Survey Deficiencies and Plans of Correction: What Do We Do Now?

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Objectives

• Provide an overview of the key regulatory issues facing hospices which may have an impact on survey findings.
• Describe the process for post survey follow up and the components and timeline for completion of the plan of correction.
• Describe hospice staff and management involvement and roles in the implementation of the plan of correction and ensure readiness for future Medicare hospice surveys.
• Q&As

IMPACT ACT & TOP REGULATORY/COMPLIANCE ISSUES
IMPACT Act

  - Effective October, 2014.
  - Mandatory surveys every 36 months through 2025.
  - Surveys conducted by state survey agency or accrediting body with deemed status (JC, CHAP, ACHC).
  - Increased medical review for hospices with higher percentage of patients with LOS greater than 180 days.
  - Discussing 40-60% threshold but not finalized yet.
- Aligns hospice aggregate cap with reimbursement (beginning with cap year FY 2017).

Top Survey Deficiencies (CMS 2015)

<table>
<thead>
<tr>
<th>CoP/Standard</th>
<th>Tag</th>
<th>Tag Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>418.76(h)</td>
<td>L629</td>
<td>Supervision of Hospice Aides</td>
</tr>
<tr>
<td>418.56(b)</td>
<td>L543</td>
<td>Plan of Care</td>
</tr>
<tr>
<td>418.54(c)(6)</td>
<td>L530</td>
<td>Drug Profile</td>
</tr>
<tr>
<td>418.54(c)(2)</td>
<td>L545</td>
<td>Content of the Plan of Care</td>
</tr>
<tr>
<td>418.56(c)(2)</td>
<td>L547</td>
<td>Scope and Frequency of Services</td>
</tr>
<tr>
<td>418.56(b)</td>
<td>L523</td>
<td>Standard: Timeframe for Completion of the Comprehensive Assessment</td>
</tr>
<tr>
<td>§418.78(e)</td>
<td>L647</td>
<td>Standard: Level of Activity: Volunteers</td>
</tr>
<tr>
<td>§418.56(c)(2)</td>
<td>L555</td>
<td>Standard: Coordination of Services</td>
</tr>
<tr>
<td>§418.56(d)</td>
<td>L552</td>
<td>Standard: Review of the Plan of Care</td>
</tr>
<tr>
<td>§418.76(g)</td>
<td>L625</td>
<td>Standard: Hospice Aide Assignments and Duties</td>
</tr>
</tbody>
</table>

Source: NHPCO and CMS

Additional Regulatory Considerations

- 418.116 Compliance with State/Federal/Local Laws.
- State Hospice Agency Licensure Regulations.
- Accreditation Requirements (JC, CHAP, ACHC).
- The US Drug Enforcement Administration’s (DEA) Final Rule for the Disposal of Controlled Substances
Additional Regulatory Considerations

- Patient Rights.
- Volunteer Program Requirements.
- Quality Assessment/Performance Improvement.
- Infection Control.
- Contracted Services and Facilities.
- Hospice in Skilled Nursing/Nursing Facilities SNF/NF and Assisted Living Facilities (ALF):
  → Professional Management.
  → Coordination of Care.
- Hospice SNF Education.
- Bereavement support for SNF/NF staff.

Top 10 Survey Deficiencies: L629 Compliance Strategies

- Ensure ongoing supervision of hospice aides at least every 14 days.
  → Recommend documentation of indirect supervision with each RN visit.
- Indirect supervision should document patient/family feedback that the hospice aide services ordered by the IDG meet the patient/family's needs.
- Direct supervision should contain the name of the hospice aide supervised.
- Note that if the HHA is not following plan of care, this also may be cited under L629.

Top 10 Survey Deficiencies: L543 Compliance Strategies

- Ensure IDG plan of care (POC) is individualized for each patient.
- Ensure IDG plan of care is updated with each IDG meeting. Do not utilize “canned” EMR language.
- Ensure that all IDG team members involved update the plan of care and state patient specific goals and interventions.
- The goals/interventions on physician ordered plan of care should be consistent with IDG plan of care and updated with each recertification.
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Top 10 Survey Deficiencies: L523 Compliance Strategies

- Establish a process and adequate staff coverage to ensure timely assessments performed by the Medical Director, hospice RN, social worker, and spiritual counselor/assessment.
- Ensure that spiritual and bereavement assessments are performed within 5 days after election of the hospice benefit.
- If services are refused on admission, reassess need with each IDG.

Top 10 Survey Deficiencies: L647 Compliance Strategies

- Provide evidence of calculation demonstrating day-to-day administrative and/or direct patient care services that equal 5% of the total patient care hours of all paid hospice employees and contracted staff.
  → Example: Hospice provides 10,000 of paid direct patient care during 1 year must provide a minimum of 500 hours in eligible direct patient care or administrative activities.
- Maintain records on the use of patient care/administrative services, including type of services and time worked.
- KNOW difference between what is allowable and not allowable.
- Ensure recruitment efforts support having enough volunteers to meet patient needs.

Top 10 Survey Deficiencies: L555 Compliance Strategies

- Review the IDG POC at each visit to ensure services are provided per the POC.
- Ensure that the IDG POC updates include frequency of each service provided.
- Ensure that all members of the IDG have access to the patient’s current plan of care and that it is updated in a timely manner.
- Ensure that coordination and communication between disciplines is documented with each visit by all disciplines.
Top 10 Survey Deficiencies: L552 Compliance Strategies

- Review the IDG POC during every clinical visit to ensure current needs are being addressed.
- Communicate any patient status changes to the Medical Director, Attending Physician (if applicable) and other members of the hospice team and facility staff (if applicable) in a timely manner.
- Ensure that physician orders are obtained for any POC revisions due to status changes.

Top 10 Survey Deficiencies: L625 Compliance Strategies

- Hospice aide written instructions for patient care are prepared by the RN responsible for the supervision of the aide and must be patient specific and not generic.
  → Do not use PRN.
  → For SNF/facility patients, specify what Hospice Aide will provide/frequency and what SNF CNA will provide.
- Ensure hospice aides providing care have appropriate competency and proficiency.
  → Includes contracted aides.
- Ensure HA assignment sheets match care plan.
  → RN is notified if patient refuses care or if patient’s condition changes.

CMS POST-SURVEY PROCESS OVERVIEW

[Diagram showing checklist items]
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Survey Deficiencies and Plans of Correction: What to Do Now?

CMS State Operations Manual Appendix M-Hospice

- Part III Survey Tasks:
  - Task 1 Pre Survey Preparation.
  - Task 2 Entrance Interview.
  - Task 3 Information Gathering.
  - Task 4 Information Analysis.
  - Task 5 Exit Conference.

Task 4 - Information Analysis

- Surveyors must review and analyze all information gathered during the survey from all areas:
  - Record Reviews.
  - Document Review.
  - Staff Interviews.
  - Home Visits.
  - Patient/Family Interviews.

- Analysis of Findings Based On:
  - Effect or potential effect on the patient(s).
  - Degree of severity.
  - Frequency of occurrence.
  - Impact on the delivery of services.

Task 5 - Exit Conference

- Informs Hospice of Observations and Preliminary Findings.
- Conducted with Hospice Administrator, Supervisors and Hospice-Invited Staff.
- Describes Regulatory Requirements that Hospice Does Not Meet and Findings.
Sample Deficiencies Based on Survey

- Failure to promote and protect the patient’s rights;
- Failure to accurately conduct a patient-specific comprehensive assessment that identifies the patient/family’s need for hospice care and services, and the patient/family’s need for physical, psychosocial, emotional, and spiritual care;
- Failure to develop and implement a plan of care that meets the needs identified in the initial or comprehensive assessment;
- Failure of the IDG to meet the physical, medical, psychosocial, emotional, and spiritual needs of the hospice patient/family.

Sample Deficiencies Based on Survey

- Failure to provide all covered services, as necessary, including the continuous home care level of care, respite care and short-term inpatient care;
- Failure to provide nursing and physician services, drugs and treatments on a 24-hour basis;
- Failure to retain professional management responsibility for all hospice services provided under contract to patients, and
- Failure to develop, implement, and maintain an effective, ongoing, hospice-wide data-driven QAPI program.

Task 6-Formation of the Statement of Deficiencies

- Form CMS 2567 Sent to Hospices within 10 Working Days.
- Plan of Correction must be Submitted within 10 Calendar Days of Receipt of Statement of Deficiencies (Form CMS-2567).
- Refer to Missouri Department of Health and Senior Services Website for forms and instructions:
  → http://health.mo.gov/safety/homecare/correctionforms.php
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**Timeline for 90 Day Termination**

- Day 15 - notify agency of 90 day termination;
- Day 45 - revisit if credible allegation;
- 2nd Revisit between 45-90 days;
- Day 55 - certify noncompliance, notify Regional Office (RO);
- Day 65 - RO confirms support;
- Day 70 - RO sends official termination letter;
- Day 90 termination effective immediately.

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**Immediate Jeopardy: CMS SOM Appendix Q**

**Definition:**
- A situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

**Only ONE INDIVIDUAL needs to be at risk.**

**Harm does NOT have to occur before considering Immediate Jeopardy.**
- Consider both potential and actual harm when reviewing the triggers in the table.
- Psychological harm is as serious as physical harm.

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**Immediate Jeopardy Triggers-Examples**

- Patient injuries.
- Physical abuse.
- Verbal abuse.
- Restraint use.
- Incorrect medication/Adverse reactions.
- Failure to assess/follow up regarding patient changes.
- Failure to follow plan of care.
- Failure to manage patient’s symptoms.
- Failure to perform wound care.
- Improper handling blood/body fluids.
Immediate Jeopardy - Surveyor Decision Tree

- Did the harm meet the immediate jeopardy definition?
- Is the harm likely to recur?
- Was the provider aware?
- Did the provider investigate the circumstances?
- Did the provider implement corrective action?

Immediate Jeopardy Termination Timeline

- 3rd working day - overnight to RO for review.
- 5th working day - RO notifies HHA & public.
- 10th working day - HHA & RO notified of all deficiencies, state Medicaid agency notified.
- 23rd calendar day - termination effective.
  → Unless threat removed.
- If condition level deficiencies are still out, 90 day termination cycle.

Plan of Correction Requirements

- Address each L-Tag separately.
- Must include the following:
  → Corrective action for patients directly affected;
  → Identification and corrective action for patients potentially affected;
  → Implementation of measures/systematic changes;
  → Ongoing monitoring processes;
  → Identify staff member by title and date of completion of each corrective action plan component.
- Recommend inclusion of all citations even if the agency is appealing findings.
CMS State Operations Manual Appendix M

- Complaint Investigations:
  - Critical certification activity.
  - Each complaint must be documented, investigated and resolved.
  - Guidance in Chapter 5 SOM.
  - If one or more condition-level deficiencies are identified during the complaint investigation, all conditions must be reviewed.

Staff Involvement in Survey/Post Survey

- Check surveyor identity upon entrance.
- Provide work place.
- Work with staff in identification of patients and records.
- Determine and provide information needed.
- Keep list of records and visits.
- Plan with surveyor for exit conference.

Exit Conference

- Audiotape the exit conference (copy for surveyor required).
- Have appropriate staff participate/available.
- Have surveyed clinical records, regulations, other pertinent information available.
- Maintain professional atmosphere.
- Avoid comments that could be interpreted as admission of error.
- Avoid arguments.
Exit Conference

- Insist on specifics about citations.
- Use patient records to correct (refute) erroneous interpretations/misperceptions.
- Request specific regulatory references.
- Request specific standard or State references.
- Use CMS manuals, letters to support compliance.
- Request clarification if cited for single incidence.

Post Exit Conference

- Determine validity of stated deficiencies:
  - Are surveyor’s interpretations of regulations and policies correct?
  - Is citation for failure to comply with own policy?
  - Correct valid problems.
  - Request surveyor clarification.
  - Assemble evidence/supporting documentation.
  - Dispute disagreements in plan of correction.

Disputing Deficiencies

- Ascending Order:
  - Surveyor
  - Surveyor supervisor.
  - State agency director.
  - CMS Regional Office.
  - CMS Central Office.
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Appeals

- Process is in accordance with State Operations Manual and State licensing agency:
  - Right to Comment.
  - Formal Appeal Rights.

- Statement of Deficiency Response Options:
  - Accept all deficiencies and submit a Plan of Correction.
  - Submit Plan of Correction and record objections to cited deficiencies.
  - Record objections to cited deficiencies.

- Recommend that all deficiencies have a draft POC developed even if the agency is appealing:
  - Timeline does not change if appeal is denied.

CMS Survey and Enforcement Guidance 3026B - Plan of Correction (POC) Disagreements

- If a provider or supplier disagrees with a SA or RO finding of a cited deficiency, the provider or supplier may, in lieu of submitting a POC, state on Form CMS-2567 the factual basis for disagreeing that a deficiency occurred.
  - Provider should reference the specific regulatory provision and what factual evidence was available at the time of the survey to demonstrate compliance.
    - Corrective actions taken after the survey started as a basis for removal of a deficiency citation.
- The original termination date is not changed due to provider disagreement.
- If the SA or RO determines that a deficiency did not exist, it is removed from Form CMS-2567.

Key Plan of Correction Documentation - Examples

- Address immediate needs.
- Policy Review/Revision.
- Document Review/Revision.
- Staff Training on all policies, practices, forms:
  - Include staff competency and ongoing training.
- Baseline clinical record audit.
- Ongoing audits with thresholds for compliance.
Sample Plan of Correction: L.524 Content of Comprehensive Assessment

- **Finding:** Pain assessment was not complete which resulted in poor pain management and negative outcome for the patient. Infusion pain meds not managed properly by nursing staff.

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#1: Corrective Action for patients affected by the deficiency:
- Patient #3 expired.
- Patient 19 discharged for extended prognosis on 4/10/16.
  - Review of discharge by Hospice Supervisor occurred to ensure appropriateness of discharge.

#2: Identification of other patients having the potential to be affected by the same deficiency:
- All patients have the potential to be affected by this practice.

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#3: Measures/Systematic Changes that will be put into place to ensure that the deficiency does not recur:
- A new template for admission and revisit narrative documentation has been developed that includes a standardized pain and symptom assessment.
  - All nursing staff will be trained on the use of the standard pain assessment in EMR and need for assessment on all symptoms and proper use of pain and symptom management in template narrative by 4/30/16.
Sample Plan of Correction: L524 Content of Comprehensive Assessment

#3: Measures/Systematic Changes that will be put into place to ensure that the deficiency does not recur (cont’d):

- Developed nursing process (CADD Pump Checklist) to prevent inadequate supply of IV analgesia in home for all shifts.
  - All nursing staff will be trained on the use of the CADD Pump Checklist by 4/30/16.
- Re-educate all nursing staff on use of narcotic count sheet for patients on continuous home care to document all boluses given by agency staff.
  - Training to be completed by 4/30/16.

Sample Plan of Correction: L524 Content of Comprehensive Assessment

#3: Measures/Systematic Changes that will be put into place to ensure that the deficiency does not recur (cont’d):

- Revise Agency Policy on Pain and Symptom Management to include use of standardized pain assessment.
- The Hospice Director will train all nursing staff on the Medicare Hospice Conditions of Participation addressing Patient Rights and Agency Policy on Pain and Symptom Management.
  - Training will be completed by 4/30/2016.
  - Any nursing staff member on paid time off or leave of absence during the training period will complete the education within 1 month of returning to work.

Sample Plan of Correction: L524 Content of Comprehensive Assessment

#3: Measures/Systematic Changes that will be put into place to ensure that the deficiency does not recur (cont’d):

- All newly hired nursing staff will be trained on the Medicare Hospice Conditions of Participation addressing Patient Rights, pain and symptom management and documentation. Training materials will be developed and implemented by 5/1/16.
- Effective 5/1/16 as part of the ongoing annual in-service training requirements, all nursing staff will be required to complete Agency webinar education on the Hospice Conditions of Participation and Pain and Symptom Management with evidence of passing score of 80% from post-test.
Sample Plan of Correction: L524 Content of Comprehensive Assessment

#4: How the agency will monitor its corrective action to ensure that the deficiency will not recur:
- Conduct a baseline review of 100% of records for all active patients to ensure documentation of effective pain assessment and symptom management. Date completed 4/30/16.
- Ongoing all admissions/recertifications will be reviewed by the Clinical Supervisors to ensure documentation of effective pain assessment and symptom management.
- Ongoing monthly record review of 10% of census or 25 records, whichever is greater, until 90% compliance achieved documentation of effective pain assessment and symptom management.

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Sample Plan of Correction: L524 Content of Comprehensive Assessment

#4: How the agency will monitor its corrective action to ensure that the deficiency will not recur:
- When above goal achieved, records will be reviewed as part of the quarterly record review process.
- Results of monthly/quarterly audits will be followed up by the Quality Department and reported to Professional Advisory Committee and Governing Body.

#5: Responsible Person:
- Hospice Director.

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Plan of Correction Implement Reminders

- Must ensure oversight of Plan of Correction to ensure it is implemented as noted.
- Incorporate into agency QAPI Program priorities.
- Quarterly review of the Plan of Correction to address any areas not meeting deadlines or achieving improvement.
- Report to Governing Body at least quarterly regarding progress.
- Include previous deficiencies in survey readiness program.
- Hold staff accountable.
Survey Readiness Strategies

- Ensure all staff is knowledgeable about the hospice Conditions of Participation (CoPs).
  - Build education into orientation program for new staff.
  - Include updates/review for current staff.
- Keep a Survey Readiness book in the office and online. Make sure all staff knows where the book and the required contents can be found.
  - Conduct a mock survey to assess CoP compliance and to determine areas that require improvement. Use Appendix M and Chapter 2 of the State Operations Manual as a guide.

Survey Preparation Documents

- Agency organizational chart (including patient).
- Board/PAC minutes.
- List of current contracts with Provider Numbers and evidence of contract oversight and SNF education.
- List of employees with title.
- QAPI Program components and list of QAPI Committee members with projected meeting dates for year.
- Infection Control, Complaints, Quality Monitoring, Incidents.
- Volunteer Program Information including list of active volunteers and personnel records.
- In-service calendar and evidence of staff in-service.
- Evidence of SNF orientation in-service.
Survey Deficiencies and Plans of Correction: What to We Do Now?

Survey Preparation Documents

- Patient listings:
  - Current patients inc. SOC date, location of service, level of care, DX, services provided.
  - Unduplicated census for last 12 months.
  - Discharged patients-last 6 months.
- Clinical records with all components and instructions re: how to access the information if EMR.
- Admission packet and sample clinical record (if not EMR).
- Marketing materials.
- Policies and Procedures.
- After hours on call log.
- IDG minutes.

Survey Preparation Documents

- Personnel files (including, but not limited to licenses, PEs for new hires, PPDs, in-service hours, performance evaluations).
- Map of geographical area served.
- Bereavement program information and documentation of bereavement contacts during the past 12 months.

Medicare CoPs Audit Tool - Sample

<table>
<thead>
<tr>
<th>Medicare CoPs Audit Tool - Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>418.24</strong> Referral Intake Form complete. The patient is only admitted on the recommendation of the Medical Director in consultation with or with input from, the patient's attending physician.</td>
</tr>
<tr>
<td><strong>418.25</strong> Election Statement is complete, dated, signed and present in the clinical record.</td>
</tr>
<tr>
<td><strong>418.52</strong> Interpreter provided for non-English speaking/hearing impaired patient.</td>
</tr>
<tr>
<td><strong>418.53</strong> Informed Consent including Bill of Rights is signed and dated by the patient, OAP or authorized representative.</td>
</tr>
<tr>
<td><strong>418.54</strong> Advance Directives: Copy in record or intent documented (DNR and/or Living Will).</td>
</tr>
<tr>
<td><strong>418.55</strong> DNR: Signed and dated by patient, OAP or authorized representative in accordance with CT law.</td>
</tr>
<tr>
<td><strong>418.56</strong> Physician orders must be signed by the AD under the Patient's name and title as DNR.</td>
</tr>
</tbody>
</table>
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Contract Review Checklist - Sample

<table>
<thead>
<tr>
<th>Item</th>
<th>Written Contract Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Services to be provided.</td>
</tr>
<tr>
<td>2.</td>
<td>Requirement that contractor is required to perform work in accordance with Hospice’s applicable policies and procedures.</td>
</tr>
<tr>
<td>3.</td>
<td>Requirement that contractor agrees that all personnel providing care have the education, training, and qualifications specified by Hospice.</td>
</tr>
<tr>
<td>4.</td>
<td>Mechanisms for the contractor to participate in performance improvement activities.</td>
</tr>
<tr>
<td>5.</td>
<td>Mechanisms for evaluating compliance with applicable Hospice policies and procedures.</td>
</tr>
<tr>
<td>6.</td>
<td>Procedures for submission of required patient-related documentation that verifies the provision of services in accordance with the written service contract.</td>
</tr>
<tr>
<td>7.</td>
<td>Procedures for ensuring that contractor personnel records contain documentation required by Hospice.</td>
</tr>
<tr>
<td>8.</td>
<td>Stipulation that Hospice will retain responsibility for evaluating services, maintaining professional management responsibility, and ensuring continuity of care in all settings through its QAPI program and/or corporate compliance program.</td>
</tr>
<tr>
<td>9.</td>
<td>Stipulation that all care provided will be in accordance with the hospice plan of care and documented in the clinical record.</td>
</tr>
<tr>
<td>10.</td>
<td>Effective date and term of the contract.</td>
</tr>
<tr>
<td>11.</td>
<td>Signed by both the Hospice Administrator and Contractor.</td>
</tr>
</tbody>
</table>

Additional Survey Readiness Tools

- Survey Readiness Tools (NHPCO members only):
  - [http://www.nhpco.org/surveyreadiness](http://www.nhpco.org/surveyreadiness)

- Missouri Department of Health and Senior Services Hospice Certification Tool:

- Missouri Department of Health and Senior Services Quality Assessment/Performance Improvement Tool:

Survey Preparation Documents

- Regulatory Resources to Include the Survey Preparation Manual:
  - CMS State Operations Manual:
    - Chapter 2 - Certification Process.
    - Appendix M-Hospice (includes 42 CFR 418 Conditions of Participation for Hospice and L-Tags).
  - Applicable State Licensure Regulations.
  - Evidence of surveyor guidance (if applicable).
  - Accreditation Standards (if applicable).
Simione Healthcare Consultants provides solutions for your core home care and hospice challenges – organizational, financial, sales & marketing, technology, and mergers & acquisitions. Over 1000 organizations use our practical insight and tools to reduce costs, mitigate risk and improve efficiencies to steward the way they conduct business.

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