PROACTIVE MEDICAL REVIEW

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Writing an Acceptable Plan of Correction

Objectives

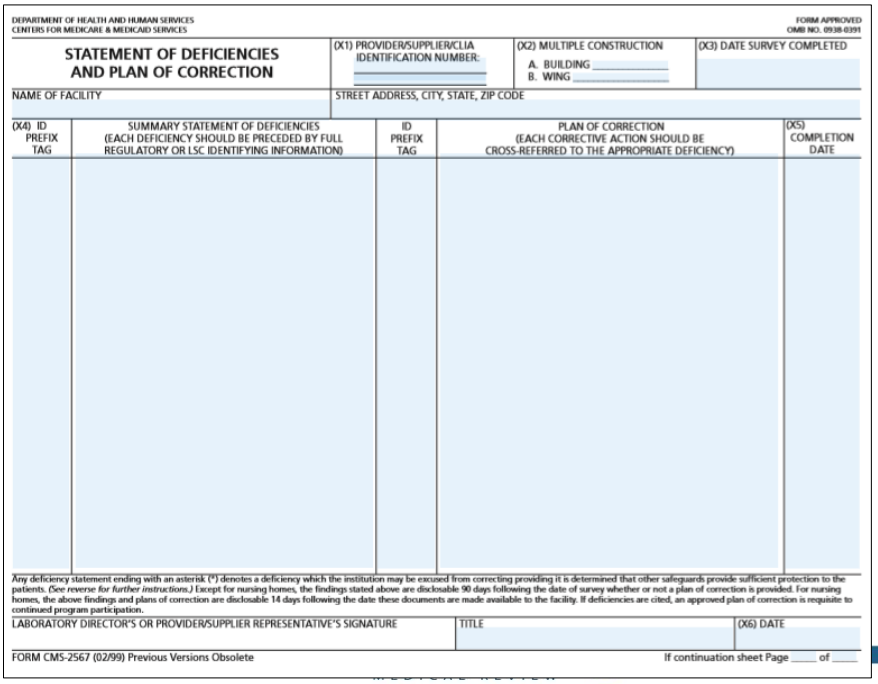
1. Understand the five core elements required by CMS for an acceptable plan of correction
2. Become familiar with the time frame requirements for submission of an acceptable plan of correction
3. Demonstrate the ability to write an acceptable plan of correction

Health Inspection Processes

- Based on federal regulations
  - National interpretive guidance
  - Federally-specified survey process
- Federal staff train state inspectors and oversee state performance

Documentation of Deficiencies

- Form CMS-2567
  - Identifies violation of regulations
  - Official record of the survey
  - Official document of compliance/noncompliance
  - Identifies the impact of the facility's noncompliance on the individuals
  - Available to the public upon request
  - Used by the facility to write the Plan of Correction (POC)



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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. *(See reverse for further instructions.)* Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

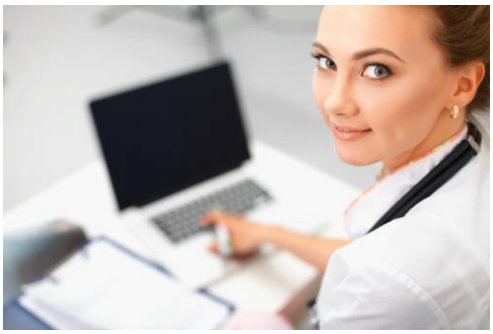
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

FORM CMS-2567 (02/99) Previous Versions Obsolete — If continuation sheet Page ____ of ____

Form CMS-2567

Components of a Deficiency Citation

1. Regulatory reference
2. Deficient practice statement
3. Relevant findings



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Regulatory Reference

- Survey data tag number
- CFR (Code of Federal Regulation) or LSC (Life Safety Code) reference
- Language from that reference which specifies the aspect(s) of the requirement with which the entity was noncompliant
- Explicit statement that the requirement was “NOT MET”

Deficient Practice Statement

- Specific action(s), error(s), or lack of action (deficient practice)
- Outcome(s) relative to the deficient practice, when possible
- Description of the extent of the deficient practice or the number of deficient cases relative to the total number of such cases
- Identifier of the individuals or situations referenced in the extent of the deficient practice
- Source(s) of the information through which the evidence was obtained

Relevant Facts and Findings

- Illustrate the noncompliance with the requirement
- Answer the questions:
  - Who
  - What
  - Where
  - When
  - How

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Statement of Deficiencies

- Receive Form CMS-2567 Statement of Deficiencies within 10 business days following exit (via email)
- Once received – 10 calendar days to submit acceptable plan of correction to the Survey Agency
- Public Document
  - Available to consumers
  - Potential customers may use when making decision on where to place their loved one
- Legal Document
  - Often used in litigation
  - 2567 and POC often scrutinized and used as supporting documentation in lawsuits

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review, the facility failed to ensure finger nails were kept short for 1 of 1 residents reviewed for activities of daily living (Resident 16). Findings include: The clinical record for Resident 16 was reviewed on 8/16/18 at 11:08 A.M. Diagnoses included, but were not limited to, dementia, anxiety disorder, and osteoarthritis. A Minimum Data Set (MDS) assessment dated 5/17/18 indicated Resident 16 had a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. The assessment also indicated Resident 16 needed extensive assistance			

Statement of Deficiency Example

What is a Plan of Correction?

- Plan of Correction (POC)
  - Facility's response to the survey deficiency findings
  - Facility's venue for demonstrating how substantial compliance will be attained
  - Opportunity to investigate why noncompliance occurred and how to correct it and prevent it from reoccurring in the future
  - Must be submitted to State within 10 calendar days of receiving the 2567

Why is a POC necessary?

- Required by Center for Medicare and Medicaid Services (CMS)
- Serves as the facility's allegation of compliance
- Without it, CMS and the survey agency cannot verify compliance with the federal and state regulatory requirements
- Outlines the plan to achieve and maintain compliance leading to improved quality of care

When is the POC completed?

- Directed to complete the POC within 10 calendar days of receiving a 2567 with listed deficiencies
- A letter will accompany the 2567 and provide the requirements of the POC including the **five criteria** that must be addressed in the POC
- If an acceptable POC is not received within 10 calendar days, the survey agency will notify the facility that it is recommending to the Regional Office imposition of category 1 remedies and/or denial of payment for new admissions

Post-Survey Management

- Begins at Day of Exit
  - Plan an all-staff meeting to explain survey outcomes
- Begin the POC right away
  - Write the POC based on information received from the exit and immediately begin working the plan
- Make adjustments to the POC once the final 2567 is received

Post-Survey Management

- Daily activities until survey cleared
  - Daily stand up meeting with management team to review POC progress
    - Review each tag and tasks for the day
    - Assign tasks for the day
    - Hand in items for the POC book
  - Daily stand down meeting
    - Hand in items for POC book
    - Reward accomplishments

Analyzing the Statement of Deficiencies

- Thoroughly read every example cited
- Multiple issues can be written under the citation for one tag
- Each issue requires corrective action

Why did the deficiency occur?

- What systems were lacking or incomplete?
- Was there something we should have been doing but weren't?
- Is this related to a knowledge deficit?
- Is the problem isolated or discrete?
- Is the problem system-wide or systemic?

Plan of Correction Elements

1. How the corrective action will be accomplished for identified affected individuals
2. How will other individuals with the potential to be affected or in similar situations be identified and protected
3. What systemic changes will ensure that the deficient practice will not recur
4. How the facility will monitor its corrective actions/performance
5. When will corrective action be accomplished

Element 1

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice
  - What the corrective action was
  - Date of implementation
  - Who was responsible for making the corrections (position title)

Element 2

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice
  - How the facility determined no other residents were affected by the deficient practice
  - The date this was determined; and,
  - By whom
    - Not acceptable to state “All residents have the potential to be affected”

Element 3

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
  - Detail the actions taken
  - Policy reviews/revisions
  - Staff training
  - Provide the dates of action and the titles of staff completing the action

Element 4

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained
  - Include the title of who will monitor the corrective action
  - How the actions will be monitored
  - When the monitoring will occur (frequency); and,
  - How the results will be evaluated and by whom
    - Cannot be for a limited number of months. Needs to be ongoing system of how you are going to monitor through QAPI process

Element 5

- Include dates when corrective action will be completed.
  - The date of compliance for the deficient practice cannot be a date on or prior to the survey exit date and cannot be a date when action is being taken by the facility
  - The corrective action completion dates must be acceptable to the State
    - If the plan of correction is unacceptable for any reason, the State will notify the facility
    - If the plan of correction is acceptable, the State will notify the facility by phone, email, etc.
  - Facilities are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely

(CMS SOM Chapter 7 7304.4 – Acceptable Plan of Correction, Rev 63)

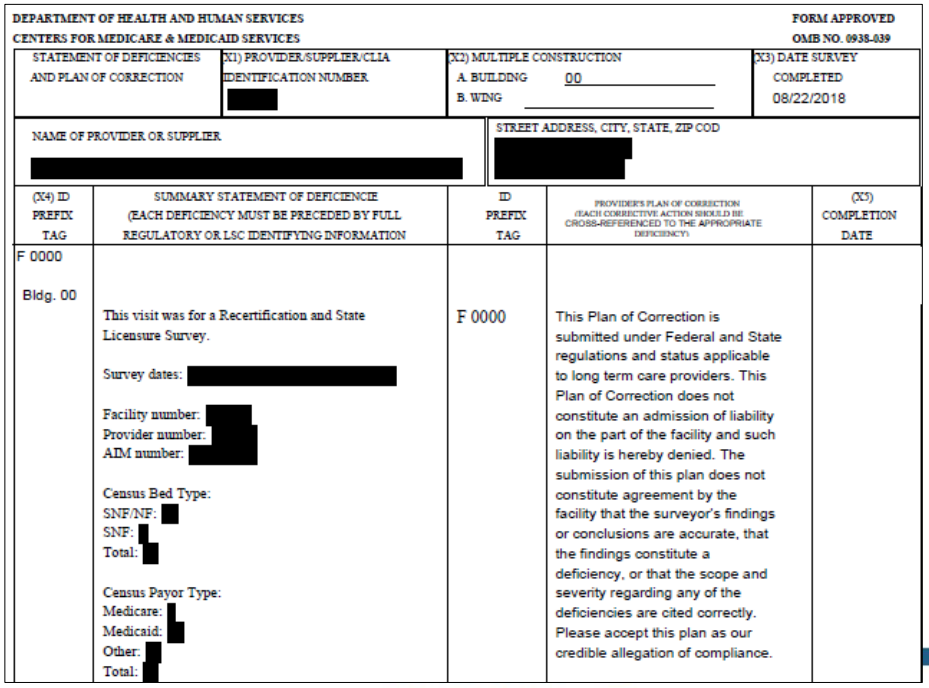
Date of Compliance

- Ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies but the State survey agent may recommend that additional time be granted…
- Don't put allowable time for completion of deficiency
  - Allow time for re-survey and potential correction prior to sanctions
- Select date in which you can reasonably fix the problem

(42 CFR 488.28)

Disclaimer

- Always include the disclaimer
  - This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law; or
  - Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of requirements under state and federal laws.



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	[redacted]	A. BUILDING 00 B. WING	08/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
[redacted]	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: [redacted] Facility number: [redacted] Provider number: [redacted] AIM number: [redacted] Census Bed Type: SNF/NF: [redacted] SNF: [redacted] Total: [redacted] Census Payor Type: Medicare: [redacted] Medicaid: [redacted] Other: [redacted] Total: [redacted]	F 0000	This Plan of Correction is submitted under Federal and State regulations and status applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Please accept this plan as our credible allegation of compliance.	

Disclaimer

Systemic Thinking

- Citation - CNA transferring resident with Hoyer lift without assistance. Resident care planned for 2 assist with all transfers.
  - Address the issue with the CNA named in the deficiency
  - Evaluate root cause of why the incident occurred
    - Isolated incident or normal practice?
    - Barriers that contributed to event occurring?
  - Evaluate transfers by ALL CNAs to determine if this issue is occurring with other residents
  - Evaluate facility processes for initial training and ongoing supervision

Common Mistakes

- Excluding language that would support and/or defend the facility's approach
- Insufficient response to the basic federal requirement of a POC
- Referring to employment matters
  - Stating an employee was "disciplined" which implies guilt
- Using specific staff/resident names

Follow-Up Survey

- Onsite Visit
  - Based on Date of Correction
- Desk Review
  - An accurate, complete, and well written plan of correction with low level deficiencies may lead to a desk audit (desk review) for compliance. In such cases, surveyors will not return in person for the re-survey but will find the provider in compliance based on an acceptable plan of correction

Plan of Correction Book

- Prepare a Plan of Correction/Allegation of Compliance Book that contains the following:
  - Copy of Plan of Correction
  - Tab for each tag
  - Section for all training and education
    - Include all participants
    - Include content and competency testing
  - Section for any material that supports allegation of compliance
  - Keep the book up too date and ready to provide to surveyors upon revisit

Informal Dispute Resolution

- Review process conducted by ISDH IDR program – may be either a desk (paper) review or face-to-face review as requested by facility.
- Opportunity to refute survey findings that facility believes should not have been cited and to present evidence to support that belief.
- May not use the process to delay formal imposition of remedies or challenge any other aspect of survey process, including but not limited to:
  - Scope and severity
  - Remedies imposed
  - Failure of survey team to comply with a requirement of the survey process
  - Inconsistency of the survey team in citing deficiencies
  - Inadequacy of the IDR process

Informal Dispute Resolution (cont.)

- Available to facilities for State-only tags
- Not a formal or evidentiary hearing – intended to allow facility staff to directly communicate with ISDH IDR Program staff and address issues identified in the survey findings
  - Non-facility employees not allowed to attend
  - No fee for the IDR process
- To request IDR, the facility must submit the completed IDR request electronically, including supporting documentation, with the plan of correction through the ISDH Survey Report System
- IDR review and final determination will be completed within 45 days of the initial receipt of the complete desk (paper) review request or the face-to-face meeting.

IDR – Should We?

- Does the 2567 include
  - Inaccuracies in the citation (dates, details)?
  - Incomplete data that if provided could change the citation?
  - Incorrect statements or quotes?
  - Survey examples do not address failure to meet intent of regulation cited?
  - Specific facts not listed, calling into question the validity of citation?

Practice Session

Writing a POC

Example: F 757 – Free from Unnecessary Drugs

- Resident #9 had Cardiologist notified of PT/INR results prior to survey exit. New orders were obtained with no negative outcomes. Resident #14 had physician notified of missing labs.
- Residents that have labs ordered have the potential to be affected by the alleged deficient practice. Lab orders within the past 30 days have been audited for being obtained, MD and family notification, and proper follow up by nursing administration to assure compliance. No other residents were identified as affected.
- The SDC will provide education to LNs on the policy/protocol for obtaining, reporting, and following up on lab orders by date of compliance. PRN nurses will be required to receive education prior to first scheduled work day
- Nursing administration will audit PT/INR results for residents receiving Coumadin and HGB results for residents receiving Aranesp twice weekly for 4 weeks, then twice monthly for 3 months, then 3x quarterly until compliance is achieved. Any negative trends will be reviewed in monthly QAPI meeting
- Date of compliance

References and Resources

- CMS. Quality, Safety & Oversight – Guidance to Laws and Regulations. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes
- ISDH. Informal Dispute Resolution Information Center. https://www.in.gov/isdh/25304.htm

QUESTIONS?

PROACTIVE MEDICAL REVIEW

Thank you for attending!

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Proactive partners with providers for regulatory compliance, training, & medical review solutions.