause

- **Step 1:** Investigate the incident and complete a root cause analysis with the team using gathered information.



Solution Recall: A "Survey and Safety Memo" was previously sent regarding this exact scenario.

The memo recommended ordering and placing wheelchair bags on all wheelchairs to keep foot pedals accessible.

STEP 2 Understand the Requirements to be in compliance

Review LTC Survey Pathways

https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursing-homes

Appendix PP- State Operations Manual

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

Appendix Q- Immediate Jeopardy

State Operations ManualState Operations Manual

What Are My Potential Tags?

- Go to the State Operations Manual and review potential tags
- **F 580 Notification of Changes**

  Why is this a possible citation?
- **F 689 Accidents**

  Why is this a possible citation?
- **F 658 Services Provided Meet Professional Standards**

  Why is this a possible citation?

Was there patient harm? Yes - Fractured Femur requiring surgery, it's been reported to the state

Step 3- Think “Plan of Correction

1. What did you do for the resident affected by the deficient practice?
2. How did you identify others having the potential to be affected by the same deficient practice?
3. What measures will be put into place or systematic changes were made to ensure the deficient practice does not recur?
4. How will you monitor performance for sustained compliance?

Element 1

Element 1 for a plan of correction identifies any residents that the non-compliance has affected in the situation that alerted you to the problem.

(This may be one resident or several residents based on your identified issue)

After you have identified which residents alerted you to this issue, you must identify what you are going to do for those residents to address the issue.

Element 1 Example

- Resident MJ was affected by this practice.
- Resident MJ was assessed and sent to the ER for further evaluation.
- Care plan was reviewed and updated to reflect using foot pedals when transporting resident in wheelchair
- Wheelchair bag ordered for resident wheelchair to keep foot pedals in for easy access

Element 2

- Now that you have Mrs. Jones taken care of. We need to consider that if this occurred with Mrs. Jones, it has the potential to be a problem for other residents too.

- Element 2 – Identify criteria for what other residents that have the **potential** to be affected by this same practice.

- Ask yourself

  Who are your other potentially at risk residents?

  What will you do for these residents to ensure they are safe related to this issue?

- When identifying this list of individuals, be specific and narrow the scope to the problem that occurred.

Element 2 Example

- All residents who use a wheelchair for mobility have the potential to be affected.
- Care plans have been reviewed and updated as needed
- Wheelchair bags have been ordered for all residents with wheelchairs to keep foot pedals in

Remember - we also tagged ourselves for notification of change in condition

- Any resident who has had an incident/event in the past 7 days has the potential to be affected.
- These residents charts were reviewed to ensure legal representatives were notified of incident that occurred. The legal representative will be notified of any incident found to have not notified the legal representative at time of incident.

Element 3 - Process Changes

- Now that we have ensured all our other residents are ok, we now need to look at how we are going to fix the process to address the concerns identified. What will you do?

- This is typically done through:
  - Policy Review with changes if needed
  - Process review and modifications if needed based on Root Cause Findings
  - Education to the staff responsible for the process

Element 3 Example

- Wheelchair bags have been ordered and will be kept in the central supply for any resident who admits and needs a wheelchair for mobility

- All direct care licensed nurses, CNAs, Medication Aides, and Activities professionals will be re-educated on the standard practice and expectation to put foot pedals in wheelchair bag when not in use and to put them on prior to pushing a resident.

- All direct care licensed nurses will be re-educated on notification to legal representatives following any incident or accident.

Element 4

- How will you ensure continued compliance with the process changes, re-education, etc to ensure that the issue is corrected?

- This means – AUDITS!

  The audits must be written to verify that the solution is working and staff understand and are compliant either by interview or performance.

  Frequency of audits is up to you – but keep in mind when deciding – How likely is it that staff may not do this consistently?

Element 4 Example

- Under the direction of the Quality Assurance and Process Improvement Committee, t*hree residents who use a wheelchair for mobility will be audited each week by the DON or designee to ensure foot pedals are used when pushing resident.*
- Under the direction of the Quality Assurance and Process Improvement Committee, *three incidents/accidents will be audited each week by the DON or designee ato ensure notifications are made to legal representatives when incidents occur.*
- Audits will be submitted and reviewed by QAPI committee for management of ongoing compliance and will continue until determined by QAPI

Step 4- Document your action steps

- Critical event analysis and action planning workshet
- PDSA Cycle
- Action Plan Template
- Timeline of Events

pdsacycledebedits.pdf

Action Planning

Performance Improvement Plan –

Facility: Date:

Area of Concern	Root Cause	Action Items	Person (s) Responsible/ Due date	Status/Progress of each area

- Outlines action steps
- Assigns accountability
- Monitor implementation

Finally - The Date of Compliance

- The final part of the Past Non Compliance is determining when you can have the facility back in compliance with the regulatory requirement.
- Keep in Mind:

  If it is a more serious issue and the state has the potential to come investigate the concern – the Date of Compliance should be ASAP – same day or next day.

  This may mean a little longer days and lots of teamwork.

  To be in compliance ALL components (elements 1-4) must be done

  Elements 1 and 2 should be completed ASAP regardless of Date of Compliance to ensure resident safety and quality of care

QAPI Committee Involvement

- Involve the Medical Director
- Review plan and monitoring results with team
- Address ongoing actions, other potential systems/process affected
- Involve the entire team
- Document review, discussion and recommendations in minutes
- Do not wait until next scheduled meeting - call a special meeting with a short agenda
- Obtain signatures for attendance

What can prevent achieving past non-compliance?

- Not enough time to prove substantial compliance
- Did not meet all conditions of requirements-missed some steps
- Lack of reporting from the front line
- Delay in initiating investigation
- Lack of thorough investigation
- No systematic way to address adverse events/identify potential for adverse events

Teamwork and Delegation

- This is typically a big task. Utilize all resources you have available to help
- They must be able to complete the assigned tasks within their scope of practice
- If you are in charge of the Past NonCompliance, you are responsible to follow up with the team and ensure all parts are completed and on track to be done on time.

Put it All Together

- When all components are completed you will want to put each portion into a packet or binder, organized, and separated out by each element
- If an audit was completed for element 2 to determine who else was actually affected, put it in the binder.
- Any follow up completed in elements 1 and 2 must be printed and placed in the binder.

  (If you can print it you can prove it.)
- If an assessment was done on the resident, make sure a clinical note was written, print this off and put in the binder
- Include all education given and attendance sign in sheets
- Include a copy of master audits for element 4
- Scan and upload the completed packet with all elements that relates to the issue identified to designated location

What if Staff Don’t Work Before Date of Compliance?

- Anyone who has not completed the necessary education by the date of compliance must not work until they have completed the education
- Look up their next scheduled work day and make sure you make a plan to have the education completed before their shift.

Be Alert

We need to identify and correct these **before a surveyor identified.** Look for the opportunities to self-correct.

- Read 24-hour reports and validate implementation of policy/procedures/care plans
- Review Incident Reports/Unusual Occurrences
- Review Grievances
- Listen to Staff Concerns
- Round the units and look for any concerns
- Any Facility Reported Incidents (FRIs) that are substantiated

Do Not Offer Unless Necessary

- These are for you to resolve problems to make improvements in your building

  Do not automatically hand over all PNCs when they enter the building

- However, for example, if they look back in the last year and note that there is a concern with the fall r/t this patient and tell you they have a concern with this

  NOW – you tell them. “Yes, we did identify that and we immediately submitted this issue to QAPI. We completed this improvement project.”

    NOW you give them all components of the Ad Hoc QAPI that you had completed.

    (Keep in mind - the “fix” must still be in place)

What if they don't say there is a concern?

- Good survey management means good communication with the surveyors throughout the survey.
- You want to be checking in with them and ask

  Is there anything else you need right now?

  So far, do you have any concerns that I can help clarify for you or get you more information?
- If they acknowledge that they do have concerns, ***NOW*** offer up the past non-compliance that applies to that issue

CRITICAL

- You **MUST** have the past non-compliance completed when the surveyors walk in the door otherwise they likely will not accept it.
- This means EVERYTHING you listed in each element must be done and you must be able to prove it.
- Remember – If you can print it, you can prove it. Make sure it's printed and in your binder or packet.
- Do Not make them look through charts to find the proof - you don't want them finding something else

QAPI Monthly Reports

- Incorporate into your QAPI program
- Make sure you include any Ad Hoc QAPIs you have completed in your monthly reports with the results of your audits included (trends noted)
- Continue the audits until QAPI deems them no longer necessary.
  - Make sure this is noted in your QAPI minutes to DC the Audits
  - Surveyors may ask to see your audits.
  - **Make sure these are kept up** as indicated on your PNC plan

QUESTIONS

References

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/downloads/scletter06-01.pdf

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationEnforcement/Downloads/NH-Enforcement-FAQ.pdf

CMS QAPI Resources