Writing Acceptable Plans of Correction

For Intermediate Care Facilities for Persons with Intellectual Disabilities (ICFs/ID)

Welcome

This training covers the requirements for writing an acceptable plan of correction for Intermediate Care Facilities for Persons with Intellectual Disabilities in Idaho.

Main Menu

- This training is divided into four sections concerning the process surrounding the development of acceptable plans of correction.

- Use the menu below to navigate to each of the sections. At any time, press the "Main Menu" button in the bottom right corner of the slide to return to this page.

- Section 1 – Introduction
- Section 2 – The Provider and the Regulatory Process
- Section 3 – Developing an Acceptable Plan of Correction
- Section 4 – Submitting an Acceptable Plan of Correction and On-site Revisits

Writing Acceptable Plans of Correction for ICFs/ID

Section 1

Introduction

Target Audience

- *This training was designed to help intermediate care facilities for persons with intellectual disabilities (ICFs/ID) understand* what constitutes an acceptable plan of correction (PoC) for identified deficient practices.

- *This training was developed to improve the effectiveness of and promote consistency in writing plans of correction.* The purpose of this training is to promote quality of care and quality of life for individuals in ICFs/ID.

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Objectives

When you have completed this training, you will be able to:

- List the elements required for writing an acceptable PoC;
- Evaluate a deficiency to determine if all the PoC elements have been addressed in the PoC; and
- Identify the requirements for submitting an acceptable PoC.

Additionally, you will have an understanding of how PoCs are evaluated by the State Agency (SA) to determine it's acceptability.

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Writing Acceptable Plans of Correction of ICFs/ID

Section 2

The Provider and the Regulatory Process

Licensure and Certification

- *State licensure* is based on the Idaho Administrative Procedures Act (IDAPA).

- *Federal certification* is based on the Code of Federal Regulations (CFR) and requirements established through the Centers for Medicare & Medicaid Services (CMS).

- Providers must demonstrate compliance with Federal and State requirements, *and;*
  - Demonstrate an ability to remain in compliance continually; *and*
  - Implement corrective actions and follow-up measures to ensure that the deficient practice does not recur.

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Licensure and Certification Continued

- ICF/ID licensing standards can be found at www.icfmr.dhw.idaho.gov under the "Statutes and Rules" heading.

- Information related to certification requirements for ICFs/ID can be found in *State Operations Manual Appendix J - Guidance to Surveyors: Intermediate Care Facilities for Persons With Mental Retardation.* Retrieved from http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_j_intermcare.pdf

- Information related to the survey process can be found in the *State Operations Manual Chapter 2 - The Certification Process at* http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf

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Initiative and Responsibility

- *Participation in Medicaid mandates that facilities take the initiative and responsibility for monitoring their own performance continuously so that they are always in substantial compliance with Federal regulations.*

- *In Idaho, the Bureau of Facility Standards (BFS) is the State Agency (SA). SA surveyors conduct surveys of ICFs/ID to determine if the care the facility provides meets minimum Federal and State standards.* When a surveyor finds evidence indicating standards are not being met, a deficiency is written.

- *Facilities should not rely on surveys or investigations to identify compliance problems.*

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Deficiencies

- A **deficiency** is a failure on the part of the facility to meet:
  - a **federal standard specified in the SOM, Appendix J; and/or**
  - **a state rule** specified in IDAPA 16.03.11.

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Deficiencies

- *The Form CMS-2567, Statement of Deficiencies and Plan of Correction, specifies the deficient practice identified during a survey and supports the citation with evidence about how the facility failed to comply with federal requirements (W tags).*

- *The Bureau of Facility Standards State Form, Statement Deficiencies and Plan of Correction, specifies the state deficiencies identified during a survey and supports the citation with evidence about how the facility failed to comply with the state requirements (M tags). The deficiencies may be stated as a referral to a W tag. Additionally, Life Safety Code (LSC)* deficiencies (K tags) are cited on this form through a separate survey process.

- The Form CMS-2567 and State Form are sent to the facility within 10 business days from the date of exit.

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Form CMS-2567 and State Form

The Form CMS-2567 and the State Form are important because:

- They are the official records of the survey;
- They are the official documents of compliance/noncompliance with Federal regulation and State rule;
- They identify the impact of the facility's noncompliance on the individuals;
- They are available to the public; and
- The facility uses them to write its PoC.

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Structure of a Deficiency

Deficiencies have three components:

- A regulatory reference;
- A deficient practice statement; and
- Relevant findings or evidence.

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1st Component
The Regulatory Reference

The regulatory reference includes the survey tag (W tag, M tag, K tag); indicates the references (i.e., CFR, IDAPA, or LSC), and describes the requirements that are to be met by the facility.

<u>Example of a regulatory reference:</u>

W251 - §483.440(d)(3), Program Implementation

"Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan must be implemented by all staff who work with the client, including professional, paraprofessional, and nonprofessional staff."

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Regulatory Reference Categories

There *are three categories that a regulatory reference can fall into.*

Structure Requirements: These are initial conditions that must be present and are expected to remain as is.

- *Example: W198 – "Clients who are admitted by the facility must be in need of and receiving active treatment services."*

Process Requirements: These requirements specify the manner in which a facility must operate and do not allow the facility discretion to vary from what is expected.

- *Example: W206 (excerpt) – "Each client must have an individual program plan developed by an interdisciplinary team…"*

Outcome Requirements: These requirements specify the results that must be obtained or events that must occur or not occur following an act.

- *Example: W247 – "(The individual program plan must also) Include opportunities for client choice and self-management."*

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2nd Component
The Deficient Practice Statement

The Deficient Practice Statement indicates the part of the requirement that is not met. It summarizes the issues that demonstrate the facility's actions or failures to act that resulted in noncompliance with the requirements.

It also includes the extent of the deficient practice. This is the number of individuals (or items) affected or potentially affected by the deficient practice (e.g., 4 out of 6 individuals were affected by the deficient practice, or 3 out of 7 individuals with behavior intervention plans, or 15 out of 47 sprinkler heads).

- Example for W231:

  "Based on record review and staff interview, it was determined the facility failed to ensure the objectives of the IPP were behaviorally stated in measurable terms so as to accurately monitor progress towards the objectives for 4 of 5 individuals (Individuals #1, #2, #4 and #5) whose IPPs and objectives were reviewed. This resulted in individuals participating in activities for which progress and regression could not be assessed."

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3rd Component
The Relevant Findings

Relevant findings are the "evidence" collected by the survey team to demonstrate the existence of the deficient practice.

Findings are the result of observations, interviews, and record reviews.

The findings allow the facility to compare what it did or failed to do against what is required.

The listing of the pertinent facts identified in the deficiency allows the facility to discover what caused the deficient practice.

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Examples of Relevant Findings

- Example 1:

  Individual #5's 6/25/10 IPP stated he was an 11 year old male diagnosed with severe autism and ADHD. His record included a training program for combing his hair, undated, which stated he was to complete hair brushing given a verbal prompt. The plan include a prompt hierarchy that staff were to follow which included both indirect verbal and direct verbal prompts. Without specification of which verbal prompt staff were to give (direct or indirect verbal), it would not be possible for the facility to determine whether Individual #5 met the objective.

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Examples of Relevant Findings Continued

- Example 2:

  Individual #3's 2/14/07 IPP stated she was a 40 year old female whose diagnoses included moderate mental retardation. Her record included a optometrist's note, dated 9/15/09, which stated she wore glasses at all times.

  However, during observations at the facility on 7/8/07 from 4:20 - 5:10 p.m. and 6:10 - 7:15 p.m., and on 7/9/07 from 7:10 - 8:45 a.m., Individual #3 was not observed to wear glasses. Additionally, during an observation at the facility's day program, on 7/9/07 from 10:35 a.m. - 12:10 p.m., Individual #3 was not observed to wear glasses.

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Structure of a Deficiency Example

W230 – 483.440(c)(4)(ii) INDIVIDUAL PROGRAM PLAN

The objectives of the individual program plan must be assigned projected completion dates.

← Regulatory Reference

The STANDARD is not met as evidenced by:

Based on record review and staff interview, it was determined the facility failed to assign individualized projected completion dates to objectives for 1 of 4 individuals (Individual #1) whose IPPs were reviewed. This resulted in the potential for an individual to receive training on objectives for extended periods of time without his rate of learning, strengths, and abilities being taken into consideration. The findings include:

← Deficient Practice Statement

1. Individual #1's 3/21/08 IPP stated he was an 11 year old male whose diagnoses included severe autism and ADHD. His objectives for brushing his hair, using the bathroom, washing his hands, brushing his teeth, bathing, taking his medications, taking turns, answering yes/no, money identification, identify emotions, choose a task, engage in an activity, and use a picture schedule all included a projected completion date of 10/30/11.

← Relevant Findings or Evidence

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Determining the Root Cause of a Deficiency

The PoC process mandates that facilities develop and implement policies and procedures to remedy deficient practices promptly and to ensure those corrections are lasting.

Facilities must take *the initiative and responsibility for monitoring their own performance to sustain compliance.*

To develop the PoC, the facility must first analyze the deficient practice to determine what happened and why the problem exists or occurred.

When the facility understands the root cause of the deficient practice, it can develop the solutions needed to correct the problem and sustain compliance. Deficient practice results from either system failures or discrete failures.

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ICF/ID Systems

Merriam-Webster's Dictionary defines a system as "a regularly interacting or interdependent group of items forming a unified whole."

In an ICF/ID, systems that promote individual care, comfort, safety, and well-being can include, but are not limited to:

- Daily management and operation of the facility;
- Provision of active treatment;
- Protection of individuals from abuse and neglect;
- Delivery of health care to individuals;
- Ensuring freedoms and choices are honored; and
- Ensuring staff competency.

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Systemic Problems

When the failure involves significant or many items within the system, then it is a system failure.

The system itself may be absent, or facets of an existing system may not be working. Even minor problems may be indicative of a systemic problem.

Example: If one out of seven individuals had a dead battery in an adaptive communication device, the problem could be systemic if the facility has no policy on replacing batteries for adaptive equipment and none of the staff knew who was responsible for doing it or when to do it.

A systemic problem requires a PoC that:

- *Describes what changes in the system will occur to fix the problem; or*
- *Plans for the development and implementation of a new system.*

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Discrete Problems

Discrete Problems may be more difficult to identify. Discrete problems may occur within a system but may only affect a small extent of the entire system.

For example: the problem may reflect an isolated incident, affect one or fewer individuals or staff, or be present at one or a limited number of times or locations.

Because even relatively isolated problems could stem from a systemic problem, it is imperative that the facility examine all problems carefully to determine whether there is a system failure before assuming the problem is discrete.

When there are minor or few problems within a system, then the deficiency <u>may</u> be related to a discrete problem, rather than a systemic problem.

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System or Discrete Failure?

Let's look at an example of a situation in which a direct care staff (DCS) confessed that he had been abusing individuals.

This could represent a system failure OR a discrete failure.

How could it be a system failure?

- Other staff suspected or observed the abuse and failed to report the incident to administration due to a lack of training.

How could it be a discrete failure?

- Perhaps the DCS worked by himself, there were no physical signs of abuse and his victims were not able to communicate and the facility had systems for prevention of abuse but were not aware of this instance of abuse.

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Example of a System Failure

Here is an example of a system failure:

- A surveyor observes that Individual #1 coughed four times while eating whole chicken he received during a meal. At another meal, the same individual coughed two times while eating whole bacon.

- The occupational therapist's (OT) assessment, dated three weeks prior to this observation, recommended a diet texture changed to chopped food.

- The doctor's orders changed the diet to chopped food effective the same date as the OT's assessment.

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Example of a System Failure Continued

- Interviews with direct care staff indicate they were not aware of a diet change.
- The diet card states, “regular texture.”
- The QIDP said, “It’s the house supervisor’s job to change diet cards and train staff.” She then said that she did not call an interdisciplinary team (IDT) meeting because, in her words, “choking is a nursing issue.”

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Example of Discrete Failure

Here is an example of a discrete failure:

- A surveyor observed Direct Care Staff (DCS) B enter Individual #4's bedroom without knocking. Individual #4 was in the act of changing his underwear.

- Interview with DCS B revealed that he thought that Individual #4 was in the living room.

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Differentiating Between Deficiencies

- Differentiating between deficiencies that represent a breakdown in a system and those that represent a discrete problem is not always *easy, but if the facility does not identify the source of the failure, it probably will NOT succeed in correcting it.*

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Differentiating Between Deficiencies

Here is an example of a deficiency. How would you determine whether this is a system failure or a discrete failure?

W473 483.480(b)(2)(ii), Food must be served at appropriate temperature;

This STANDARD is not met as evidenced by:

Based on observation and staff interview, it was determined the facility failed to ensure that food was served at an appropriate temperature for 6 of 6 individuals (Individuals #1 - 6) residing at the facility. This resulted in the potential for food borne illnesses to occur. The findings include:

1. During an observation on 6/23/10 from 5:00 – 7:30 p.m., the evening meal was observed. At 5:30 p.m., DCS A and Individuals #1 - #6 arrived at the facility with take out chicken. At the same time, DCS B removed 2 pizzas from the oven. Both the chicken and the pizza were observed to sit on the kitchen counter until 6:00 p.m., at which time Individuals #1 - #6 were served.

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Differentiating Between Deficiencies
Example - continued

A summary of the findings includes:

- At 5:02 p.m. Individuals #1 - #6 and DCS A went to a fast food place and purchased boxes of chicken for dinner. They returned at 5:30 p.m.
- Upon their return, DCS B removed 2 pizzas from the oven.
- Dinner was served at 6:00 p.m. (30 minutes after the pizzas were taken from the oven and the chicken had arrived).
- Individuals #1, #2, and #4 ate chicken, and Individuals #3, #5 and #6 ate pizza.
- Individuals #1, #2 and #4 complained that the chicken was too cold and did not taste good. Individual #3, #5 and #6 complained that their pizza was cold also.
- DCS C stated she was trained that hot food should be served right away.
- The QIDP stated she trains staff on an annual basis to serve hot food immediately after it is done.

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Things to Consider?

- You might *investigate the reason for the 30 minute delay from when the food was ready to eat to the time dinner was served or whether the food was actually cold.*
- *Is there a pattern of meals being delayed at this time of day?*
- *Are meals delayed at other times during the day?*
- *Or was this an isolated situation caused by unusual circumstances?*
- *If there is a pattern of delayed meals, how could present systems be modified, or could new systems be implemented to correct the problem?*

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Writing Acceptable Plans of Correction for ICFs/ID

Section 3

Developing an Acceptable Plan of Correction

Examining the plan of Correction Elements

Let's examine the elements for writing a PoC.

Plans of correction provided on Form CMS-2567 must address five core elements.[1]

Those elements require the development of very specific strategies that delineate exactly what actions will be taken to correct deficiencies.

Once the facility has gathered answers for its questions and analyzed its problems, it can begin to develop a PoC.

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Plan of Correction Elements

These five elements apply to all ICF/ID PoCs:

- *Element 1: What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;*
- *Element 2: How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;*
- *Element 3: What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;*
- *Element 4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,*
- *Element 5: Include dates when corrective action will be completed.*
- 42 CFR 488.28(a) states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies.

Element 1:
Identified Individuals Affected

Element 1 asks: What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice.

Individual-centered deficiencies are violations of the requirements that must be met for each individual. The deficiency will include an identifier for each individual affected. (Identifiers are codes representing individuals whom surveyors identified as having been affected by the deficient practice.)

<u>Examples of individual-centered deficiencies include but are not limited to:</u>

- Failure to provide individuals with training;
- Failure to protect the dignity and rights of individuals;
- Failure to provide individuals with protection from harm; and
- Failure to adequately assess individuals.

Facilities must state what they have done for the identified individuals.

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Element 1:
Deficiencies That DO NOT include Identifiers

Element 1 also applies to *deficiencies that do not include specific identifiers; in other words, the deficiencies do not affect specifically identified individuals.*

However, these are violations of certain operational requirements that have the potential to affect all individuals of the facility. Typically, the deficiency will identify those individuals directly impacted along with those potentially impacted. On rare occasions, no specific individuals will be identified (i.e., condition level deficiencies).

Examples of deficiencies without identifiers:

- *Failure to develop policies that prohibit abuse and neglect;*
- *Failure to prohibit the employment of child and/or client abusers;*
- *Failure to ensure quarterly evacuation drills; and*
- *Failure to designate a director of food services.*

If no individuals are identified, then facilities must state what they have done about the identified issue(s).

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Element 1:

Deficiencies That Include More Than One Example of Relevant Findings

Occasionally, the deficient practice statement will include more than one example of a relevant finding.

Example of multiple relevant findings under the responsibility of the QIDP:

The QIDP failed to:

- Follow up for three months following a recommendation that an individual needed glasses for 1 of 3 sample individuals;
- Ensure that individuals' money management programs were carried out at individuals' work sites for 6 of 6 individuals; and
- Monitor training and services at the day habilitation center for an individual for six months following the individual's admission into the program for 1 of 2 individuals attending the center.

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Address EACH Instance of Noncompliance and ALL Evidence!

Facilities must state *what corrective actions they have taken or will take for EACH instance of noncompliance.*

- *To meet the PoC Element 1, the facility should address what actions it has taken or will take to correct ALL the supporting evidence listed for each* deficiency.

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Element 2

Identify Others Who May Be Affected

Element 2 asks: How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

Facilities must state how all other individuals who have been, or could be, affected by the deficient practice have been identified in their PoCs. (Who else may be affected?)

To meet Element 2, the facility must address:

- *How it evaluated or will evaluate* other individuals who may be affected by the deficient practice; and
- What actions it has taken or will take to protect individuals identified by the facility from the same negative outcome.

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Element 2
Example

Given a deficiency at W263 with the following information:

- *The deficiency is based on record review and interviews;*
- *The deficiency impacted 2 of 3 sample individuals started on psychoactive medications;*
- *The psychoactive medications were started prior to written informed consent being obtained;*
- *There are a total of 6 individuals at the facility on psychoactive drugs;*
- *The facility's census is 18.*

The facility's plan of correction would need to address the following:

- *What actions did the facility take to assess the other individuals of the facility (other than those identified during the survey) for the types of medication they were receiving?*
- *Informed consent is required* for all individuals taking psychotropic medication. The facility would need to determine if there were others lacking the required informed consent. If any were lacking, the consents would need to be obtained. The facility would need to document when the consents were obtained.
- How will the facility ensure that informed consent will be obtained prior to future implementation of psychotropic medication regimens for inappropriate behaviors?

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Element 3
Changes to Prevent Recurrence

Element 3 states: "What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur."

- *To meet PoC Element 3, the facility must state and address what it has done and will continue to do to prevent the deficient practice from happening again.*

- *For this element, facilities should consider whether they need to develop or modify a system.*

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Element 3:

Example of a System Facilities Can Put Into Place

Here is an example of a system to address a deficiency:

- The QIDP will review all facility incident reports on a daily basis.
- The Interdisciplinary Team (IDT) will review incidents that involved injuries (including those of an unknown cause and non-reportable injuries) or allegations of abuse or neglect on the next business day.

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Element 3:

Example of a System Facilities Can Put Into Place - Continued

- The QIDP is expected to convene an IDT meeting to address all injuries and allegations of abuse or neglect within 24 hours of the date of discovery.

- The QIDP must submit a copy of the IDT meeting minutes to the Administrator and Registered Nurse.

- The QIDP must ensure that the IDT considers the following: all of the facts gathered to date, history of similar incidents/allegations, and programs designed to address the situation.

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Element 4
Monitoring of Corrective Actions

Element 4 states: "How the facility will monitor its corrective actions/performance to ensure the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change to ensure that solutions are permanent."

For this element, facilities should consider:

- Whether they need to develop or modify a monitoring system;
- When the monitoring will occur;
- How often the monitoring will occur; and
- Who will conduct the monitoring.

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Element 4:

Example of a Monitoring System a Facility May Establish

To meet the PoC Element 4, the facility should address how its monitoring system will ensure the deficient practice will not happen again.

Here is an example of a monitoring system a facility may establish to ensure that the system corrections are effective.

- The Administrator will verify through daily review of facility incident reports that the QIDP is investigating all non-serious injuries of unknown origin.
- The Administrator will maintain a Non-Reportable Injuries of Unknown Origin Log that includes the date of the incident, the name of the individual, the injuries sustained, the suspected cause, IDT intervention, when the individual's family was notified, the date the completed investigation was submitted, and if any issues needed follow up.

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Ongoing Monitoring

Monitoring should continue after the deficient practice is corrected.

If a facility states that its corrective actions will be monitored only through its PoC date, it is not ensuring the deficient practice will not recur.

Facilities should monitor their corrective actions after the deficiency has been corrected to ensure the deficient practice does not happen again.

There should be no "completion date" for monitoring. It should be ongoing.

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Element 5
Date of Completion

Element 5 states: "When corrective action must be accomplished."

The PoC must identify the date of completion or the expected date of completion for each deficiency.

Providers should consider the significance and seriousness of each deficient practice.

- The amount of time for correction should vary, depending upon the nature of the deficiency.
- Many deficiencies, especially those involving health and safety or active treatment, can and must be corrected within shorter time frames.

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Element 5:
"Reasonable" Date Of Completion

Even though the amount of time for corrections should vary depending on the nature of the deficiency, there are other considerations.

According to the State Operations Manual, 2728B, a "reasonable period of time" to achieve compliance is generally not longer than 60 calendar days. The correction date certainly could be fewer than 60 days after the survey, depending on the circumstances of the deficiency.

- *BFS/CMS will not routinely accept time frames longer than 60-days for compliance when a deficiency can reasonably be corrected before that date.*

The PoC must also be dated and signed by the Administrator or other authorized official.

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Important Points

- To ensure that facilities are properly addressing the deficient *practice, the PoC must be specific, realistic, and complete. The PoC must state exactly how the deficient practice has been or will be corrected.*

- *A general statement indicating that compliance has been achieved or will be achieved is not acceptable. The PoC must identify the nature of the corrective action (i.e., how the corrective action will address the concerns identified in the Form CMS-2567 or State Form.*

- *The PoC must identify what systematic changes will be made to ensure that the deficient practice will not recur and how the facility will monitor its corrective action to ensure* that the deficient practice remains corrected (i.e., what quality assurance program will be put into place).

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Monitoring, Achieving, and Maintaining Compliance

The *PoC must identify the position of the staff person(s) who will be responsible for monitoring corrections, such as the Administrator, the Nurse, the QIDP, the House Manager, or Program Director, and the quality assurance mechanism that will be employed.*

Achieving and maintaining compliance relies on:

- *Detecting problems;*
- Implementing actions to correct the problems; and
- Monitoring and evaluating the corrective actions to ensure that the problems won't recur.

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All Parts of the PoC Must Be Acceptable

An acceptable plan of correction is required for all deficiencies to be in compliance.

When more than one deficiency is cited, the plan of correction for each deficiency must be acceptable in order for the overall plan of correction to be deemed acceptable.

It is acceptable to reference plans of correction for different deficiencies if the corrective action is identical. For example: the plan of corrective action for W255 may state: "Refer to W159" if the plan of corrective action for W159 is suitable to correct the issues at W255.

All deficiencies cited in the Form CMS-2567 and State Form must be individually addressed in the plan of correction.

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Use of Names or Titles

The PoC must not:

- *Include proper names,*
- *Allude to another provider,*
- *Or malign an individual.*

(SOM 2728B)

It is acceptable to use staff designated titles. For example:

- The facility LPN (Licensed Practical Nurse),
- The QIDP,
- The Program Director,
- The facility Administrator,
- The facility's contracted psychologist, etc.

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Accessing PoCs

- Remember, 42 CFR 401.133 requires that Form CMS-2567 must be made available for disclosure to the public within 90 days of the last day of the survey.
- Survey results may be viewed at the SA website: www.facilitystandards.idaho.gov
- The cover letter to the facility, the CMS-2567, State Form, and submitted PoC are available to the public via the website.

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Example of an Unacceptable PoC

Let's take a look at an example of a deficiency a facility might have received and that facility's proposed PoC that would NOT be considered acceptable.

- In the interest of brevity, the deficiency and evidence will be summarized on the subsequent pages. The proposed PoC will follow.
- Try to ascertain some of the reasons the PoC would be considered unacceptable.

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Deficiency Summary – Example Part 1

The facility received the following deficiency:

W154 §483.420(d)(3), Staff Treatment of Clients

The facility must have evidence that all alleged violations are thoroughly investigated.

This REQUIREMENT was not met as evidenced by:

Based on review of incident reports and staff interviews, it was determined the facility failed to ensure all injuries of unknown origin were thoroughly investigated for 4 of 15 individuals (Individuals #3, #5, #11, and #12) for whom injuries of unknown origin were reported. This resulted in an absence of appropriate investigations. The findings include:

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Deficiency Summary – Example Part 2

A summary of specific relevant evidence noted by the surveyor includes:

- Record review of the facility investigation reports from 5/15/08 – 5/24/09 revealed that there were 108 documented injuries of unknown origin.
- 88 of those investigation reports did not document thorough investigation.
- The QIDP stated that facility investigation reports did not include documentation of staff interviewed who had no input as to the cause of the injury.
- The QIDP further stated he felt the investigation findings were adequate.

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Deficiency Summary – Example Part 3

The relevant evidence continues.

- The Administrator confirmed that investigations of unknown injuries did not include interviews with staff to attempt to determine cause and/or rule out/confirm abuse/neglect. Further, the Administrator stated the AQIDP was responsible for initial investigation of unknown injuries.

- The AQIDP revealed that injuries to all individuals were discussed with management staff each morning. The AQIDP stated that if an injury was determined to be an injury of unknown origin, then the management team would review the individual's observation notes to determine what could have caused the injury. The AQIDP stated that she did not usually interview staff to determine the cause of the injury. The AQIDP stated that she thought that the morning management team meetings constituted the investigation.

- The Program Director for programs revealed that investigation findings typically only restated information contained in the incident report.

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Proposed PoC
Unacceptable Example – Part 1

The facility proposes the following PoC:

Element 1: "How the corrective action will be accomplished for individuals found to have been affected by the deficient practice."

- *Interdisciplinary teams will review and discuss investigation reports for affected individuals.*

Element 2: "How the facility will identify other individuals who have the potential to be affected by the same deficient practice and how the facility will act to protect individuals in similar situations."

- *From now on serious* injuries of unknown origin will be thoroughly investigated.

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Proposed PoC
Unacceptable Example – Part 2

Element 3: "What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur."

- Staff will be inserviced on conducting thorough investigations and proper documentation. The QIDP will review serious injuries of unknown origin investigation reports once a quarter to ensure injuries were thoroughly investigated. Interdisciplinary teams will review investigation reports at annual planning meetings.

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Proposed PoC
Unacceptable Example – Part 3

Element 4: "How the facility will monitor its corrective actions/performance to ensure the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change to ensure that solutions are permanent."

- *The Program Director will ensure proper monitoring.*

Element 5: "When corrective action must be accomplished."

- Completion Date: 8/22/09.

  Signature: Jane Doe, Administrator

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What Makes This PoC Unacceptable?

Specific corrective measures to address the investigations cited in the findings are not included. While the IDT will "review and discuss" the investigations, there is no indication as to actions that will be taken as a result of those meetings.

There is no specific strategy for addressing others who may have been affected by the deficient practice. The PoC only says that "from now on" investigations will be thorough.

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What Makes This PoC Unacceptable?

Continued

Specific strategies are not indicated on how the facility will ensure the deficient practice does not recur. The facility plan only calls for inservicing staff and review of investigations, rather than stating specific systemic changes designed to prevent recurrence. The person to conduct the inservicing and the staff to be inserviced are not identified. Specifics as to what the inservice will include are not indicated. Review by the QIDP quarterly and the IDT annually are not immediate or sufficient enough to ensure that the deficient practice will not recur.

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What Makes This PoC Unacceptable?

Continued

The monitoring strategy is not specific. It merely states that the Program Director will ensure that monitoring occurs.

Responsible persons are not identified.

Did you identify any other problems with this PoC?

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Example of an Acceptable PoC

Now let's take a look at an example of a facility's proposed PoC for the same deficiency for W154 that WOULD BE considered acceptable.

- Try to ascertain some of the reasons the PoC would be considered <u>acceptable</u>.

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Proposed PoC
Acceptable Example – Part 1

The facility proposes the following PoC:

The facility will ensure that the documentation of investigation reports reflects that all injuries of unknown origin are thoroughly investigated, as evidenced by:

Element 1: "How the corrective action will be accomplished for individuals found to have been affected by the deficient practice."

- The incomplete investigations for non-serious injuries of unknown cause have been reopened.
- Persons responsible: AQIDP and QIDP.

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Proposed PoC
Acceptable Example – Part 2

Element 2: "How the facility will identify other individuals who have the potential to be affected by the same deficient practice, and how the facility will act to protect individuals in similar situations."

- The Program Director reviewed investigations of non-serious injuries of unknown cause to ensure investigations were completed. Any incomplete investigations were referred to the AQIDP and QIDP for completion.
- The AQIDP, QIDP, Program Director, and the nurse manager for the facility will be re-inserviced on proper procedures for conducting an investigation. In-servicing will be completed by 6/15/09.
- Person responsible: Administrator.

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Proposed PoC
Acceptable Example – Part 3

Element 3: "What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur."

- The Preliminary Investigation Report for Injuries of Unknown Origin will be revised to ensure a more complete investigation and will be used when investigating all non-serious injuries of unknown origin. Form will be revised by 7/1/09.
- The AQIDP, QIDP, Program Director, and the nurse manager for the facility will be in-serviced on the revision. In-servicing will be completed by 7/15/09.
- Person responsible: Administrator

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Proposed PoC
Acceptable Example – Part 4

Element 4: "How the facility will monitor its corrective actions/performance to ensure the deficient practice is being corrected and will not recur, …."

- The Program Director will conduct a monthly meeting with the AQIDP and QIDP to critique investigations with regard to completeness.
- If an Injury Report with a non-serious injury of unknown cause has not been investigated within 2 working days, the QIDP will notify the AQIDP for appropriate action.
- The Administrator will monitor investigations for completeness. Any problems will be referred to the Program Director for corrective action.
- Person Responsible: Administrator

Element 5: "When corrective action must be accomplished."

- Completion Date: 8/1/09

The document is signed by Jane Doe, Administrator.

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What Makes This PoC Acceptable?

- *Corrective action was implemented to address each individual identified as being affected by the deficient practice. The investigations for each were reopened.*
- *Action was taken to identify other individuals potentially affected by the deficient practice. All non-serious injuries investigations were reviewed for completeness.*
- *System modifications were implemented to ensure deficient practice will not recur. Additional training was implemented, and reporting documents were revised to ensure more complete investigations.*
- *Monitoring systems were implemented to monitor the effectiveness of corrective actions. The plan includes monthly investigation review meetings, additional notifications processes and investigation monitoring by the Administrator.*

Did you identify anything else that makes this an example an acceptable PoC?

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Links To Examples

This page contains links to supplementary documents related to this training.

- Click here to open a document containing examples of unacceptable and acceptable PoCs intended to further illustrate the PoC criteria.

- Click here to open a document showing an example of a deficiency that you can use to complete an optional exercise to practice developing your own PoC using all of the criteria stated in this training.

You can print these documents now, then review them (or complete the optional exercise) at your leisure after exiting this course.

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Writing Acceptable Plans of Correction for ICFs/ID

Section 4

PoC Submission and On-site Revisits

Submission Time Frames

Submission Requirements

Facilities receiving the Form CMS-2567 and State Form must submit an acceptable PoC within 10 Calendar days.[2]

[2] *State Operations Manual Chapter 2 - The Certification Process.* Retrieved from http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf (pp 367).

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Submission Time Frames (continued)

Although the actual Form CMS-2567 or State Form will not be presented to the facility at the exit conference, surveyors will present sufficient information regarding problem areas to enable the facility to begin developing a PoC.

The facility is encouraged to submit a PoC as soon as possible and to implement its corrective action as soon as possible.

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Consequences

Failure to submit a PoC, or to submit an acceptable PoC, could result in termination of the provider agreement as authorized by 42 CFR §488.28(a), §488.456(b)(1)(ii), and §489.53(a)(1).

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If the PoC is NOT Acceptable

After the PoC is submitted, whether it was received in the allotted time or not, BFS determines whether the PoC is *acceptable.*

If a PoC is not acceptable, BFS rejects it and seeks an acceptable PoC by contacting the facility. If only minor revisions are required, Pen & Ink changes may be made at the request of the facility. If significant revisions to the PoC are required, it may be necessary for the facility to re-submit an amended or revised PoC.

The facility must submit an acceptable PoC in order for the SA to recommend recertification. This includes an acceptable PoC for both the Health Survey and the Life Safety Code survey.

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Informal Dispute Resolution

If the facility chooses to refute deficiencies, it can request an Informal Dispute Resolution (IDR).

A refutation submitted on the statement of deficiencies is not an "acceptable" plan of correction. The facility is still required to submit an acceptable PoC (even if requesting an IDR).

If the facility is contesting deficiencies and is considering whether to delay sending in the PoC until the dispute is resolved, the facility is taking a risk because:

- *The enforcement* process will continue even without an acceptable PoC; and
- Enforcement actions may be recommended for failing to submit an acceptable PoC within specified time frames.

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Other Plan of Correction Issues and Reiteration - 1

For every deficiency cited, a PoC must be provided. The PoC must include all PoC elements.

- *For all deficiencies, an anticipated date of completion must be provided for each tag on each form.*

- *Each deficiency may* have its own anticipated date of completion, which may be different from each of the other deficiencies listed on the Form CMS-2567 or the State Form.

- For example: the anticipated date of completion for W473 may be 07/12/09, and the anticipated date of completion for W120 may be 07/31/09.

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Other Plan of Correction Issues and Reiteration - 2

When identifying in-service training as part of a PoC, the facility should indicate:

- *Who will conduct the training;*
- *What the content of the training will include;*
- *When and how often the training will be provided; and*
- *How performance will be monitored to ensure elements addressed in the training were implemented accurately and consistently.*

Facilities should submit realistic plans of correction. Facilities should not submit plans of correction that they are not able to implement.

The PoC must identify the title of the staff person responsible for any actions or processes implemented.

The PoC must identify how corrections will be monitored and the staff person responsible for the monitoring.

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Other Plan of Correction Issues and Reiteration - 3

Staff who have been determined to have contributed to a deficient practice should not be solely responsible for implementing the corrective action(s), or for monitoring the corrective processes or actions.

For example:

- The QIDP should not be solely responsible for implementing the corrective action or for monitoring corrective processes or actions when noncompliance is cited at the QIDP tag (W159).
- The nurse should not be solely responsible for implementing the corrective action or for monitoring corrective processes or actions when noncompliance is cited at the nursing tags (W331 or W338).
- When noncompliance is cited at the governing body tags (W102 or W104), the administrator's supervisor or the provider's quality assurance director should be responsible for implementing the corrective action and for monitoring corrective processes.

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Other Plan of Correction Issues and Reiteration - 4

PoCs must reflect system corrections, not just correction of examples cited on the Form CMS-2567 and State Form.

The PoC should involve:

- *Proactive processes or actions on the part of the facility to identify the system failure;*
- *Concise information on the interventions and actions the facility will develop/revise and implement to address the issues;*
- *An ongoing system to evaluate the effectiveness or progress of implemented systems;*
- *A person who will be responsible for the system/actions; and*
- *A person who will be responsible for evaluating the effectiveness of the implemented systems.*

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Other Plan of Correction Issues and Reiteration - 5

Facilities need to ensure that they received all the pages of the Form CMS-2567 and State Form.

- *In some instances, the federal data system prints a blank last page due to the set up for the last printed line at the bottom of the previous page.*
- *The page format is not adjustable by the surveyor because it is set within the system.*
- *The document must be returned the same way it was received.*

All pages (including blank pages) must be returned to the BFS.

The PoC for each citation must include all five PoC elements.

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Onsite Follow-up Revisits

Because the survey process focuses on the care of the *individual, onsite follow-up visits are conducted to ensure that deficiencies have been corrected.*

BFS surveyors will follow up on all deficiencies cited in the Form CMS-2567 and State Form.

The purpose of the follow-up visit is to confirm that the facility has regained compliance and has the ability to remain in compliance.

The facility can show evidence of monitoring by summarizing what steps it has taken to ensure the deficient practice remains corrected.

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The PoC as a management Tool - 1

The provider plays a singular role in achieving and maintaining compliance.

The provider should know the regulations/requirements and provide services that meet those requirements.

- *Therefore, it is important that all staff learn the state licensure requirements and the federal certification requirements.*
- *Staff knowledge and individual responsibility are key factors in achieving and maintaining compliance.*

Participation in Title XIX Medicaid programs mandates that facilities take the initiative and responsibility for monitoring their own performance so that they are always in compliance.

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The PoC as a management Tool - 2

The PoC is a valuable management tool because it requires facilities to:

- *Achieve and maintain compliance;*
- Ensure that the underlying cause of cited deficient practices does not recur;
- Make changes that will result in improved care delivery for individuals; and
- Improve provider operations.

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More than Correcting Deficiencies

Developing a successful PoC involves more than just reading a deficiency and developing a plan to correct it.

It requires the provider to analyze the statement of deficiencies and determine the underlying problem that generated the deficiency.

When systems are in place for each type of service and when the facility consistently monitors its practices and makes adjustments as necessary, compliance will be achieved and maintained.

When a system or part of the system isn't working, it is the facility's responsibility to recognize and correct the problem, preferably before the survey team identifies a deficient practice.

When deficient practice is identified and cited, the provider is required to correct the identified deficient practice and ensure that it does not recur.

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Conclusion

The importance of developing a good, acceptable plan of correction cannot be over-emphasized.

Submitting and following an acceptable plan of correction goes a long way toward ensuring continued quality care for the individuals receiving the facility's services.

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References

[1] *State Operations Manual Chapter 2 - The Certification Process.* Retrieved from http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf (p 369).

[2] *State Operations Manual Chapter 2 - The Certification Process.* Retrieved from http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf (p 370).