Nebraska Hospital Association

The influential voice of Nebraska's hospitals

QI Residency Program

Module B - Accreditation & Survey

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. Plan of Correction

- Guidance on formatting
- Methodology
- Required Elements
  - Standard Level Deficiencies
  - Condition Level Deficiencies
  - EMTALA Deficiencies

4. Immediate Jeopardy

- Appendix Q
- Immediate Actions
- Removing Immediate Jeopardy Back to Compliance

5. High Risk Low Volume processes

Process to lessen risk to patients

6. Policy Review

Requirements

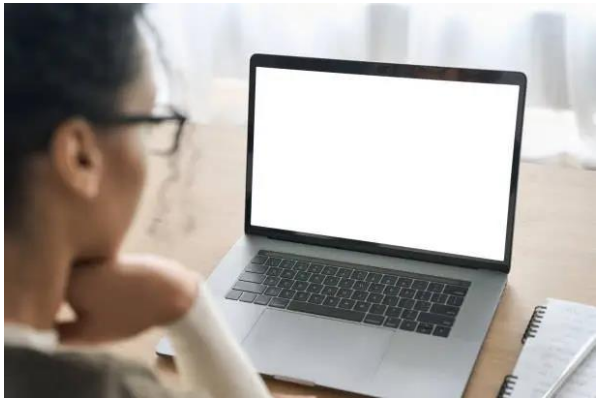
7. Deficiency Listings

    How to find

8. Top survey deficiencies

    CAH

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



Last was updated 2020

CAHs

- Still has sections that are red (meaning interpretive guidelines and survey questions are pending)

How to Keep Up with Changes

- Confirm Current CoP
- Check the survey and certification website monthly
- If new manual-Check CMS transmittal page
- Have at least one person in the 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

https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/policy-memos-states-and-cms-locations

CMS Transmittals:

http://www.cms.gov/Transmittals

https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/policy-memos-states-and-cms-locations

Survey Readiness Binder

- Survey Readiness Binder-Optional

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
- Current Annual Hospital Evaluation
- CAH Network Agreement
- Periodic Evaluation

Survey Binder

- Infection Prevention Plan
- Mission and Vision
- Patient Rights
- Patient Satisfaction

Survey Process

Who to involve

Leadership-Board

Quality leader

Supervisors/Managers

Department designees

❖Surveyor will not delay survey until staff arrive

Information shared

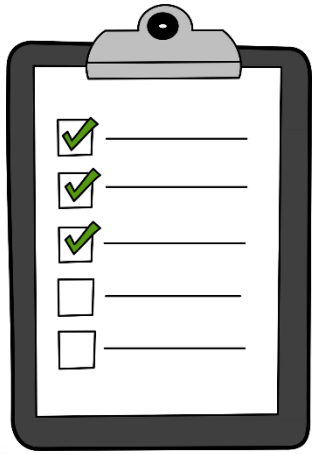
- Inform staff the state survey is on-site
  - email
  - internal communication
  - overhead announcement
- Fire Marshall site visit

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



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.

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

Immediate Jeopardy

- 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.

Immediate Jeopardy

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

Immediate Jeopardy

- 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.

Immediate Jeopardy Identified

- 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

Entity Actions Removing Immediate Jeopardy

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.

High Risk Areas

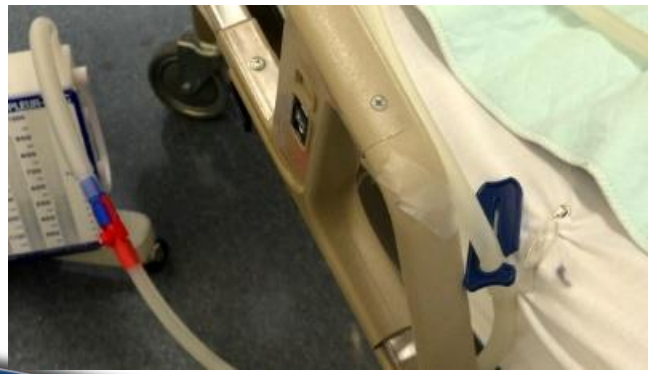
High Risk Areas

- ***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

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

Certification Referenced above

Downloads

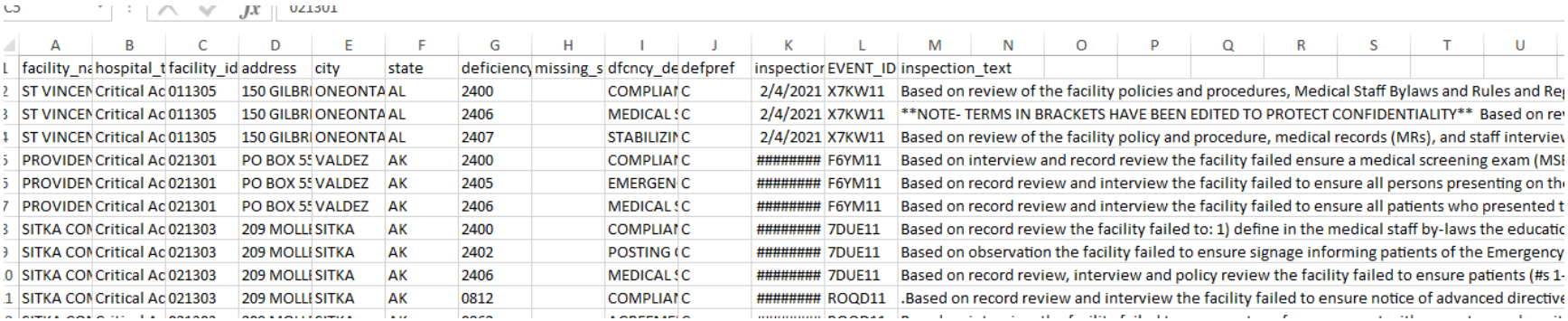
Patient's Rights Regulation published 12/8/2006 (PDF, 335 KB) (PDF)

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 rev								
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 educatio								
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								

QCOR link referenced example

Citation Frequency Report

Selection Criteria

Begin Year: 2022
End Year: 2024
Display Options: Display top 25 tags
Provider and Supplier Type(s): Rural Health Clinics
State: Nebraska

Year Type: Calendar Year **Year:** 2022 **Month:** Full Year

Citation Frequency Report

State Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
Totals represent the # of providers and surveys that meet the selection criteria specified above.		Nebraska Active Providers=139		Total Number of Surveys=18
E0004	Develop EP Plan, Review and Update Annually	4	2.9%	22.2%
E0029	Development of Communication Plan	4	2.9%	22.2%
E0013	Development of EP Policies and Procedures	4	2.9%	22.2%
E0031	Emergency Officials Contact Information	4	2.9%	22.2%

Top CAH Deficiencies

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

Timeframe: Last Shared July 2023

Critical Access Hospitals

- 0914 – Maintenance
- 1144 – Anesthetic Risk and Evaluation
- 1206 – Infection Prevention
- 1620 – Comprehensive assessment, comprehensive care plan and discharge plan

- 0912 – Construction
- 1208 – Infection Prevention
- 1110 – Medical Record
- 1140 – Surgical Services
- 0888 – Emergency Services

Questions