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Plan of Correction

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Participants will:

- Discover strategies to submit a successful plan of correction
- Identify areas of improvement
- Develop a proactive compliance program



Plan of Correction

- Reactive
- Do not have a choice
- Can impact certification if not addressed
- EXTERNAL

Process Improvement

- Proactive
- Self-motivated
- Positive reinforcement
- INTERNAL

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Plan of Correction:

- Initial Certification POC
  - RHC certification effective date on hold
- Recertification POC
  - Timelines and expectations
- Types of deficiencies:
  - Immediate Jeopardy
  - Condition (45 days from survey date)
  - Standard (60 days from survey date)
  - Zero Deficiencies!

Plan of Correction:

- Exit conference
  - There shouldn’t be any surprises
  - Take extensive notes
- Begin making documented corrections
  - Staff training
  - Policy development
  - Implementation of process
- Wait for official Statement of Deficiencies (SOD)
  - Not all comments make final document

Plan of Correction:

- Once the SOD arrives:
  - It is accompanied by a letter
    - Contains instructions
      - Make the instructions your checklist for each deficiency
    - Due dates (10 days from receipt of plan)
  - Left side is completed by surveying entity (SOD)
  - Right side is for clinic's response (POC)
  - Address every deficiency
    - Even if it seems duplicated

Plan of Correction: (CMS FORM 2567)

- Address every deficiency:
  - Use the corresponding Jcode, Ecode, etc.
  - What is your plan to correct the deficiency
  - Procedure for implementing plan
  - Plan completion date
  - Monitoring procedure
    - How do you know this won't happen again?
    - Who is responsible (titles only)
  - Evidence of correction
    - NO PHI

Plan of Correction:

- What:
  - Describe what led to the deficiency and the plan for correcting the deficient practice
- How:
  - Describe how the issue was resolved for the impacted patient population AND how it will be resolved going forward
- Who:
  - Position responsible for correction
  - Position responsible for ONGOING monitoring, maintenance, and review
  - Define frequency as applicable
- Logistics
  - Signatures, due dates, completion dates and timelines of implementation

Plan of Correction:

- After submission:
  - Wait for RHC approval letter or additional requests for clarification
  - Adhere to any new timelines
- What happens if you ignore the SOD?
  - Initial certification
  - Recertification
- Will the surveyor return?

Plan of Correction:

- Implementation
  - Create tools to assist in monitoring
  - Educate staff on change in protocols
  - Create calendar reminders to adhere to submitted timelines
  - NOTE: Next survey will likely confirm POC has been followed

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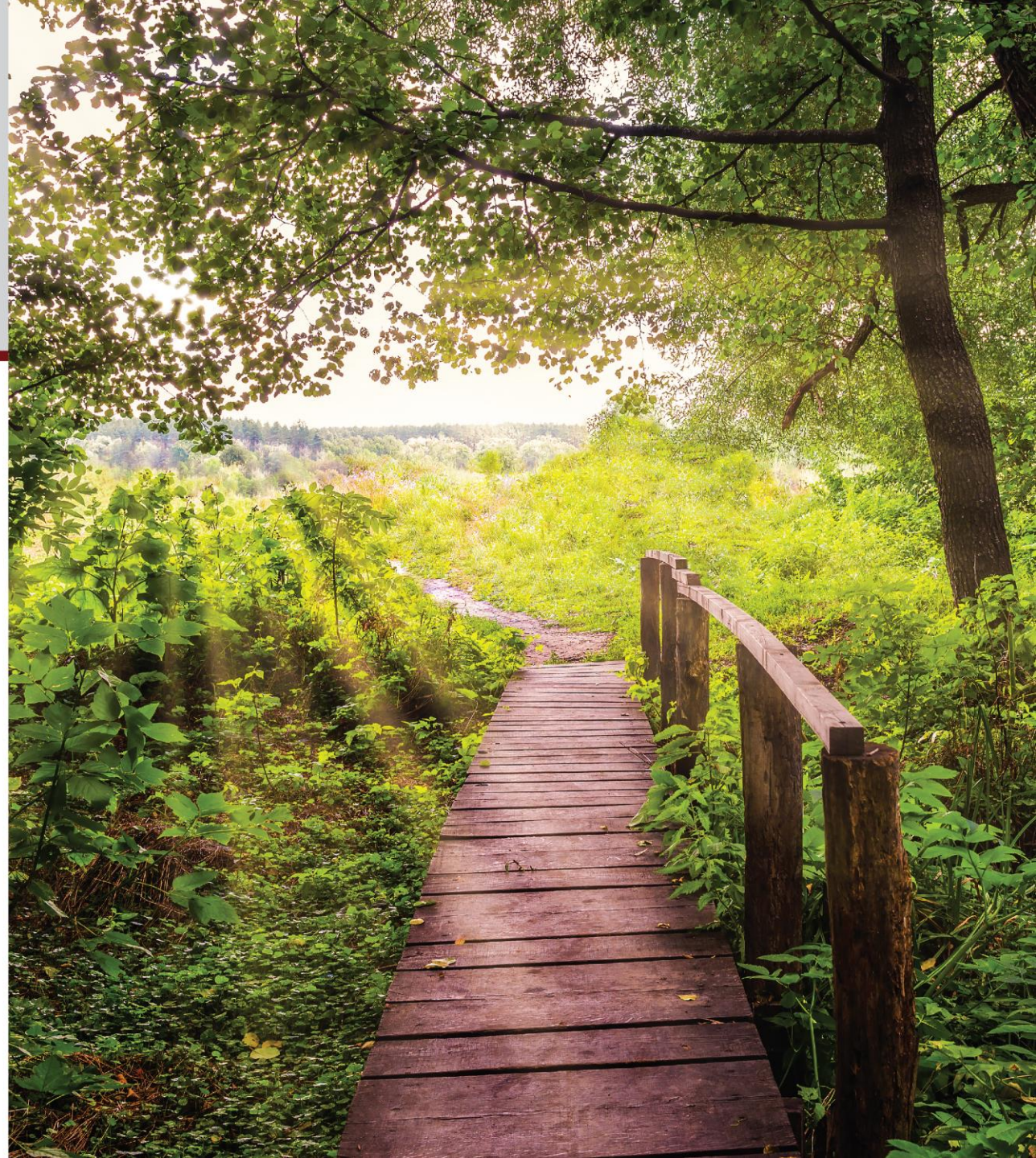
Common Deficiencies

Casper Report:

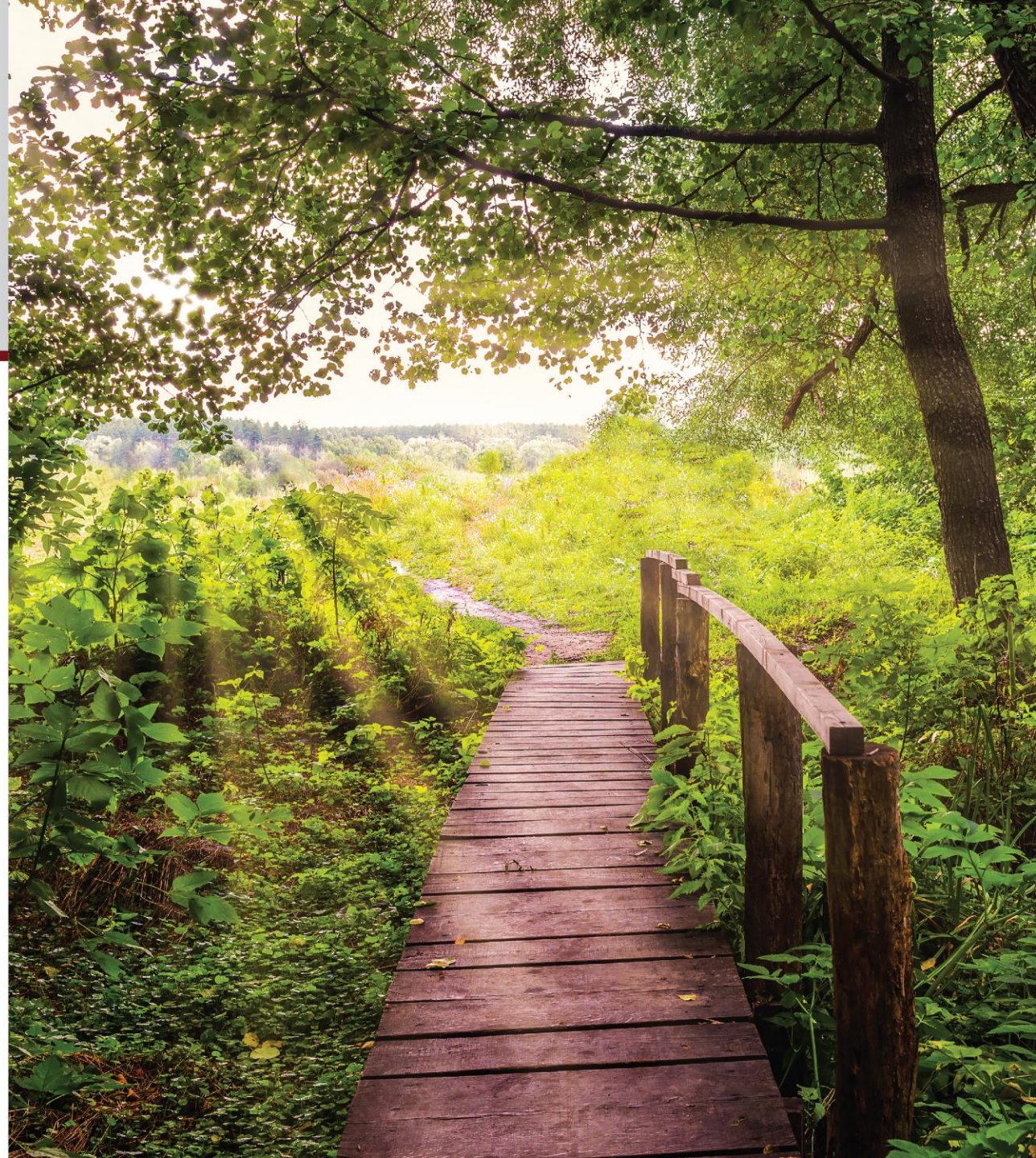
- https://qcor.cms.gov/main.jsp
  - Citation Frequency
    - Advanced Search



Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
	Totals represent the # of providers and surveys that meet the selection criteria specified above.		Oregon Active Providers = 116	Total Number of Surveys = 10
J0041	PHYSICAL PLANT AND ENVIRONMENT	5	4.3%	50.0%
E0039	EP Testing Requirements	4	3.4%	40.0%
J0161	PROGRAM EVALUATION	4	3.4%	40.0%
J0101	STAFFING AND STAFF RESPONSIBILITIES	4	3.4%	40.0%
E0037	EP Training Program	3	2.6%	30.0%
J0042	PHYSICAL PLANT AND ENVIRONMENT	3	2.6%	30.0%
J0043	PHYSICAL PLANT AND ENVIRONMENT	3	2.6%	30.0%
J0152	PATIENT HEALTH RECORDS	2	1.7%	20.0%
E0006	Plan Based on All Hazards Risk Assessment	2	1.7%	20.0%
E0004	Develop EP Plan, Review and Update Annually	1	0.9%	10.0%
E0030	Names and Contact Information	1	0.9%	10.0%
J0084	STAFFING AND STAFF RESPONSIBILITIES	1	0.9%	10.0%

Decoding the Numbers:

- Appendix G – J Tags
- Appendix Z – E Tags



Decoding the Numbers: Appendix G pg. 42

J-0041

Survey Procedures § 491.6(a)

- Observe whether the clinic's physical plant is well constructed and arranged and does not present barriers to patient access or hazards to patient safety.
- Observe whether the clinic has sufficient space given for the type and scope of services provided and the number of patients served.

Decoding the Numbers: Appendix Z pg. 101-102

E-0039

Survey Procedures §491.12(d)(2)

- Ask facility leadership to explain the participation of management and staff during scheduled exercises.
- Ask to see documentation of the exercises (which may include, but is not limited to, the exercise plan, the AAR, and any additional documentation used by the facility to support the exercise). Documentation must demonstrate the facility has conducted the exercises described in the standard.
- Ask to see the documentation of the facility's efforts to identify a full-scale community based exercise if they did not participate in one (i.e. date and personnel and agencies contacted and the reasons for the inability to participate in a community based exercise).
- Request documentation of the facility's analysis and response and how the facility updated its emergency program based on this analysis.

Decoding the Numbers: Appendix G pg. 88-89

J-0161

Survey Procedures § 491.11 (a) - (c)

- Is there evidence that the evaluation is completed at least biennially and includes review of the number of patients served and the volume of services provided?
- Is there evidence of a review of a representative sample of RHC records?
- Does the sample include the required minimum number of records?
- Who conducts which portions of the review? Are they qualified to do so?
- Is there evidence of findings and recommendations from the review, and do the findings address each required component?

Decoding the Numbers: Appendix G pg. 61

J-0101

Survey Procedures § 491.8(b)(3) & (c)(1)(ii)

- Ask the clinic's staff what its policy is for the interval at which clinical records will be periodically reviewed. Ask when the last review took place, and request documentation of the review.
- If State law requires co-signature of NP and/or PA orders by a physician, is there evidence in the clinical record of such co-signatures?
- If the RHC has more than one physician, ask whether its policy permits physicians to share the responsibility for the periodic record review.
- Ask how the RHC ensures that all records of patients cared for by non-physician practitioners are periodically reviewed.
- Is there documentation supporting that the required reviews have occurred?

Decoding the Numbers: Appendix Z pg. 87

E-0037

Survey Procedures §491.12(d)(1)

- Ask for copies of the facility's initial and subsequent (at least every 2 years or annual for LTC) emergency preparedness trainings and annual emergency preparedness training offerings.
- Interview various staff and ask questions regarding the facility's initial and subsequent (at least every 2 years or annual for LTC) training course to verify staff knowledge of emergency procedures.
- Review a sample of staff training files to verify staff have received initial and subsequent (at least every 2 years or annual for LTC), emergency preparedness training.

NOTE: For ease of demonstrating compliance that the facility has updated its training program at least every 2 years, we recommend that facilities retain at a minimum, the past 2 cycles (generally 4 years) of emergency training documentation for both training and exercises for surveyor verification.

Decoding the Numbers: Appendix G pg. 43

J-0042

Survey Procedures § 491.6(b)(1)

- Is there documentation that mechanical or electrical equipment is regularly inspected, tested and maintained in accordance with the manufacturer’s recommendations?
- If documentation is missing, ask to see the clinic’s policies and procedures for equipment maintenance, to determine whether the problem is with content of the policies and procedures, and or with failure to follow policies and procedures.
- Ask staff to provide a copy of or access to copies of the manufacturer's recommendations for mechanical or electrical equipment.
- Ask staff whether there have been any problems with equipment breakdowns or malfunctions. If yes, ask for maintenance documentation for the equipment in question

Decoding the Numbers: Appendix G pg. 44

J-0043

Survey Procedures § 491.6(b)(2)

- Verify drugs are stored according to manufacturer instructions.
- Verify that drugs are not accessible to unauthorized individuals/personnel.

Decoding the Numbers: Appendix G pg. 85

J-0152

Survey Procedures § 491.10(a)(3)(i) – (iv)

- Determine whether there is a medical history for each RHC patient whose clinical record is reviewed. Is there evidence that a practitioner reviewed the medical history?
- Ask the RHC what its policy is for updating a patient's medical history; ask for documentation of the policy.
- When applicable, determine if clinical records in the sample being reviewed include an updated medical history.
- Determine whether the RHC has adopted policies and procedures addressing when an informed consent is required.
- Determine whether there is an informed consent when required in the medical record, and that it contains the minimum required elements as well as any additional elements required under RHC policy.
- In records reviewed, is there evidence of:
  - The practitioner's assessment of the patient's health status and health care needs?
  - A documented summary of the visit, including the required regulatory information?
  - Physical examination findings, diagnostic and laboratory test results, and consultative findings.
  - Are findings and test reports appropriately authenticated by a practitioner?

Decoding the Numbers: Appendix Z pg. 25

E-0006

Survey Procedures §491.12(a)(1)-(2)

- Ask to see the written documentation of the facility's risk assessments and associated strategies.
- Interview the facility leadership and ask which hazards (e.g. natural, man-made, facility, geographic) were included in the facility's risk assessment, why they were included and how the risk assessment was conducted.
- Verify the risk-assessment is facility-based and community-based, and based on an all-hazards approach specific to the geographic location of the facility and encompasses potential hazards, such as EIDs.

Decoding the Numbers: Appendix Z pg. 20

E-0004

Survey Procedures §491.12(a)

- Verify the facility has an emergency preparedness plan by asking to see a copy of the plan.
- Ask facility leadership to identify the hazards (e.g. natural, man-made, facility, geographic, etc.) that were identified in the facility's risk assessment and how the risk assessment was conducted.
- Review the plan to verify it contains all of the required elements.
- Verify that the plan is reviewed and updated every 2 years (annually for LTC facilities) by looking for documentation of the date of the review and updates that were made to the plan based on the revie

Decoding the Numbers: Appendix Z pg. 70

E-0030

Survey Procedures §491.12(c)(1)

- Verify that all required contacts are included in the communication plan by asking to see a list of the contacts with their contact information.
- Verify that all contact information has been reviewed and updated at least every 2 years by asking to see evidence of the review.

Decoding the Numbers: Appendix G pg. 54-55

J-0084

Survey Process § 491.8(a)(4)

- Determine whether all clinical staff members who are not practitioners have a current State license or certification, as required.
- Ask clinical staff members who are not practitioners to identify their supervisor(s). .
- Is there someone responsible for supervising non-practitioners on the clinical staff at all times the RHC is providing services? Request the name of that individual. Interview other clinical staff to confirm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (CMS-2567)

Provider/Supplier/CLIA Identification Number: (X1)	Multiple Construction: A. Building: B. Wing: (X2)	Date Survey Completed: (X3)

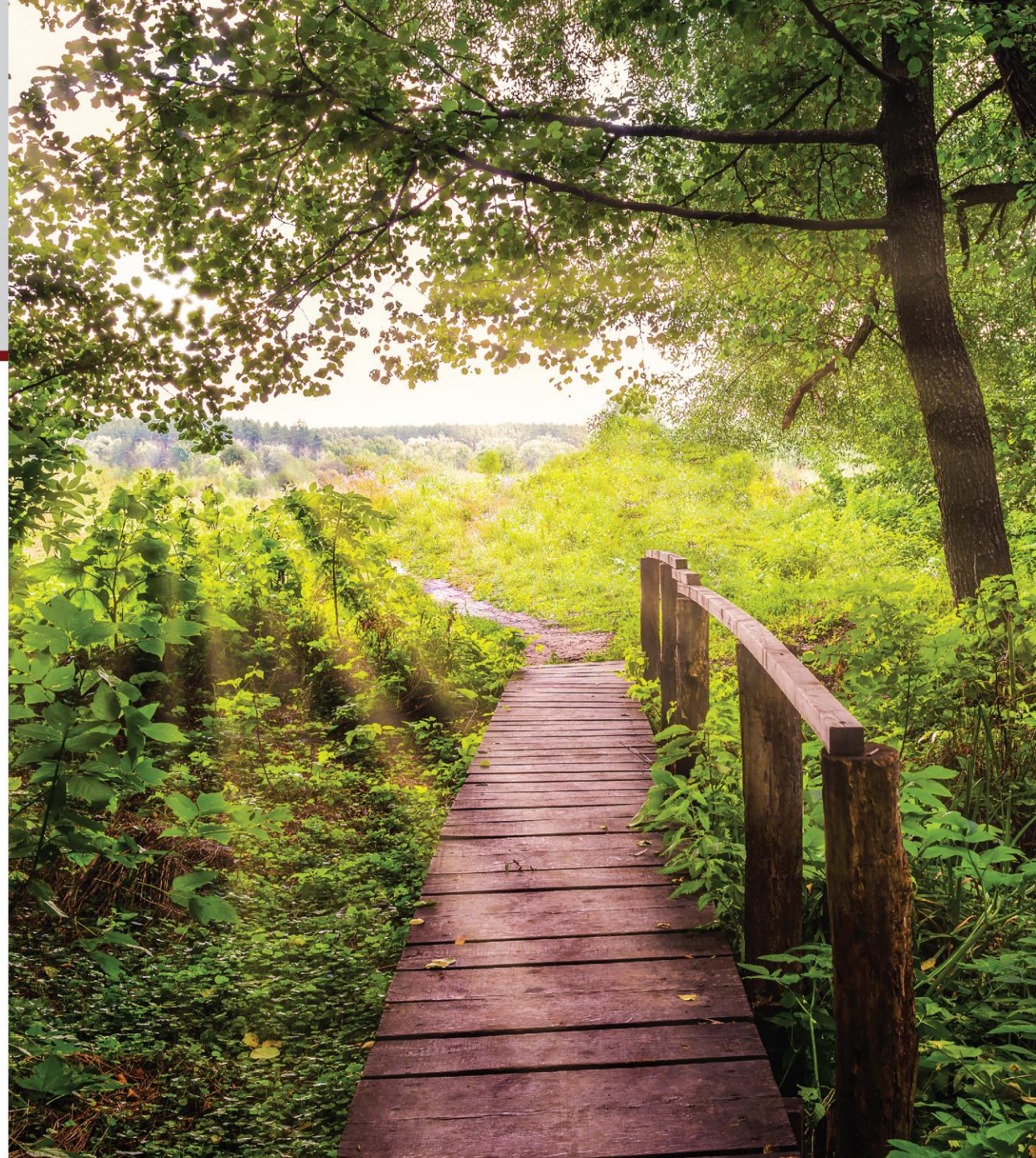
Name of Facility Surveyed:	Facility Address (Street, City, State. Zip Code)

Name of Accrediting Organization Performing Survey (if applicable):

ID Prefix Tag (X4)	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency should be preceded by full regulatory or LSC identifying information)	ID Prefix Tag	PLAN OF CORRECTION (Each corrective action should be cross-referred to the appropriate deficiency)	Completion Date (X5)
J0152	This standard was not met at a standard level, as evidenced by record review and interview. During review of patient charts, the surveyor found evidence of incomplete patient healthcare records, specifically improperly executed consent to treat forms. * 1 of 20 patient charts missing consent to treat When interviewed, the manager stated she was surprised there were no registration papers, including consent to treat, missing from the patient's chart. After speaking with front desk staff, they were not able to locate the paperwork. Failure to maintain the elements of a complete healthcare records puts the clinic out of compliance with the Medicare requirement at 42 CFR 491.10(a)(3)(i).	J0152	The clinic was cited for incomplete patient records. The clinic will educate staff on required medical record elements. The manager will conduct intensive reviews until compliance is proven and conduct periodic reviews to ensure ongoing compliance. The manager will train reception staff on how often (per policy) the consent to treat form is required, how to review the form to confirm it is complete, and how to scan and label the form within the EMR for easy navigation. The training will be completed by DATE and documentation will be maintained. The manager will conduct the first weekly audit on DATE until compliance is achieved. Then quarterly audits will begin. The clinic will utilize an audit tool and review the outcome of the audits with staff.	xx/xx/xxxx

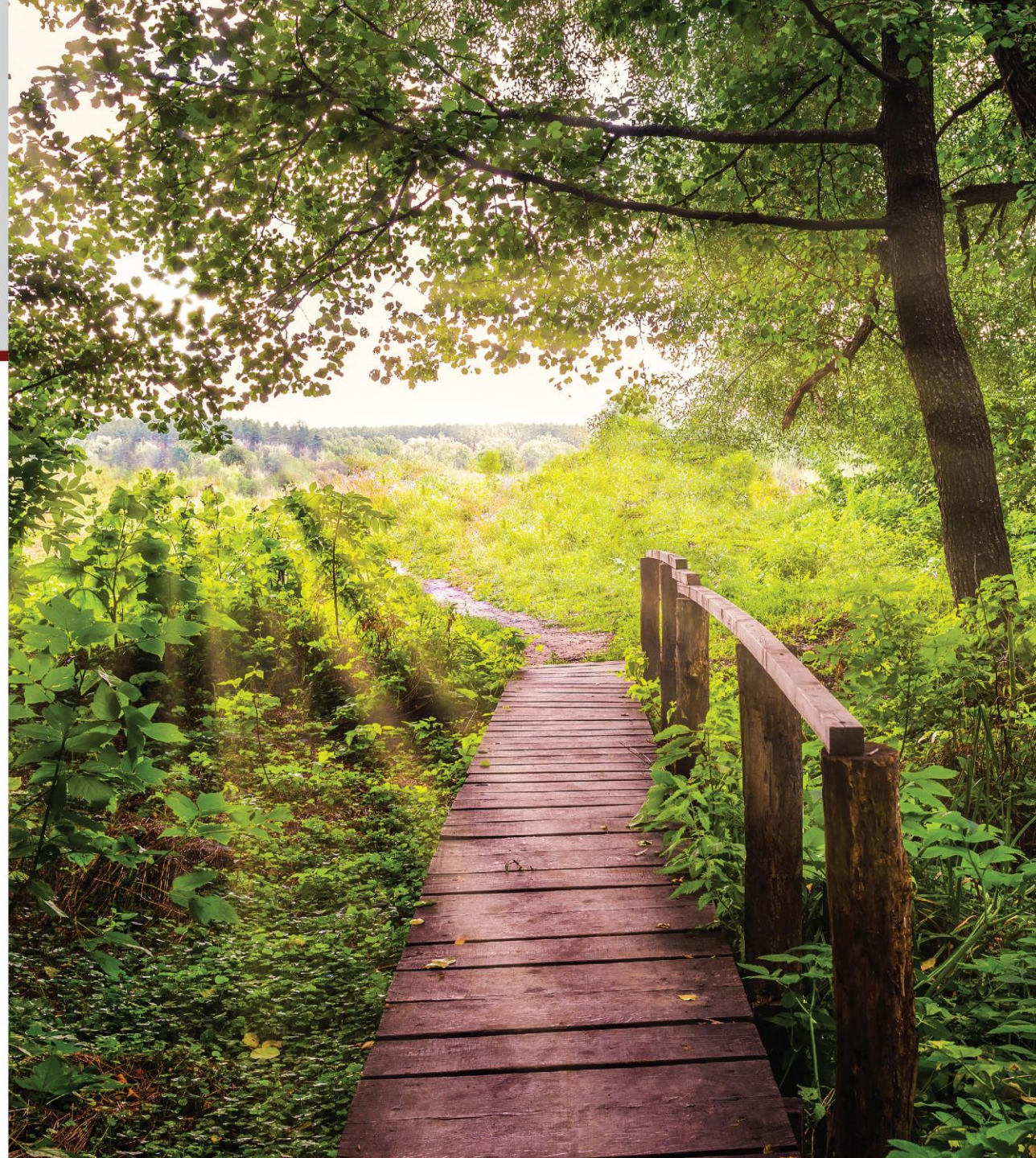
Surveyor:

- Identifies the level of deficiency
- Defines what was observed
- Provides specific details on why this was considered a deficient practice
- Defines actions taken by the surveyor to resolve the deficiency
- Defines the risk this poses to clinic/ patients and associated RHC regulation
- Some also provide expectations for resolving the issue



Clinic:

- Identifies WHAT happened
- Identifies HOW they will mitigate (training/audits)
  - Action steps, deadlines, frequency
- Defines WHO is responsible for each action
- Completes logistical actions
  - Signs form, assigns “completion date”, implements action plan and develops tools to support the plan



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Compliance Program

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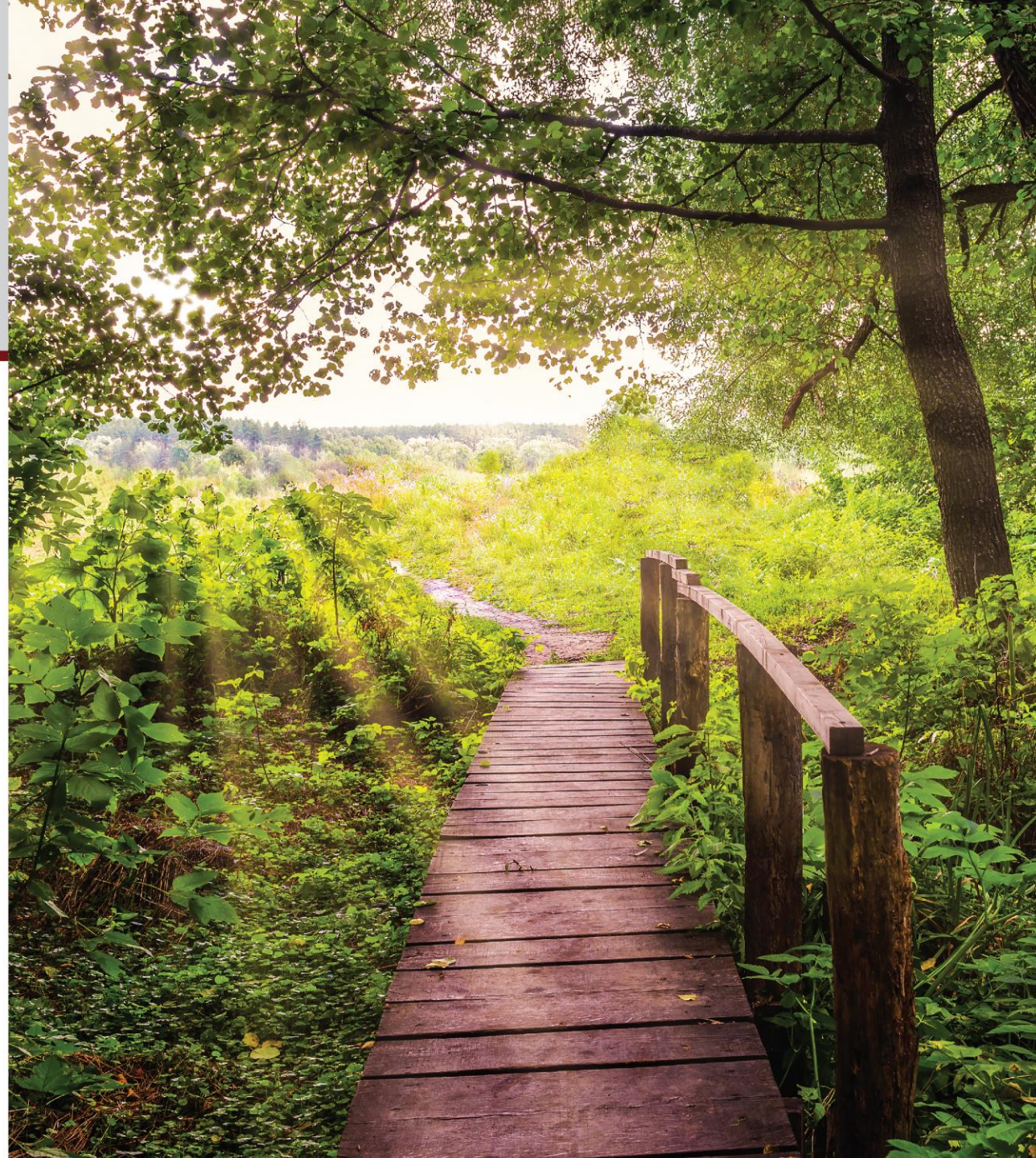
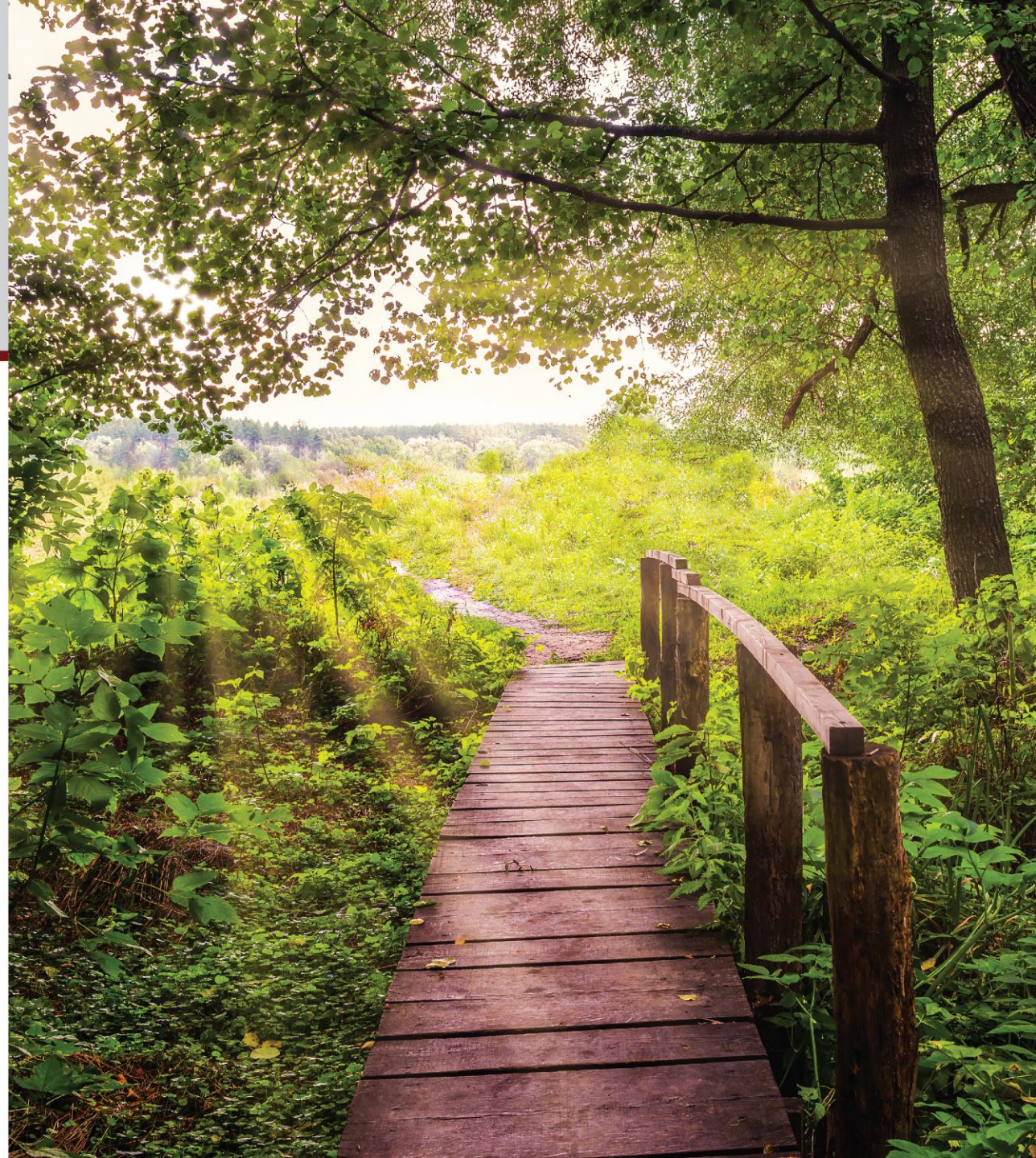
Compliance Program:

- BE PROACTIVE!
- Create a team
- Conduct self assessments
  - Physical plant
  - Personnel files
  - Medical records
  - Administrative tasks
    - Policy, EOP, Evidence



Compliance Program:

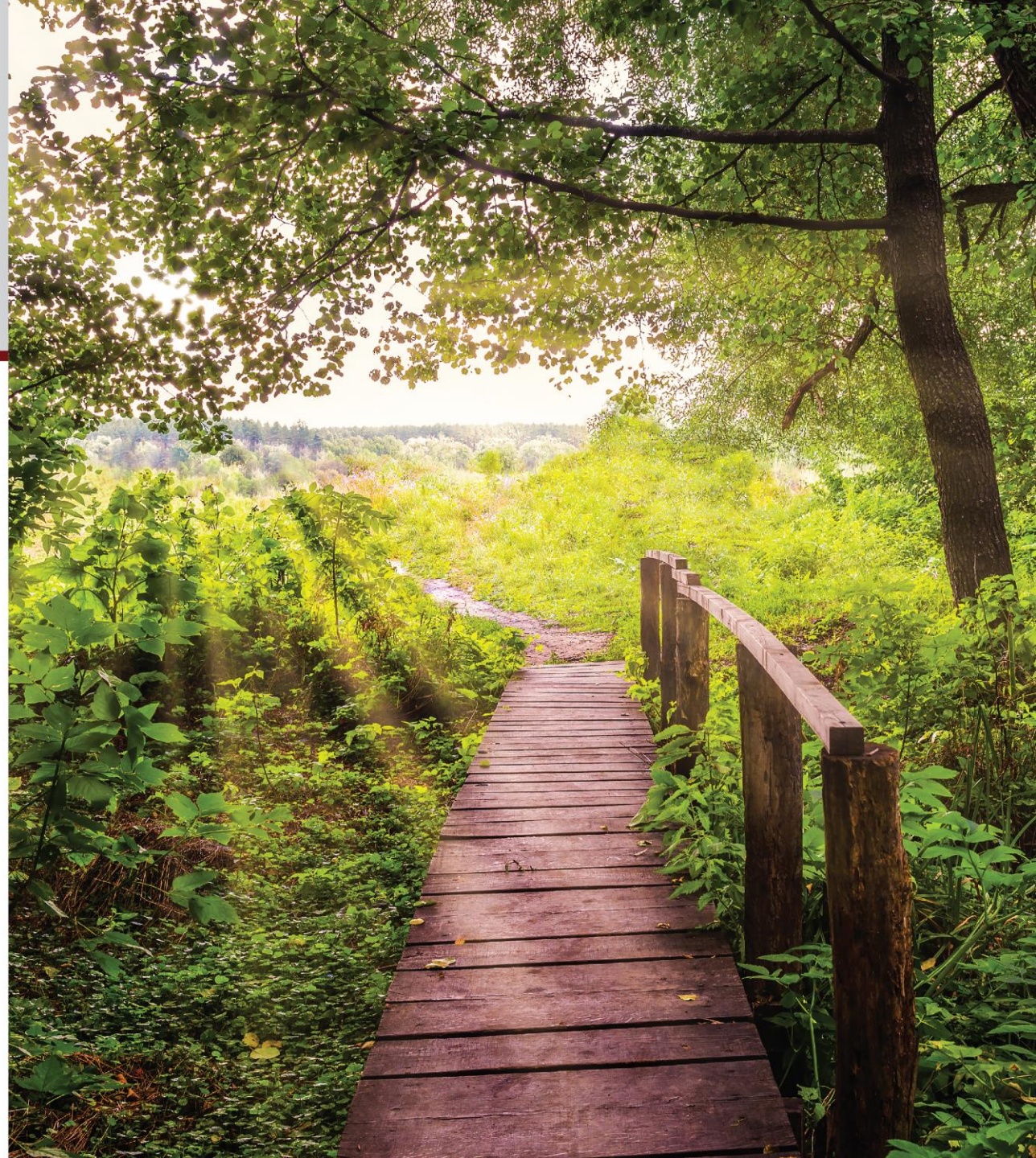
- Assign accountability
- Organize documentation
- Streamline workflows
- Recommend quarterly quality meetings



Sample Agenda

- Review administrative chart audits
- Review patient satisfaction surveys
- Review outcomes of quarterly improvement projects
- Review quality metrics
- Review updates
- Obtain staff acknowledgement

Note: Keep summaries for program evaluation



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Questions:

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