Montana DPHHS, Quality Assurance Division, Certification Bureau
Plan of Correction (PoC) Review Criteria: Health and Life Safety Code

General guidance before review:

- ✓ Resident, staff, contractor, etc. specific names shall not be written in the PoC.
- ✓ Completion dates must include the involvement of the Quality Assurance Performance Improvement (QAPI) program or other similar quality assurance programs.
- ✓ A thorough review of a PoC will aid in ensuring compliance during a by mail (desk review) or onsite revisit.

Health Example Deficiency: On 12/10/16 at 10:00 a.m., the nurse failed to administer the resident the physician ordered pain medication, which resulted in the resident exhibiting agitation, pain and crying out.
Life Safety Cody (LSC) Example Deficiency: On 01/12/17 at 11:32 a.m., the facility failed to inspect the portable fire extinguishers in 3 of 8 locations.

1. **Address how corrective action will be accomplished for those residents/locations found to have been affected by the deficient practice.**
    - Address each resident/location individually by sample number.
    - Include details of what was corrected for each resident, location or the deficient practice.
    - Include titles of the responsible parties who are completing the task, or for those who educate others, ensure they have the knowledge base to complete the assignment. Specific names shall not be used in the PoC (e.g. John Smith, Maintenance Director) will train all maintenance staff on the monthly inspection of portable fire extinguishers.
    - Include dates tasks are completed.

    To determine if corrective actions are sufficient, the surveyor should review the 2567 Based on Statement and content for each deficiency, determine in each paragraph if a failure occurred and identify steps that may need correction.

    Example Correction: The PoC should reflect:

    - How the facility attempted to identify the root cause of the failure.
    - How the facility did address all the failures in the deficiency.
    - What were the dates of the corrective actions for detailed items?
    - What were the steps taken to implement the PoC? These should be reflected in the facility's plan.

Health Example Criteria #1: The nurse providing care to the resident on --/--/-- was educated on completing the pain assessment on 12/11/16 by the ADON and the resident's pain was checked daily, along with a review of the resident's MAR to ensure medications for pain were received as ordered.
LSC Example Criteria #1: All delinquent portable fire extinguishers were checked and a facility plan with all fire extinguisher locations identified.

2. **Address how the facility will identify other residents/locations having the potential to be affected by the same practice.**
    - Steps for how the facility identified other residents/locations should be reflected in the plan. To say "All residents/locations are affected" should not be applicable for the majority of situations, but if it is, the facility should show how they determined this. Do not forget the titles of assigned parties and dates of completion.

Health Example Criteria #2: The facility reviewed the MARS for all residents relating to pain and identified residents who had not received ordered pain medication. For those affected, nursing staff were educated, resident pain assessed and the care plan updated for pain needs. These tasks were completed by the IDT by 12/08/16.
LSC Example Criteria #2: The maintenance director reviewed all portable fire extinguishers in the facility and ensured all were up to date for monthly inspections.

3. **Address what measure(s) will be put into place or systemic changes made to ensure the deficient practice will not recur.**
    - For this step, the facility should address system issues which may have been identified within the content of the deficiency, or the deficient steps leading to the root cause of the deficient practice. Again, the procedures for carrying out the plan of correction to show compliance was achieved, and will be maintained, should be reflected in Criteria # 3.

Health Example Criteria #3: The policy, Managing Resident Pain, was reviewed by the IDT on 12/12/16, to identify if the policy adequately met the facility needs for managing resident pain. The Charge Nurses were educated by the DON on 12/10/16, for: assessing pain, medication administration, accurate and complete documentation expectations, symptoms of pain, and completing, updating and following the resident care plan for pain. For those Charge Nurses not in attendance, education will be completed on their next scheduled shift and will be completed in entirety by 12/20/16. The Pain IDT, will review two resident's pain needs and documentation related to pain, each month during the IDT meeting to ensure all aspects of pain are addressed. Each of the education topics should relate to your based on failure and deficient practice(s).

Each month, the DON will meet with Medical Director, to review the pain management program. This will be ongoing and incorporated into the facility QAPI process.

LSC Example Criteria #3: All staff conducting monthly inspections of portable fire extinguishers will be required to verify all locations of portable fire extinguishers. A schedule of monthly inspections will be added to a work order program to ensure monthly reminders to review all portable fire extinguishers.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions will be sustained.**
    - Criteria #4 will be the information showing how the facility will carry out the monitoring of the deficient practice, and if needed, the identification of ongoing issues. A plan should not be acceptable unless it shows the steps for how the facility will sustain compliance.
    - Auditing may be utilized by the facility for monitoring the deficient practice but should show the details of what will be audited, the frequency and duration of auditing and what actions will be taken to address the concerns identified on the audits. The plan should include the designated title of who will be responsible for the audits.

Not acceptable: "The facility will complete random audits for a month". As you can see, the facility did not show the necessary steps for their plan of correction.

Acceptable: "The facility will audit the MAR and pain documentation for resident's utilizing pain medication each week, for three months. Auditing will be completed by the nursing management team, who will present the findings to the QAPI team the following week for discussion of issues identified and development of corrective actions. Issues identified during the audit, which may negatively impact the resident for pain, will be addressed immediately to prevent negative outcome for the resident."

Health Example Criteria #4: **In the example failure,** the resident had pain and crying, which was considered harm. Consider your resident outcome when determining whether or not the timeline for monitoring is adequate. QA-QAPI review – the facility **must show QA/QAPI** is involved in the oversight of the deficient practice. CMS has developed the QAPI oversight program to show that it is not acceptable to review a deficient concern only on a quarterly basis, but rather the QAPI oversight should be ongoing. **The QAPI program/IDT, should review the status of the plan of correction prior to the revisit survey and have documentation to reflect this review to show the facility achieved compliance by the X5 date.** The statement for Criteria #4 should reflect the steps QAPI will take to achieve and maintain the alleged compliance throughout the next survey cycle and also how they will discuss and modify the approaches implemented if deficient practices occur again.

LSC Example Criteria #4: All extinguishers will be audited for the next month after the full survey and every month thereafter for three months. All future portable fire extinguishers will be installed by maintenance staff and added to the monthly inspections. Results of audits for the first month review after survey will be shared with the QA Committee and all future audits for the next year will be presented on a quarterly basis.

5. **Completion Date:**
    - This will be the date (X5 date) in the ASPEN Central Office database and may be different for each tag. You must ensure you have identified that all corrective actions taken by the facility have occurred prior to the date of compliance. The dates must be acceptable to the State Agency, and as a policy of the Certification Bureau, not greater than 45 days from the date of exit. Remember dates cannot be the same date as the "date survey completed" in upper right hand portion of the form.

Health Example Criteria #5: No waivers are available to extend the date of compliance beyond 45 days.
LSC Example Criteria #5: The LSC dates can be extended for up to six months from the day of exit for long term care facilities with an approval by the Certification Bureau. An extension for non-long term care facilities must be made to the Certification Bureau which will ultimately be forwarded on to be approved or rejected by the CMS Regional Office in Denver. The extension requires a written request either via email or letter indication why additional time is needed to correct the deficiency. All LSC waiver requests shall be sent to mtssad@mt.gov or mailed to DPHHS QAD Certification Bureau, PO Box 202953, Helena MT 59620-2953.

When done, ask yourself:

- ✓ Did the facility utilize a process to identify the root cause of the deficient practice and implement a plan that would correct the root cause?
- ✓ Did the facility identify other residents/locations who were affected by the same practice?
- ✓ Did the facility implement systems that would sustain the progress of the correction?
- ✓ Did the facility identify a monitoring system that would assist with the oversight of the deficient practice if the deficient practice occurred in the future, that would correct the deficiency in a timely manner?