Plan of Correction
It's A QAPI Process

JPST

September 2016

Speakers

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Federal Requirements for Acceptable Plan of Correction

- 5 Criteria established by CMS
- If any component missing, the plan of correction will not be approved and remedies will be imposed immediately
- Facility cannot delay PoC due to deficiency being contested

Acceptable Plan of Correction

- The Statement of Deficiency is a public record; therefore, the appropriate facility response to each allegation is critical

Acceptable Plan of Correction

- The Plan of Correction: only ***public*** place that you address survey findings
  - Accessed by families, newspapers, financial institutions, and attorneys
  - Must be posted in a public place for residents/families to view
  - Cannot dispute findings in POC

Disclaimers

- Disclaimers are statements which deny the allegations along with the seriousness of the concern.
- Disclaimers establish the fact that the Plan of Correction is being submitted due to requirement of law, not because facility agrees with the citation
- On the first page of the POC only before any answers to deficiencies.

State Recommended Disclaimers

- **"(Facility Name) does not necessarily agree with all statements and conclusions in the CMS-2567 and submits this Plan of Correction in response to the *Statement of Deficiencies* received as requested by the State Survey Agency."**

LARA

April 4, 2013

GUIDELINES FOR THE DEVELOPMENT OF A PLAN OF CORRECTION (POC) FOR LONG TERM CARE FACILITIES

RESIDENT-SPECIFIC CITATION

Resident Specific

- Element 1: General accounting of how the deficiencies citedfor a specific resident have been corrected.
- Element 2 must state how all other residents who have been, or could be, affected by the generic deficient practice have been identified.
- Elements 3 and 4 must demonstrate that the facility has considered all residents in their plan development.

Element One

- HOW the corrective action will be accomplished for ***those residents*** found to have been affected by the deficient practice
  - Element #1: For the residents identified in this document (or 2567), we did the following:
  - Must list each resident separately even if the 2567 groups them together.

Element One

- Review each resident cited in exit and develop an individualized plan to correct the practice. Involve those providing care to the resident
- Include
  - Interview and involvement of resident and resident's choices
  - Assessment by IDT
  - Evaluation by MD or RPh if needed,
  - Review and **update** to care plan.

Element One

- Each statement should say which member of the IDT completed the action. E.g. The Clinical Care Coordinator completed a Falls Risk Assessment on Resident #2016 (may want to include the date). The IDT and resident met and reviewed the assessment, the resident's fall history and root causes. They then reviewed the resident's care plan and updated the care plan (or deemed it appropriate).

Element One

- Don’t stop with this. List all of the actions.
  - Pharmacy
  - How was the resident involved? For some plans of correction, the resident’s INFORMED choice and education may be crucial to the POC.

Element Two

- **HOW** the facility will **IDENTIFY** other residents having the potential to be affected by the same deficient practice
  - Element #2: To identify other residents who had similar circumstances, we did the following:

Element Two

- Review the sample: are there others that may appear on the 2567.
- Audit or review of the other residents with similar circumstances.

Develop a Strategy for Collecting and Using Data

- Areas to consider for Element #2
  - Quality Measure Reports identify those who trigger for the same QM
  - MDS Audit of applicable sections
  - Pharmacy reports
  - Chart audit
  - Risk Assessments
  - Similar diagnoses
  - Incident Reports
  - Infection Control Logs

Develop a Strategy for Collecting and Using Data

- Areas to consider for Element #2
  - Resident / Family Council Meetings
  - Individual Interviews with residents and families
  - Minutes of past resident / family council minutes
  - Ombudsman
  - Facility Customer Service records
  - Staff Interviews
  - Observations of care delivery
  - Round of the physical plant

Develop a Strategy for Collecting and Using Data

- Areas to consider for Element #2
  - Preventative Maintenance Logs
  - Food Safety Logs
  - Activity Calendars
  - Menus
  - Resident / Family Satisfaction Surveys

Element Two

- State how you identified other residents clearly. Do not list individually.
- Plan of Correction Instructions do not state that you need to say what you did **BUT it is an expectation.**
- Determine what needs to be done for these residents. (Hint: It may be very similar to what you did in Element 1.)

Caution

- The audits in Element #2 may be the same audits you do in Element #4.
- Make a clear distinction of the time frame of the audits in Element #2 if using same audit tool.
- For example, if auditing MAR for missing initials (potential omitted doses), do it for the month of the survey for Element #2, and then resume under Element #4 on a later date.

Element Three

- **WHAT** measures will be put into place or <u>systemic changes</u> made to ensure that the deficient practice will not recur
  - <u>Element #3</u>: To improve our systems and process related to ____________, we did the following:
  - In the previous Elements, you "corrected" for individuals.
  - In this element, you are improving the systems of care

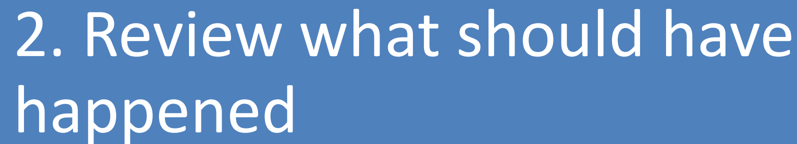
Identify Gaps and Opportunities

- Using Element 2 data plus more, look for patterns and trends:
  - MDS data for problem **patterns**.
  - **Trends** in complaints.
  - Resident and family satisfaction for **trends**.
  - **Patterns** of caregiver turnover or absences.
  - **Patterns** of ER and/or hospital use.

Getting to the "Root" of the Problem

- Root Cause Analysis (RCA) is a term used to describe a systematic process for identifying contributing causal factors that underlie variations in performance. This structured method of analysis is designed to get to the underlying cause of a problem –which then leads to identification of effective interventions that can be implemented in order to make improvements.

Root Cause Analysis



4. Generate recommendatio

Root Cause Analysis

1. Identify What Happened – the 2567 did that as well as your development of Elements #1 and #2

Root Cause Analysis

2. Review what should have happened – often missed step. Review the policies related to the statement of deficient practice. Create Process Maps.

Root Cause Analysis

3. Determine causes – what are the gaps in the process? Where are the opportunities to improve?

Root Cause Analysis

4. Generate recommendations – this is your corrective action

Element Three

- **WHAT** measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
  - This must demonstrate that the facility has considered all residents in their plan development.
  - Review and **update** policies and procedures based on root cause analysis and gap identification

Policy Review and Updating

- State who did or will do the review
- Permissible to deem the policy appropriate
- Include list of the updates (more likely to get a desk review if you are clear)
- Be sure you date the policy itself with either review date or "Updated on"
- Best practice but **not** required: Reference the regulations and attached evidenced-based outcomes resources (AMDA, journal articles, CDC guidelines, etc)

Element Three

- **WHAT** systemic changes are done
  - In-servicing of staff:
    - Outside training – watch dates!
    - Identify who is going to conduct and projected dates
    - Identify the target audience – who performs the care/tasks, who needs to know
    - State how you will train those who are excused
    - Describe oversight by DON or other management personnel

In-Servicing

- Include all changes to any and all policies
- Review basic expectations of policies and standards of practice related to the topic
- Agenda and Proof of attendance is required
- Best practice but **not** required:
  - Handouts
  - Pre and/or Post Tests
  - Summary of attendance (method to determine target audience did attend)
  - Evaluations

Element Three

- **WHAT** systemic changes are done
  - Use of consultants, resident council feedback ombudsman input, multi-disciplinary QI teams
    - Schedule and complete within 30 days of exit
    - Clearly identify when role changes from change to monitoring
  - Customer surveys
  - Interviews with residents and families

Element Three

- **WHAT** systemic changes are done
  - Physical environment enhancements
  - Staff expansion
  - Staffing adjustments and changes

Element Three

- **WHAT** systemic changes are done
  - Employee action
    - Conduct quality improvement review of the situation identified in this document
    - Identify areas for improvement
    - Train the employee on expectations
    - Establish a work performance improvement plan

Element Three

- Each action must state who completed or will complete the task – dates are great if completed before submission
- Each change must state who is responsible for carrying out the action on a daily basis

QAPI Systemic Action

- Weak: Depend on staff to remember their training or what is written in the policy. (Enhance or enforce existing processes.)
- Examples of weak actions:
  - Double checks
  - Warnings/labels
  - New policies/procedures/memoranda
  - Training/education
  - Additional study

QAPI Systemic Action

- Intermediate: Provide tools to help staff to remember or to promote clear communication. (Modify existing processes.)
- Examples of intermediate actions:
  - Decrease workload
  - Software enhancements/modifications
  - Eliminate/reduce distraction
  - Checklists/cognitive aids/triggers/prompts

QAPI Systemic Action

- More examples of intermediate actions:
  - Eliminate look alike and sound alike
  - Read back
  - Enhanced documentation/communication
  - Build in redundancy

QAPI Systemic Action

- Strong: Do not depend on staff to remember to do the right thing. Provides strong controls. (Change or re-design the process.)
  - Detect and warn so there is an opportunity to correct before the error reaches the patient.
  - Involve hard stops which won't allow the process to continue unless something is corrected or gives the chance to intervene to prevent significant harm.

QAPI Systemic Action

- Examples of strong actions:
  - Physical changes: grab bars, non slip strips on tubs/showers.
  - Forcing functions or constraints: design of gas lines so that only oxygen can be connected to oxygen lines; electronic medical records – cannot continue charting unless all fields filled in.
  - Simplifying: unit dose.

Element Four

- HOW the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur
  - This must demonstrate that the facility has considered all residents in their plan development.
  - **Quality Assurance monitoring** the continued effectiveness of the systemic changes

Element Four

- HOW the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur
  - Who is doing the monitoring?
  - Sample size
  - What
  - Frequency
  - Expected Outcome
  - Action Taken When Improvement Needed
  - Who the monitor reports to
  - Who reports how often to QA

Element Four

- For example
  - Who is doing the monitoring? The Clinical Care Coordinators will observe
  - Sample size: 25% of the residents
  - What: using pressure reduction wheelchair cushions
  - Frequency: twice weekly at random times on different shifts
  - Expected outcome: to determine if cushions are present

Element Four

- For example
  - Expected outcome: to determine if cushions are present
  - Action Taken When Improvement Needed: They will take corrective action when needed
  - Who the monitor reports to: They will report monthly to the DON.
  - Who reports how often to QA: The DON will report patterns and trends to the QA Committee monthly for further recommendations.

Remember

- This is a QA process.
- QA Committee has authority to increase/decrease sample size and frequency.
- POC is not a commitment to do the exact same monitoring until next annual survey.

Element Four

- HOW the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur
  - Return demonstrations
  - Documentation audits
  - Observation of care
  - Staff interviews
  - Environmental Rounds

Element Four

- HOW the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur
  - Quality indicators
  - Surveillance
  - Customer surveys,
  - Resident council feedback, interviews with families/residents

Element Four

- *Must end with a statement of:* Who, within your organization, will be responsible for assuring that substantial compliance is **attained** through the PoC and within the allowable time frames **and** who will be responsible for sustained compliance thereafter
- Usually NHA or DON – occasionally another department head

Criteria Five

- Completion date
  - Realistic
  - ASAP but , , ,
  - 40th day after exit of the survey that opened the cycle

FACILITY-CENTERED CITATIONS

Facility-Centered

- Element #1: How corrective action has been or will be accomplished for the facility centered deficient practice;
- Element #2:What measures have been or will be put into place or systemic changes made to ensure that the deficient practice will not recur; and
- Element #3: How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; i.e., what quality assurance program will be put into place.
- Element #4: Completion Date

Organize by elements

Identify each element in the POC – don’t expect the manager to hunt for them

REMINDERS

Golden Rules for Content

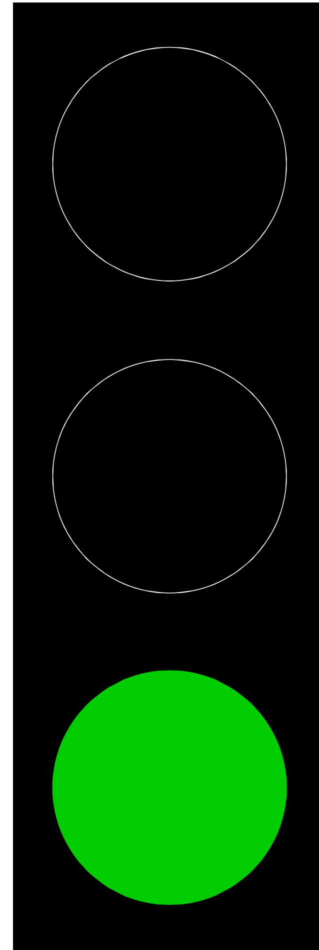
1. Do **not** include resident or facility staff names, allude to another facility or supplier, or malign an individual.
2. Do **not** use all-inclusive wording such as “all”, “everyone”, “at all times”, “always”
3. Do Not offer more than “what’s in the bank”
4. Every action statement state who by position did or will do it

Resident Specific versus Facility Specific

- If the citation is resident specific such as failure to prevent pressure ulcers, dignity of residents, assessment of residents than the POC must have all four components
- If the citation is facility centered such as water temperature, general infection control standards, staffing, then the POC need only to have three components
- However, some citations may deal with both resident and facility systems. For example, F248 - Activities. For deficiencies that have both facets, be sure to address each facet in the corrective response.

Do **NOT** wait until 2567 arrives

- Have to submit POC even if disputing
- Time is short
- Memories fade



Involve the caregivers and staff who perform the work in the citation

- Let everyone know what the findings are
- Have an open discussion about quality concerns and that it is safe to do so, and that everyone is encouraged to think about systems.
- Establish their understanding of what should have happened – what are your current systems, policies, and procedures?

Involve Your Support Team

- Be sure consultants and contractors are also aware of citations that cross into their expertise.

Prioritize Quality Opportunities and Charter PIPs

- Charter PIP Teams for like citations
  - Involve others and gather data
  - Develop preliminary POC steps
  - Reports back to the IDT no less often than weekly
  - Important assignment that team members and their supervisors must take seriously.

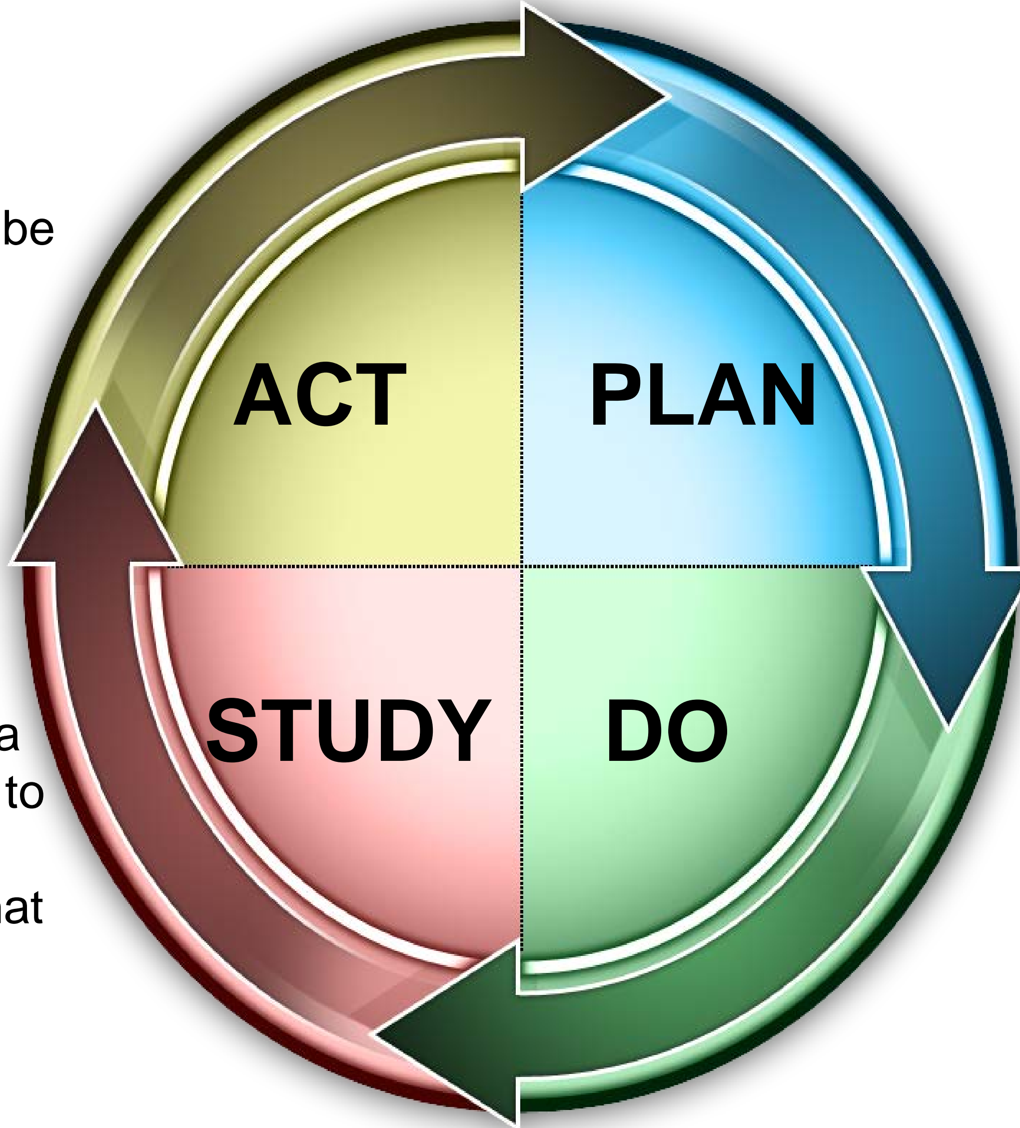
Plan. Conduct and Document PIPs

- Use a problem solving model like PDSA (Plan-Do-Study-Act).

PDSA Cycle

- Change to be made
- Next cycle

- Objective
- Questions / Predictions
- Plan to carry out (who, what, when, where, how)



- Compare analysis of data
- Compare data to prediction
- Summarize what was learned

- Carry out plan
- Document Problems and observations
- Begin analysis

Slide 62

Past Compliance

Good News!

Overview

- Past noncompliance may be cited on Health and Life Safety Code surveys of nursing homes.
- Past noncompliance may be cited on any type of survey (standard recertification, abbreviated standard, e.g., complaint and revisit).
- Data about past noncompliance tags are <u>not</u> carried forward to subsequent revisit surveys.

Overview

- IDR will be allowed for past noncompliance tags
- May not IDR using the basis that, while it occurred, it should have been considered Past Noncompliance

Determination of PNC

- Three criteria must be met:
  - The facility was not in compliance with the specific regulatory requirement(s) (as referenced by the specific F-tag or K-tag) at the time the situation occurred;
  - The noncompliance occurred after the exit date of the last standard recertification survey and before the survey (standard, complaint, or revisit) currently being conducted; and

Determination of PNC

- Three criteria must be met:
  - There is sufficient evidence that the facility corrected the noncompliance and is in substantial compliance at the time of the current survey for the specific regulatory requirement(s), as referenced by the specific F-tag or K-tag.

Determination of PNC

- To cite past noncompliance there must have been a
  - Violation after the last standard survey
  - Evidence that it was corrected before the current survey event
  - Currently in compliance with the same regulatory requirement.

Determination of PNC

- Variety of methods to determine whether correction of the past noncompliance occurred and continues.
  - Interviews with facility staff, such as the administrator, nursing staff, social services staff, medical director, **quality assessment and assurance committee members**, and/or other facility staff, as indicated, to determine what procedures, systems, structures, and processes have been changed.

Determination of PNC

- Variety of methods to determine whether correction of the past noncompliance occurred and continues.
  - Reviewing through observation, interview and record review, how the facility identified and implemented <u>interventions</u> to address the noncompliance.

Determination of PNC

- Evaluating whether the facility has a functioning QAAC, whose responsibilities include
  - Identification of quality issues;
  - Providing timely response to ascertain the cause;
  - Implementing corrective action;

Determination of PNC

- Evaluating whether the facility has a functioning QAAC, whose responsibilities include
  - Implementing monitoring mechanisms in place to assure continued correction and revision of approaches as necessary to eliminate the potential risk of occurrence to other residents and to assure continued compliance.

Vickie's Understanding

- The Basics of PNC
  - Facility must have identified violation at or near the time it occurred,
  - Occurred after the last standard survey
  - Current survey information must indicate the facility is in compliance with same tag,
  - Correction action was taken (the four step POC) and completed before current survey.

Enforcement

- Recommend the imposition of a CMP for past noncompliance cited at the level of immediate jeopardy.
  - Per-Day
  - Per-Instance CMP: when it is difficult to accurately establish when the past noncompliance occurred

Enforcement

- A civil money penalty is the only applicable enforcement action for a past noncompliance cite.

Vickie’s Understanding

- If PNC is D-I, then no citation, no 2567 entry, no CMP.

Lessons Learned

- Facility must be in compliance with the entire F-tag at the time of survey for an event to be reviewed as Past Noncompliance
- If event and root causes are addressed and resolved by PNC, but another practice results in noncompliance; the original event becomes part of the citation

Resources

- CMS Survey and Certification Letter 06-01. Downloaded July 10, 2016 from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCLetter06-01.pdf
- Bureau of Health Care Services, Department of Licensing and Regulatory Affairs (LARA). April 4, 2013. GUIDELINES FOR THE DEVELOPMENT OF A PLAN OF CORRECTION (POC) FOR LONG TERM CARE FACILITIES
- Presentation at Joint Provider Training in April 2011 by BHCS. Downloaded on July 10. 2016. http://s.michigan.gov/search?q=past+noncompliance&site=som&btnG=Search&client=som&output=xml_no_dtd&proxystylesheet=som_frontend&oe=UTF-8&ie=UTF-8&num=10&lr=&sort=date%3AD%3AL%3Ad1&wc=200&wc_mc=1&ud=1&exclude_apps=1