Nebraska Hospital Association
The influential voice of Nebraska's hospitals

QI Residency Program

Module B - Accreditation & Surveys

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What We Will be Covering

How to be as ready as possible for a hospital survey

1. Being aware of the standards of care

*Appendix W updates

*How to keep up with updates and changes of these standards of care

*Survey readiness binder

2. Survey process for a hospital

*Who to Involve

*What information to share and how

3. Immediate Jeopardy

*Appendix Q

*Immediate Actions

*Removing and Immediate Jeopardy

4. Plan of Correction

*Guidance on formatting

*Methodology

*Required Elements

- *Standard Level Deficiencies
- *Condition Level Deficiencies
- *EMTALA Deficiencies

5. High Risk Low Volume processes

*Process to lessen risk to patients

6. Policy Review

*Requirements

7. Deficiency Listings

*How to find

8. Top survey deficiencies

*CAH

*RHC

Being aware of the standards of care and operations for the hospital

February 21, 2020 Updates

- CAHs
  - Deleted multiple tags number
  - Renumbered all the tag numbers in 2020
  - Revised table of contents to include special requirement for CAH of LTC services
  - Revised the survey protocol
    - Grant immediate access or can terminate Medicare
    - Cannot refuse to permit copying of records or information by the surveyor

2020 Updates cont'd

- Other changes
  - No advance notice of survey
  - Will assess compliance with all areas under CCN
  - Surveyor must complete basic surveyor course
  - Will not withhold areas of concern until the end
  - Surveyor questions to the staff
  - Make sure surveyors have access to copiers and printers

How to Keep Up with Changes

- Confirm Current CoP
- Check the survey and certification website monthly
- If new manual-Check CMS transmittal page
- Have one person in hospital responsible for monitoring for changes

Keep Up With Changes

- List of Appendix:

https://www.cms.gov/files/document/som107appendicestoc.pdf

CMS General Quality Info:

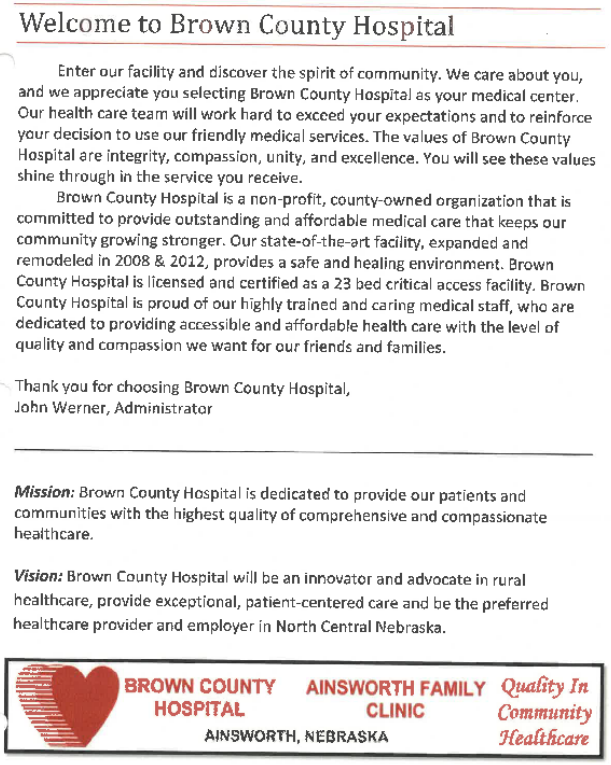
- http://www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

CMS Transmittals:

http://www.cms.gov/Transmittals

Survey Readiness Binder

- Survey Readiness Binder-Optional



Welcome to Brown County Hospital

Enter our facility and discover the spirit of community. We care about you, and we appreciate you selecting Brown County Hospital as your medical center. Our health care team will work hard to exceed your expectations and to reinforce your decision to use our friendly medical services. The values of Brown County Hospital are integrity, compassion, unity, and excellence. You will see these values shine through in the service you receive.

Brown County Hospital is a non-profit, county-owned organization that is committed to provide outstanding and affordable medical care that keeps our community growing stronger. Our state-of-the-art facility, expanded and remodeled in 2008 & 2012, provides a safe and healing environment. Brown County Hospital is licensed and certified as a 23 bed critical access facility. Brown County Hospital is proud of our highly trained and caring medical staff, who are dedicated to providing accessible and affordable health care with the level of quality and compassion we want for our friends and families.

Thank you for choosing Brown County Hospital,
John Werner, Administrator

Mission: Brown County Hospital is dedicated to provide our patients and communities with the highest quality of comprehensive and compassionate healthcare.

Vision: Brown County Hospital will be an innovator and advocate in rural healthcare, provide exceptional, patient-centered care and be the preferred healthcare provider and employer in North Central Nebraska.

BROWN COUNTY HOSPITAL
AINSWORTH FAMILY CLINIC
AINSWORTH, NEBRASKA
Quality In Community Healthcare

Survey Binder

- Overview and Purpose
- Scope of Services
- Organizational Chart-CAH and Board
- Contracted Clinical Services
- Quality Plan
- Grievance Procedure

Survey Binder

- Policy and Procedure Review
- Annual Hospital Evaluation
- CAH Network Agreement
- Periodic Evaluation
- Telehealth Agreements
- Credentialing Agreement or Policies

Survey Binder

- Last State Survey
- Infection Prevention Plan
- Mission and Vision
- Patient Rights
- Patient Satisfaction
- Pain Management

Survey Binder

- Patient Portal
- Discharge Education Process
- Community Discharge Services Available

Survey Process

Who to involve

Leadership-Board

Supervisors/Managers

Department designees

Quality leader

- Surveyor will not delay survey until staff arrive

Information shared

- Inform staff to state survey on-site
  - email
  - internal communication
  - overhead announcement
- Fire Marshall site visit

Information shared

- Electronic medical record knowledge
- Fluid review of charts
- Protected information should not be visible for surveyors

Small Group Work

- Develop checklist for initial setup of survey

Immediate Jeopardy

Immediate Jeopardy

- State Operations Manual Appendix Q – Core Guidelines for Determining Immediate Jeopardy Table of Contents (Rev. 187, Issued: 03-06-19)
- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_q_immedjeopardy.pdf

IJ

- Represents a situation in which entity noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment or death.

IJ

- Noncompliance cited at IJ is the most serious deficiency type, and carries the most serious sanctions for providers, suppliers, or laboratories (entities).

IJ

- The hospital must take immediate action to remove the systemic problems which contributed to, caused, or were a factor in causing the serious adverse outcome, or making such an outcome likely.

IJ

- Determination IJ exists:

Survey team must immediately:

- Notify the administrator IJ has been identified and provide a copy of the completed IJ template to the entity
- Request a written IJ removal plan.

Removing IJ

The removal plan is not required to completely correct all noncompliance associated with the IJ, but rather it must ensure serious harm will not occur or recur. The removal plan must include a date by which the entity asserts the likelihood for serious harm to any recipient no longer exists.

Plan of Correction

Plan of Corrections

- Statement of deficiencies (Form CMS-2567) will be mailed within 10 business days to the CAH.
- Written plan of correction (POC) must be submitted to the survey agency within 10 business days following receipt of the written statement of deficiencies.

Plan of Corrections

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE

(X4) ID PREFIX TAG	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)	(X5) COMPLETION DATE

Plans of Corrections

- Ref: S&C: 17-34-ALL
- Guidance for the Formatting of the Plans of Correction
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-34.pdf

- Start each plan of correction with a description of the following:
  - Who reviewed the deficiencies cited in the report (senior leadership involvement is key)
  - How and when the review was performed (in-person meeting, phone conference, date performed, etc.)
  - The fact that senior leadership directed that a POC be developed and implemented

POC

The characteristics of an acceptable POC include:

- Separately addressing each citation if have more than one deficiency
- You cannot reference a POC from one finding to another. Each finding must have its own POC

POC

- A Quality Assessment and Performance Improvement (QAPI) methodology for each citation and address improvements in the hospital's systems in order to prevent the likelihood of the cited deficient practice from recurring;

POC

- A procedure for implementing each corrective action taken;

Procedure for Corrective Action-Document

- For a POC that includes developing or revising a document, note:
  - The specific name of the document
  - The specific changes (language) made to the document that address the deficiency(s)
  - What body or entity approved the development / changes

Procedure for Corrective Action-Training

- For a POC that includes training or educating staff and/or physicians, note:
  - The specific training /education that has or will be provided
  - The specific types of staff and/or physicians that have or will receive the training /education

Procedure for Corrective Action-Informing Individuals

- For a POC that includes informing individual(s) about actions that have been or need to be taken, note:
  - The specific information that has or will be provided
  - The specific types of individual(s) that have or will receive the information
  - Who the information was sent by

Procedure for Corrective Action- Tangible Assets/Resources

- For a POC that includes tangible assets / resources, note:
  - The specific asset / resource involved
  - The specific actions that have or will be taken with respect to the asset / resource
  - Financial commitment (if any) necessary to implement the POC

POC

- A procedure for monitoring the corrective actions taken for each citation. Providing the identity or position of the person who will monitor the corrective action and the frequency of monitoring;

POC

- Most POC will require an audit or measurement of some kind. Must describe:
  - What will be measured
  - Data construct of the measurement (population, sample size, collection methodology)
  - How long measurement will be performed
  - Who will be responsible for data collection, aggregation, analysis
  - Where the data will be reported to and frequency of reporting
  - How the monitoring process will be integrated into the QA/PI program

POC

- Dates each corrective action for each citation was/will be completed;
- The administrator or appropriate individual must sign and date the Form CMS-2567 before returning it to the survey agency

For standard-level deficiencies

- Who (by job title) is responsible for correcting the deficiency
- Specifically, how the deficiency will be corrected
- A realistic date of correction by month, date, and year
- A process to ensure the deficiency remains corrected
- Who (by job title) is responsible for monitoring to ensure the deficiencies remain corrected
- A plan for how long the monitoring will occur to ensure the deficiencies stay corrected

For condition-level deficiencies

- The specific nature of the corrective actions for each deficiency
- Reasonable completion dates for all deficiencies prior to the listed termination date, unless an extension is requested and approved
- How the corrective action plan will prevent recurrence for the deficiency cited
- The title (not the name) of the person responsible for implementing and monitoring the plan of correction for future compliance with the regulations

For EMTALA deficiencies

- The plan for correcting each specific deficiency cited
- The plan for improving the processes that led to the cited deficiencies, including how the hospital is addressing improvements in its systems in order to prevent the likelihood of recurrence of the deficient practices
- A completion date for correction of each cited deficiency
- The monitoring and tracking procedures that will be implemented to ensure that the PoC is effective and that the specific cited deficiencies remain corrected and in the compliance with the regulatory requirements

POC

- The CMS Form 2567 and accompanying POC are publicly releasable documents, so providers are required to omit any Privacy Act or Protected Health Information.

High Risk Areas

High Risk Areas

- ***C-1321***
- ***(Rev. – Effective March 30, 2021)[§485.641 (d) Standard: Program activities. For each of the areas listed in paragraph (b) of this section, the CAH must:]***
- ***(3) Set priorities for performance improvement, considering either high volume, high-risk services, or problem prone areas***

High-Risk Areas

Problem Prone Areas

- Possible experience and competency shortcomings for bedside nurses given the demands of complex treatments they do not often provide.

Policy Review

Policy Review

- C-0962

§485.627(a) Standard: Governing Body or Responsible Individual

- The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing and monitoring policies governing the CAH'S total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment.

Policy Review

- C-1008 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)

  §485.635(a)(2) The policies are developed with the advice of members of the CAH's professional healthcare staff, including one or more doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff under the provisions of §485.631(a)(1).

- §485.635(a)(4) These policies are reviewed at least biennially by the group of professional personnel required under paragraph (a)(2) of this section, and reviewed as necessary by the CAH.

How to find deficiencies

How to Find Deficiencies by Quarter

- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Hospitals

Downloads

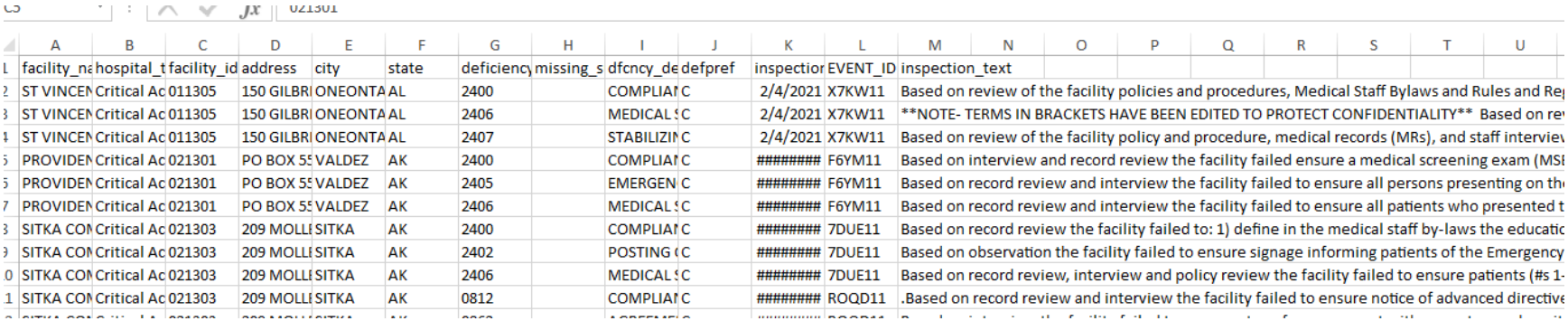
Patient's Rights Regulation published 12/8/2006 (PDF, 335 KB) (PDF)

EMTALA (PDF)

Chapter 2 - The Certification Process (PDF)

Full Text Statements of Deficiencies Hospital Surveys - 2021Q4 (ZIP)

Full Text Statements of Deficiencies Transplant Surveys - 2021Q4 (ZIP)



	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
1	facility_na	hospital_t	facility_id	address	city	state	deficiency	missing_s	dfcncy_de	defpref	inspectior	EVENT_ID	inspection_text								
2	ST VINCEN	Critical Ac	011305	150 GILBR	ONEONTA	AL	2400		COMPLIAI	C	2/4/2021	X7KW11	Based on review of the facility policies and procedures, Medical Staff Bylaws and Rules and Reg								
3	ST VINCEN	Critical Ac	011305	150 GILBR	ONEONTA	AL	2406		MEDICAL S	C	2/4/2021	X7KW11	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on re								
4	ST VINCEN	Critical Ac	011305	150 GILBR	ONEONTA	AL	2407		STABILIZIN	C	2/4/2021	X7KW11	Based on review of the facility policy and procedure, medical records (MRs), and staff intervie								
5	PROVIDEN	Critical Ac	021301	PO BOX 5	VALDEZ	AK	2400		COMPLIAI	C	########	F6YM11	Based on interview and record review the facility failed ensure a medical screening exam (MSE								
6	PROVIDEN	Critical Ac	021301	PO BOX 5	VALDEZ	AK	2405		EMERGEN	C	########	F6YM11	Based on record review and interview the facility failed to ensure all persons presenting on th								
7	PROVIDEN	Critical Ac	021301	PO BOX 5	VALDEZ	AK	2406		MEDICAL S	C	########	F6YM11	Based on record review and interview the facility failed to ensure all patients who presented t								
8	SITKA CON	Critical Ac	021303	209 MOLL	SITKA	AK	2400		COMPLIAI	C	########	7DUE11	Based on record review the facility failed to: 1) define in the medical staff by-laws the educatic								
9	SITKA CON	Critical Ac	021303	209 MOLL	SITKA	AK	2402		POSTING (	C	########	7DUE11	Based on observation the facility failed to ensure signage informing patients of the Emergency								
10	SITKA CON	Critical Ac	021303	209 MOLL	SITKA	AK	2406		MEDICAL S	C	########	7DUE11	Based on record review, interview and policy review the facility failed to ensure patients (#s 1-								
11	SITKA CON	Critical Ac	021303	209 MOLL	SITKA	AK	0812		COMPLIAI	C	########	ROQD11	.Based on record review and interview the facility failed to ensure notice of advanced directive								

Top CAH Deficiencies

Nebraska DHHS Top Deficiencies for Critical Access Hospitals and Rural Health Clinics

- Timeframe: 10-1-21 through 3-30-22
- **Critical Access Hospitals**
- 0914 – Maintenance
- 1140 – Surgical Services
- 0812 – Compliance w/Fed, St, and local laws and regs

- 0962 – Governing Body or Responsible Individual
- 1004 – Provision of Services
- 1008 – Patient Care Policies
- 1016 – Patient Care Policies

- 1046 – Nursing Services
- 1048 – Nursing Services
- 1104 – Records System
- 1608 – SNF Services

- 1610, 1620, 1624 – Admission, Transfer, and Discharge Rights; Comprehensive Assessment, Care Plan and Discharge; Dental Services.

Top CAH Deficiencies

- Orders/entries dated and timed
- Verbal Orders
- Cluttered hallways and other Life Safety Code issues
- H&Ps
- EMTALA

Top CAH Deficiencies

- Medications
- Meeting Nutrition Needs of Patients
- Healthcare services P&P
- Timing of Medications
- Documentation Reflecting Nursing Process

Top Deficiencies

- Hand Hygiene and Gloving
- Restraint and Seclusion for Acute hospitals
- Suicide precautions
- Infection Control
- Informed Consent
- Privacy and Whiteboard

Top Deficiencies

- Legibility
- No Orders
- Safe Injection Practices
- Equipment and supplies used in life saving procedure

Rural Health Clinics

- Timeframe: 10-1-21 through 3-30-22

Emergency Preparedness Plan – all components

- 0123- Staffing and Staff responsibilities
- 0136 – Provision of Services
- 0161 – Program Evaluation

- 0125 – Provision of Services
- 0042 – Physical Plant and Environment
- 0162 – Program Evaluation
- 0086 – Staffing and Staff Responsibilities
- 0152 – Patient Health Records

Questions