PLAN OF CORRECTION (PoC) SUBMISSION DIRECTIONS

Important note: All Statement of Deficiencies and PoCs are considered public documents; therefore, releasable to any person or entity upon request.

The Statement of Deficiencies is a State or Federal report which provides you with a detailed description of the deficient practices based on the recent survey of your facility/agency. The lower left hand corner of the report will either show "FORM CMS – 2567" (Federal report) or "State Form" (State report).

Column 1	Column 2	Column 3	Column 4	Column 5
ID Prefix Tag	Summary Statement of Deficiencies	ID Prefix Tag	Provider's Plan of Correction	Completion date
Tag Number	Regulation requirement is spelled out here, followed by the evidence to support the decision of noncompliance.	Tag Number	You will either: Write you PoC here OR Refer to your PoC which was submitted as a separate document	You will write your completion date here

- Column 1 – "ID Prefix Tag" – This is the number associated with the regulation.
- Column 2 – "Summary Statement of Deficiencies" – This section has 3 basic components:
    - The **regulation** – The regulation is quoted as it appears in either the Federal or State set of regulations for the provider type.
    - The **deficient practice statement** – This statement begins with the words "Based on". The statement summarizes the types of findings (observation, interviews, records review, etc.) used to document the deficient practice. It is followed by a summary statement on how the regulation was not met.
    - The **findings** – These are the separate points that the surveyor noted when evaluating your regulatory compliance. There may be multiple findings for one regulation.
- Column 3 – "ID Prefix Tag" – repeat of Column 1.
- Column 4 – "Provider's Plan of Correction" – This section is where you either write your PoC, or refer to your PoC which was submitted as a separate document.
- Column 5 – "Completion Date" – This is the date on which you will have completed your action plan and you expect to be back in compliance with the regulation. Only one date for each tag should appear in this column. This date should be within 60 days of the survey exit date.

The PoC provides your agency/facility with the opportunity to show that you have taken the issues noted in the Statement of Deficiencies seriously and have addressed them appropriately.

There are three (3) distinct sections to a PoC. Each section must be addressed for a PoC to be acceptable.

Section A

- State what you did to immediately address the issue for each individual (patient or staff) or each area that was impacted by the deficient practice.
- Include the activity and responsible position/job title.
- Each finding must be addressed.
- If you could not fix the problem for the individual impacted, then just say so and explain why. Examples of deficiencies that cannot be corrected retrospectively:

- If a patient was required to have a comprehensive history and physical 30 days prior to a procedure, but the patient already had the procedure and was discharged.
- If a comprehensive assessment was not completed within the required timeframe.

Section B

- Determine the processes that lead to the deficiency. This should include a review of: policies & procedures; training to determine if staff has received adequate instruction; QAPI practices.
- Develop and state your action plan to "fix" the deficient practice so it does not reoccur. For example, you may have to: write/revise a policy and provide training to staff to implement the action plan.
- Reference and provide supporting evidence that you completed your action plan. For example, label attachments/exhibits with an identifier (i.e. Exhibit A) and reference the attachment/exhibit identifier in the text of your PoC.

Section C

- What quantitative measurements will you put into place to determine if your action plan was successful? Putting an action into place to fix a problem is not effective unless you follow up to make sure that the action was successful & solved the problem.
- You may need to develop a tool to monitor the improvements in your deficient practice. Always keep in mind that regulations are minimum requirements and the compliance expectation should be 100%.
- Pick your sample carefully. The sample must be big enough to give you the data you need. For example, if you are looking at issues with wounds, do not pick a sample from total admissions. Pick a sample from admissions with wounds.
- List the position of the staff member that will monitor the success of your action.

What not to include in a PoC:

- Do not include the names of patients or employees. All patients and employees are given identifiers during the survey. Use those identifiers in your PoC. If including an employee not identified in the Statement of Deficiencies, use a job title.
- Do not put more than one date for each tag in Column 5. Multiple dates may be included in the body of your PoC in Column 4 but Column 5 is for the final date on which you expect to be in compliance with the regulation.
- Do not simply write, "The deficiency has been corrected". This is not acceptable.

Submitting a PoC:

- ✓ The Provider Representative's signature is required on the first page of the CMS-2567 for the PoC. If you submit your PoC as a separate attachment, you must attach the signed first page of the CMS-2567.
- ✓ Make sure that you have addressed each deficiency.
- ✓ Make sure that the PoC is written in the format prescribed and that any & all additional pages are attached.
- ✓ Make sure that there is one completion date for each tag in Column 5.
- ✓ If you have referenced attachments/exhibits in your PoC, make sure they are all included in your PoC submission. If an attachment/exhibit is referenced multiple times, only one copy needs to be submitted.
- ✓ Send via regular mail or electronically. If sending electronically, respond to all individuals that were copied on the e-mail in which you received the Statement of Deficiencies.
- ✓ You have **10 calendar days** to complete and submit your PoC regardless of whether you submit the PoC via mail or electronically.

PoC FAQs

1. What do you mean by individual or area impacted?
This may be a patient, an employee, a medical record, a wall or anything else that is identified by the surveyor.

2. What is the time frame to take corrective action?
Corrective action for Section A must occur immediately or as soon as possible. This is particularly true for patient care issues and patient records. It is not acceptable to wait until the next time something is due or scheduled. System changes and regulatory compliance must be accomplished within 60 days of the exit date of the survey.

3. *What do you mean by a system change?*
Once you have determined the processes that lead to the deficiency, these are steps that you take with your employees, policy and procedure implementation, and educational offerings that you institute to avoid a recurrence of the deficient practice.

4. Sometimes several tags contain the same findings, can I just copy the same answer over and over?
Rarely. The same problem frequently supports different regulatory violations. Each regulation is different. You are expected to fix the problem in the context of that regulation. For example, if one of the regulations cited is about governing body, system changes that fail to include a reference to the governing body would not be acceptable.

5. *Do I have to indicate that an employee was disciplined or terminated?*
When an agency/facility feels that the policies and procedures are sound, and the issue that led to the deficient practice was noncompliance, you are encouraged to indicate "supervisory intervention" versus disciplined or terminated.

6. What if my corrective action is greater than 60 days?
There are <u>some</u> (although rare) instances where certain types of corrective action cannot be completed in 60 days. One example might be construction. When this occurs, your response should identify the time line for the planned activity (construction) and the activities (planning, bids, contracts, purchase order, etc.) that will occur within the 60 days to establish compliance.

7. What do you mean by evidence?
Evidence is the documentation of the action you took and may be in the form of: new policies; revised policies; lesson plans for educational offerings; attendance sign-in sheets; meeting minutes; purchase orders; contracts; new or revised forms; etc. If you highlight (preferably in yellow) the information that explains your actions, it is helpful in allowing the OHFLC to focus their attention.

8. What is an appropriate sample size?
This may change with each deficient practice. This will be determined by you dependent upon the scope and severity of the problem and must be adequate enough to allow you to determine if you fixed the problem. A minimum sample size of 10% is expected. Make sure that your sample is reflective of the deficiency cited (if the deficiency cited was related to wound care, then your sample should be of patients requiring wound care, not the entire patient population).

9. How long do I have to monitor or measure?

You have to monitor or measure until you determine that you fixed the problem or until you determine that your current plan did not work and you need to try something else. An example of how monitoring/measuring might be conducted appears below:

- Monitor the sample for the identified deficient practice daily until you consistently reach 100% success over 3 consecutive evaluations. THEN,
- Decrease monitoring your sample to three times a week until you consistently reach 100% success at 3 consecutive evaluations. THEN,
- Decrease monitoring your sample to one time a week until you consistently reach 100% success over 3 consecutive evaluations. FINALLY,
- Measure one more time a month later. If you still reach 100%, you can conclude that you have successfully addressed the problem.

10. What is a measurement tool?

A measurement tool is a concrete method used to document, evaluate and report the data collected during your evaluation. It can be a newly created form, an existing form, a report, meeting minutes, a memo or an email. Verbal communication is not acceptable as a measurement tool.

11. Can I measure monthly or annually?

Not initially. If the changes you made did not work, the deficient practice will continue to occur for a month or a year before you know that your change was not successful. This is not acceptable.

12. How do I document staff education as it relates to the deficient practice?

Be specific as to who is being educated (all staff; all nurses; all physical therapists, etc.); include lesson plans; include staff attendance records; identify who provided the education, including their qualifications.

This document is intended to help you through the PoC completion process. Should you have any questions as you complete your PoC, you may call the OHFLC and we will be glad to address your question.

See Page 5 for one example of an acceptable PoC.

V 113	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station. This STANDARD is not met as evidenced by: Based on observation, policy review and staff interview, it was determined that for 1 of 9 in-center hemodialysis patients (Patient #16) observed during discontinuation of dialysis treatment, staff failed to perform hand hygiene and/or change gloves as required. Findings included: The facility policy entitled "Hand Hygiene" stated, "...Hands will be...Decontaminated using alcohol based hand rub or by washing hands with antimicrobial soap and water...Before and after direct contact with patients...Entering and leaving the treatment area...Before performing any invasive procedure such as vascular access...Immediately after removing gloves...After contact with inanimate objects near the patient..." A. The following was observed on 7/19/17 between 11:02 AM and 11:55 AM during discontinuation of Patient #16's dialysis treatment, performed by Certified Clinical Hemodialysis Technician (CCHT) #1: - sanitized hands - donned gloves - placed glove on patient's right hand - touched inanimate surfaces and items near patient (television, - cable, intravenous bag, blanket) - touched patient's blood tubing and access needle extension set - touched patient's blanket while assisting to stand - touched dialysis machine - assisted patient back to dialysis chair - removed blood pressure cuff - disconnected the blood tubing from the access needle extension set - touched blanket - removed gauze/tape covering needle and access site - withdrew 1st needle from patient's left arm access site - placed gloved hand with clean gauze over site holding pressure to stop bleeding - assisted patient to place his/her gloved hand over site - removed tape over 2nd needle - withdrew 2nd needle from access site - held pressure over 2nd needle site - assisted patient to hold pressure on both sites - discarded needles into sharps container - removed gloves - sanitized hands CCHT #1 failed to perform hand hygiene and change gloves: - after contact with inanimate objects near patient - before vascular access - before direct contact with patient During an interview on 7/19/17 between 2:50 PM and 3:00 PM, these findings were reviewed with Clinic Manager A who confirmed that CCHT #1 had not adhered to the facility's required practices for handwashing and infection prevention.	V 113	A. To ensure immediate compliance, on 9/8/17 immediate remediation was provided by the Clinical Manager (CM) to Certified Clinical Hemodialysis Technician (CCHT) #1 who failed to perform hand hygiene and don new gloves according to policy. The policies reviewed were: Hand Hygiene (Attachment A). Special emphasis was placed on performing hand hygiene and donning new gloves before vascular access, after touching inanimate objects and before direct patient contact. B. All direct patient care (DPC) staff will be re-in serviced by the Education Coordinator (EC) on the Hand Hygiene Policy (Attachment A), Personal Protective Equipment Policy (Attachment B). Focus on proper hand hygiene and glove use will be reinforced at the meeting. The in-services will be completed by 9/22/17. Documentation of the in-servicing is attached (Attachment A1 & B1) along with the current DPC roster (Attachment C). C. For ongoing compliance, the CM or designee will conduct daily audits of all DPC staff on each shift providing care to the patients. Unannounced hand hygiene and personal protective equipment use audits using a Plan of Correction (POC) monitoring tool (Attachment D) will be performed daily for 1 week on all shifts until 100% compliance is achieved for 3 consecutive days. Monitoring will then be decreased as follows: frequency will be decreased to 3 times a week, all shifts. When 100% compliance achieved for 3 consecutive evaluations of all shifts tri- weekly, frequency will be decreased to weekly, all shifts. When 100% compliance achieved for 3 consecutive weeks, frequency will be decreased to monthly, all shifts. If 100% compliance is achieved for all shifts at monthly observation the auditing will be completed monthly following the Quality Assessment Performance Improvement (QAPI) audit calendar (Attachment E) utilizing the completed POC Audit Tool (Attachment S) All audit findings will be reviewed by the CM monthly during QAPI meetings. Sustained compliance will be monitored by the QAPI committee. Non-adherence by the staff will result in re-education and counseling.	9/30/17