Understanding the CMS-2567 & Writing Acceptable Plans of Correction

For Psychiatric Residential Treatment Facilities

(PRTFs)

Welcome

This training covers the structure and purpose of the CMS-2567 and the requirements for writing an acceptable plan of correction for Psychiatric Residential Treatment Facilities.

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 PRTFs

Section 1

Introduction

Target Audience

- This training was designed to help PRTFs 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 services for PRTF residents.

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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 PoC are evaluated by the State Agency (SA) to determine it's acceptability.

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Writing Acceptable Plans of Correction for PRTFs

Section 2

The Provider and the Regulatory Process

Certification

- 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 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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Certification

- Information related to certification requirements for PRTFs can be found in *State Operations Manual Appendix N - Guidance to Surveyors: Psychiatric Residential Treatment Facilities (PRTF) Interpretive Guidance. Retrieved* *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-14.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 PRTFs to determine if the care the facility provides meets minimum Federal requirements. When a surveyor finds evidence indicating requirements are not being met, a deficiency is written.

- Facilities should not rely on surveys or complaint 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 State Operations Manual (SOM), Appendix N.**

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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 (N tags for Health, E tags for Emergency Preparedness requirements, and K tags for LSC requirements).

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

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Form CMS-2567

The Form CMS-2567 is important because:

- It is the official record of the survey;
- It is the official document of compliance/noncompliance with Federal regulation;
- It identifies the impact of the facility's noncompliance on the patients;
- It is available to the public; and
- The facility uses it 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; indicates the references (i.e., CFR or LSC), and describes the requirements that are to be met by the facility.

Example of a regulatory reference:

N0110 - §441.155(b), Individual Plan of Care

The plan of care must –

(1) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the beneficiary's situation, and reflects the need for inpatient psychiatric care;

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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: N0102 – “Beneficiary and Accreditation Requirements
  (a) Inpatient psychiatric services for individuals under age 21 must be:
  (1) Provided under the direction of a physician”

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: N127 – “An order for restraint or seclusion must not be written as a standing order or on an as-needed basis.”

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Regulatory Reference Categories

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

- Example: N0126 – “Each resident has the right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation.

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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 requirement.

It also includes the extent of the deficient practice. This is the number of residents (or items) affected or potentially affected by the deficient practice (e.g., 4 out of 6 residents were affected by the deficient practice, or 3 out of 7 residents whose records were reviewed, or 2 out of 3 seclusion rooms).

- Example of Deficient Practice Statement for N0131:

Based on observation, review of facility policies and resident records, and staff interview it was determined the facility failed to ensure restraint was not used simultaneously with seclusion for 3 of 8 residents (Residents #1, #3 and #5) whose records were reviewed. This failure resulted residents being placed at increased risk of experiencing negative impacts to their health and safety due to simultaneously intervention use.

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3rd Component
The Relevant Findings

Relevant findings are the “evidence” collected by the survey team which 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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Relevant Findings

- Example of relevant findings:

The facility's records did not include a written arrangement with one or more hospitals to receive residents in the case of an emergency.

The Administrator was interviewed on 8/15/18 at 2:00 PM. The Administrator stated the facility did not have a written agreement with a hospital to receive residents in the case of an emergency.

The PRTF failed to ensure a written arrangement with one or more hospitals to receive residents in the case of an emergency was obtained.

Structure of a Deficiency Example

N0133 – 483.35(c) Notification of facility policy. At admission, the facility must -

(1) Inform both the incoming resident and, in the case of a minor, the resident's parent(s) or legal guardian(s) of the facility's policy regarding the use of restraint or seclusion during an emergency safety situation that may occur while the resident is in the program;

← Regulatory Reference

The STANDARD is not met as evidenced by:

Based on record review and staff interview, it was determined the facility failed to provide residents or their parent(s) or legal guardian(s) with complete information regarding the use of restraint or seclusion for 4 of 4 residents (Residents #1 - #4) whose records were reviewed. This resulted in residents and their parent(s) or legal guardian(s) not being fully informed of restrictive intervention use and their potential negative impacts on residents. Findings include:

← Deficient Practice Statement

1. The facility's "Restraint and Seclusion" policy, dated 7/01/18, stated "The resident or in the case of a minor, the resident's parent(s) or legal guardian(s) is to receive, in writing, comprehensive information regarding restraint and seclusion use..."

Upon request, the facility's Social Worker provided a sample packet of information given to residents and their representatives at the time of admission. The sample packet did not include information regarding restraint and seclusion use. Additionally, Resident #1 - #4's records were reviewed. Documentation that comprehensive information regarding restraint and seclusion use had been provided upon admission could not be found in Resident #1 - #4's records.

When asked during an interview on 8/16/18 at 11:40 AM, the Social Worker stated information related to restraint and seclusion use was not provided to residents and their representatives.

The PRTF failed to provide restraint and seclusion information to residents and their representatives at the time of admission.

← Relevant Findings or Evidence

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Determining the Root Cause of a Deficiency

The PoC process mandates that facilities 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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PRTF Systems

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

In a PRTF, systems that promote patient care, comfort, safety, and well-being can include, but are not limited to:

- Daily management and operation of the facility;
- Provision for the development, implementation and monitoring of effective individualized plans of care
- Provisions for safe intervention practices during emergency safety situations; and
- Ensuring staff competency.

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Systemic Problems

When the failure is significant or involves 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 of Systemic failure: If one out of three residents observed was not provided with in-person continuous assessment and monitoring while in seclusion, the problem could be systemic if the facility has no policy for seclusion and/or none of the staff knew who was responsible for ensuring in-person assessment and monitoring occurred.

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 portion of the entire system.

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

Because even relatively isolated problems could result from a systemic problem, it is imperative that the facility carefully examine all problems 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 may 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 Registered Nurse (RN) confessed that he had been abusing residents.

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 due to a lack of training.

How could it be a discrete failure?

- Perhaps the RN was alone with a combative resident, there were no physical signs of abuse, his victim did not report the abuse to the facility, and the facility had systems for prevention of abuse but were not aware of this instance of abuse.

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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.

Things to Consider?

- Investigate the reason why the deficient practice occurred.
- Is there a pattern of other similar incidents?
- Was this an isolated situation caused by unusual circumstances?
- If there is a pattern, 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 PRTFs

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 must address 6 core elements described in Chapter 2 of the CMS State Operations Manual, Section 2728B [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 to its questions and analyzed its problems, it can begin to develop a PoC.

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Plan of Correction Elements

These six elements apply to all PoCs:

- Element 1: What corrective action(s) will be taken to correct each specified deficiency;
- Element 2: How the actions taken will improve the processes that led to each deficiency;
- Element 3: What the procedure is for implementing the corrective action for each deficiency;
- Element 4: How the corrective action(s) will be tracked and monitored to ensure the PoC is effective in bringing the PRTF into compliance, and that the PRTF remains in compliance, i.e., what quality assurance program will be put into place;
- Element 5: The title of the person responsible for implementing the PoC; and,
- Element 6: 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.

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Element 1
Deficiencies With and Without Identifiers

Element 1 asks: What corrective action(s) will be taken to correct each specified deficiency;

Element 1 applies to deficiencies that impacted specific residents and deficiencies that are violations of certain operational requirements that have the potential to affect all residents of the facility. Typically, the deficiency will identify those residents directly impacted along with those potentially impacted. On rare occasions, no specific residents will be identified (i.e., condition level deficiencies).

<u>Examples of deficiencies with identifiers:</u>

- Failure to ensure the date and time restraint orders were obtained was documented for 2 of 2 residents (Residents #1 and #2) whose records were reviewed; and
- Failure to ensure parents and legal guardians were notified of seclusion use for 4 of 4 residents (Residents #1 - #4) under the age of 18, whose records were reviewed.

<u>Examples of deficiencies without identifiers</u>:

- Failure to ensure the seclusion room allowed staff a full view of the residents in all areas of the room; and
- Failure to ensure care was provided under the direction of a physician.

In either case 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 more than one relevant finding under plan of care (N114):

The facility failed to ensure post-discharge plans included coordination of relevant services to ensure continuity of care:

- Failure to ensure coordination with the resident's family.
- Failure to ensure coordination with the resident's school.

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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 PRTF must address what specific changes have or will occur. Changes may include changes to policies, procedures, equipment, the environment, staff training, etc.
- The facility must address EACH specific example listed for each deficiency.

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Element 2

How Has the Process Improved

Element 2 asks: How the actions taken will improve the processes that led to each deficiency.

- To meet Element 2, the facility must address: How the specific changes are expected to improve resident care and services and compliance with the regulatory requirements.

For example if the PRTF developed a policy and procedure designating a particular staff to observe restraint use during emergency safety situations, the expected outcome would be a decrease in the possibility that restraints were applied inappropriately, which improves resident care and regulatory compliance.

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Element 3
Changes to Prevent Recurrence

Element 3 asks: What the process is for implementing the corrective action for each deficiency.

- To meet PoC Element 3, the facility must state how the corrective actions will be implemented.

For example, if the PRTF developed a policy and procedure designating a particular staff to observe restraint use during emergency safety situations, the implementation of that policy may involve training of staff and documentation of the observations of restraints.

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.

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Element 4
Tracking and Monitoring

Element 4 asks: How the corrective action(s) will be tracked and monitored to ensure the PoC is effective in bringing the PRTF into compliance, and that the PRTF remains in compliance, i.e., what quality assurance program will be put into place;

- To meet PoC Element 4, the facility must state how the correction has been incorporated into the PRTF's monitoring program to prevent the deficient practice from happening again.

- For this element, facilities should include the specific quality indicator, the data which is to be collected, the frequency of the data collection, and the frequency of data analysis (monitoring) to ensure compliance.

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Element 5
Title of the Person Responsible

Element 5 asks: What is the title of the person responsible for implementing the PoC.

The person responsible is not always the same for each deficiency.

For example, a PRTF may identify the Registered Nurse as responsible for ensuring medical care is immediately obtained for resident injury deficiencies and the Social Worker as responsible for notification of parents and guardian's. However, in accordance with the PRTF regulations, the physician has overall responsibility for the services being provided, and therefore achieving and sustaining compliance with regulatory requirements.

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.

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Element 6
Date of Completion

Element 6 states: “When corrective action must be accomplished.”

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

Facilities 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, can and must be corrected within shorter time frames.

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Element 6:
“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).

- 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 will not 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 a Condition level deficiency may refer to the standard level deficiencies under the Condition.

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

A PoC Review Checklist may be used prior to submission.

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Use of Names or Titles

The PoC must not:

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

(SOM 2728B)

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

- The facility LPN,
- The RN,
- The facility Administrator, 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, and submitted PoC are available to the public via the website.

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Writing Acceptable Plans of Correction for PRTFs

Section 4

PoC Submission and On-site Revisits

Consequences

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

If the PoC is NOT Acceptable

After the PoC is submitted, 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 to CMS.

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Other Plan of Correction Issues and Reiteration

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

- 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. It is set within the Federal software system.
- The document must be returned the same way it was received.

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

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Onsite Follow-up Revisits

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

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

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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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, through its quality assessment and performance improvement system, 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 residents 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. (Section 2728B)