STROUDWATER

OPERATIONALIZING SURVEY READINESS: A FRAMEWORK FOR DAILY EXCELLENCE

Carla Brock Wilber, DNP, RN, NE-BC, CATC, CPHQ
Principal
Christie Bishop, RN, MSN
Consultant

OBJECTIVES FOR TODAY

- Define survey readiness
- Why is this important?
- Review the types of surveys
- Understand how the surveyor is preparing
- Review state and regional 2567 survey deficiency data
- Building your Survey Readiness Toolbox

OVERVIEW: SURVEY READINESS

Survey Readiness: Achieving and maintaining an ongoing “prepared” state in which an organization can confidently ensure compliance with regulatory requirements, patient safety, and quality standards.

WHY IS “READINESS” IMPORTANT?

- Health and Safety
- Financial Consequences

Data.CMS.gov
Centers for Medicare & Medicaid Services

As of January 2025

By the numbers

68.5M
Total Medicare Enrollment

50.9%
Enrolled in MA & Other Health Plans

90.2%
Age 65 and Over

81.1%
With Medicare Part D Coverage

By the end of 2020 there were approximately 62 million Medicare beneficiaries[1] and, according to AARP, that number is projected to grow to almost 80 million by 2030[2]. In addition, Medicaid/CHIP enrollment increased by more than 9 million people between February 2020 and January 2021[3], with all states experiencing a 7% to 25% increase in Medicaid/CHIP enrollment during that same period[4].

https://www.jcrinc.com/-/media/jcr/jcr-documents/products/advisory-services/cms-survey-whitepaper-final-83021.pdf

READINESS IMPACT ON HEALTH AND SAFETY

Delayed or Inconsistent Care

- Critical processes like timely assessments, medication reconciliation, infection control, and patient monitoring may not be followed properly, leading to worse clinical outcomes.

Increased Risk of Harm:

- Noncompliance with standards increases the likelihood of patient safety events, such as falls, medication errors, hospital-acquired infections, or delayed recognition of clinical deterioration.

Poor Patient Experience:

- Gaps in communication, care coordination, and responsiveness can cause patient dissatisfaction, anxiety, and lower trust in the hospital.

Regulatory Citations &Financial Penalties:

- Survey deficiencies can lead to CMS sanctions, including loss of Medicare/Medicaid funding, fines, or being placed under a systems improvement agreement, all of which divert resources from patient care.

READINESS IMPACT ON HEALTH AND SAFETY, CONT.

Higher Readmission Rates:

- Poor discharge planning and education can lead to patients returning unnecessarily to the hospital, resulting in increased readmissions and poorer long-term health outcomes.

Staff Morale and Turnover:

- Operating in a state of crisis or under corrective actions can cause staff burnout, resentment, and turnover, which further destabilizes patient care.

Reputation Damage:

- Survey findings become public and can negatively impact the hospital’s reputation in the community, leading to out-migration of patients to other facilities.

Loss of Accreditation:

- Severe findings can threaten the hospital's accreditation status, further affecting the ability to attract providers, patients, and funding.

TYPES OF CAH SURVEYS

CERTIFICATION SURVEYS

VALIDATION SURVEYS

REVISIT SURVEYS

COMPLAINT SURVEY

CERTIFICATION SURVEY

Certification surveys include both **initial** certification and **recertification** surveys.

CMS describes: “These surveys determine if a prospective or current participant in Medicare and Medicaid meets all applicable requirements for participation and to evaluate the performance and effectiveness of the participant’s care.”

VALIDATION SURVEY

CMS uses validation surveys to validate the performance of an Accrediting Organization (AO) and to make sure all requirements to participate in Medicare are met.

Currently, there are 4 CMS Approved Accrediting Organizations for CAHs

- Accreditation Commission for Health Care (ACHC)
- The Joint Commission (TJC)
- Center for Improvement in Healthcare Quality (CIHQ)
- Det Norske Veritas- Healthcare (DNV)

CMS selects providers or suppliers for validation surveys on a random basis.

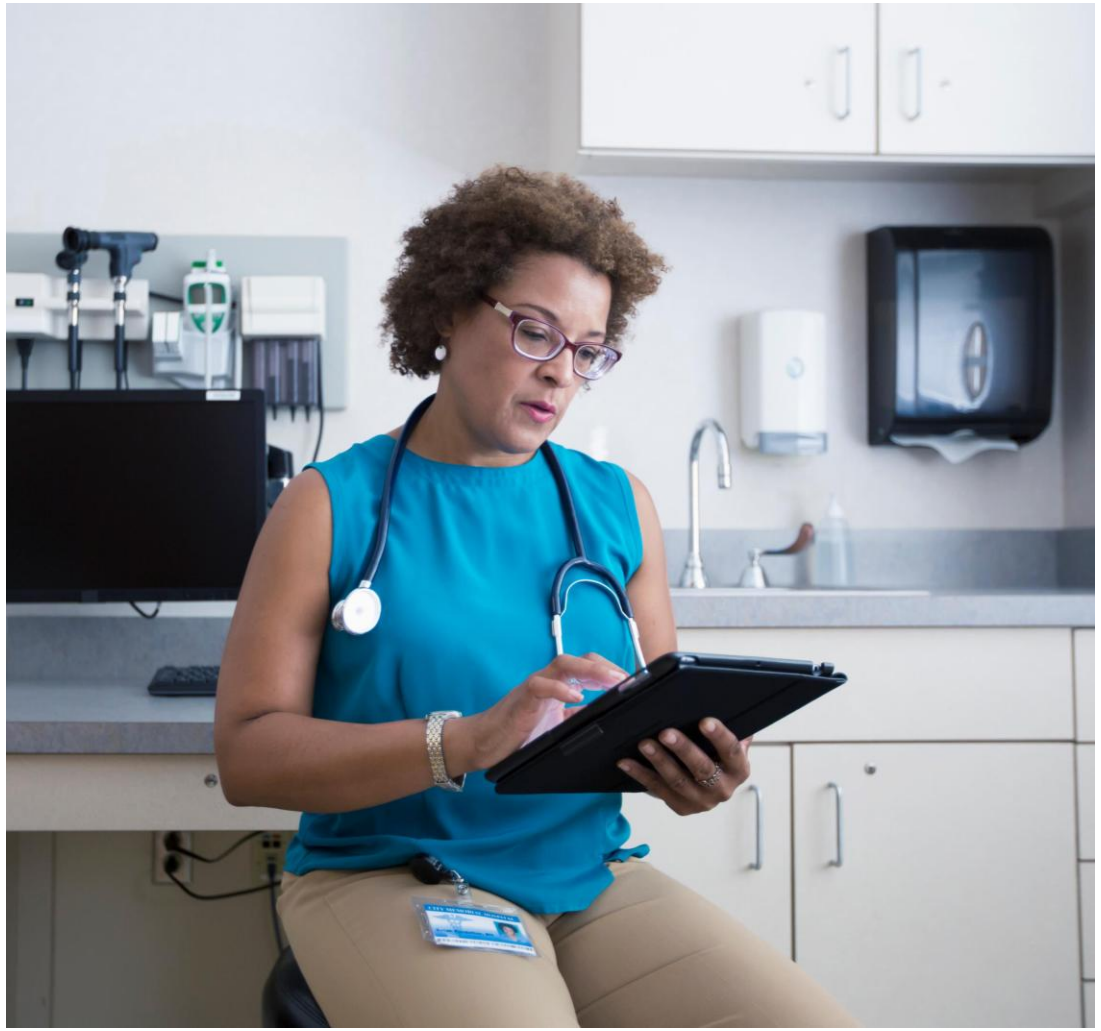
CMS announced last February plans to strengthen the oversight of AOs.

https://qsep.cms.gov/

https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/downloads/accrediting-organization-contacts-for-prospective-clients-.pdf

REVISIT SURVEY

- A revisit survey is one in which a survey team re-evaluates a specific deficient area that was cited during a certification survey or a substantiated complaint survey.
- The revisit survey verifies that the previously cited deficiencies have been corrected.



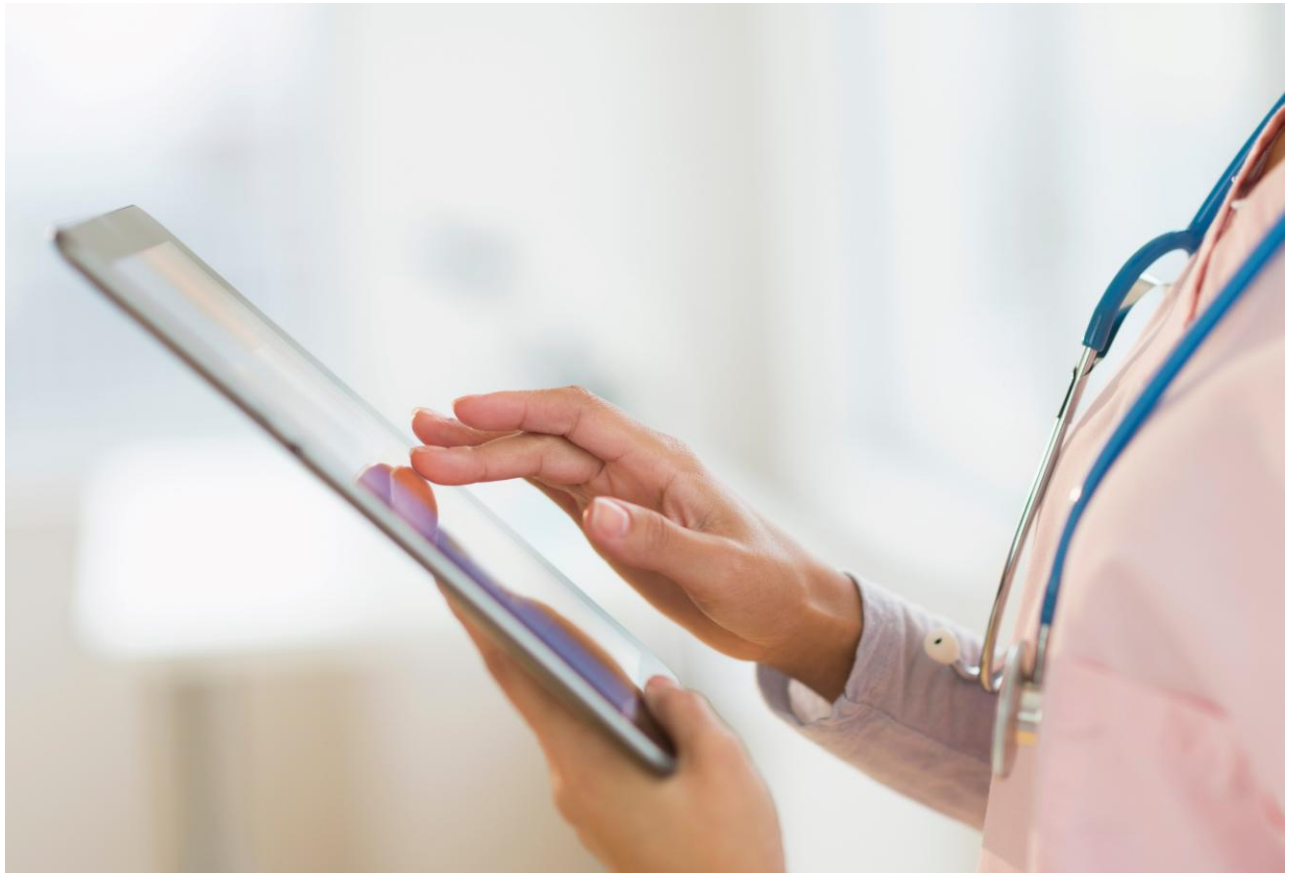
COMPLAINT SURVEY

A complaint survey is conducted after a complaint is filed, which is an allegation of noncompliance with Federal or State requirements or both.

A State Survey Agency can conduct complaint investigations, referred to as an SA, by the applicable CMS location, an approved State program or State licensure program, or an Accrediting Organization (AO).

Investigation into a complaint may or may not result in an onsite survey.

FULL SURVEYS



Certification and validation surveys are always **full surveys that assess an entity's compliance with all Conditions of Participation (CoPs).**

Generally, complaint surveys and revisit surveys are more **focused;** however, they can be expanded if the findings **warrant further** investigation.

HOW DOES THE SURVEYOR PREPARE?

Surveyors review information about your hospital

- Special features
  - Swing beds, psychiatric, rehabilitation DPUs, off-site locations
- Prior application forms
- Previous survey results
  - POC
- Licensure records
- Media reports
  - Facebook
- Organization website

Surveyors prepare for observations, interviews, record review

During a survey, a surveyor notices a damaged blood pressure machine. A brief interview with the nursing staff reveals that the machine malfunctions frequently and has been broken multiple times in the past few months, preventing the staff from using it. One nurse tells the surveyor that staff have submitted numerous requests for it to be fixed, but no one seems to be working on the issue.

https://qsep.cms.gov/

During a survey, a surveyor decides to interview a patient regarding a fall. The interview may go something like:

Surveyor: You fell out of bed on Wednesday, is that correct?

Interviewee: Yes, it is.

Surveyor: Would you tell me a little more about how that happened?

https://qsep.cms.gov/

At the beginning of a survey, a surveyor reviews the facility's incident log and finds several reports of medication errors related to antibiotics. Two of the errors were not caught in time and caused harm to the patients. While at the facility, the surveyor conducts interviews with the pharmacy staff and with staff who were involved in patient care. During the interviews, the surveyor learns the pharmacy is using a new label and barcode system, but staff claim they were not trained on how to read the new labels before implementation.

https://qsep.cms.gov/

STATEMENTS OF DEFICIENCIES (CMS-2567)

Statement of deficiency data is available for Skilled Nursing Facilities, Nursing Facilities, Hospitals & Critical Access Hospitals.

2567 is the number associated with the official document used, “Form CMS-2567, Statement of Deficiencies and Plans of Correction.”

When state survey agencies conduct surveys of acute hospitals, Critical Access Hospitals, and psychiatric hospitals on behalf of CMS, they assess compliance with Medicare health and safety regulations for the hospitals, known as the “Conditions of Participation (CoPs).”

The surveyors prepare their survey report on an electronic version of Form CMS-2567 available in a CMS data system that supports survey work. This system contains the text of the regulations, broken down by surveyors into smaller sections called “tags” to facilitate the work of the surveyors to identify regulatory deficiencies and choose the applicable tag.

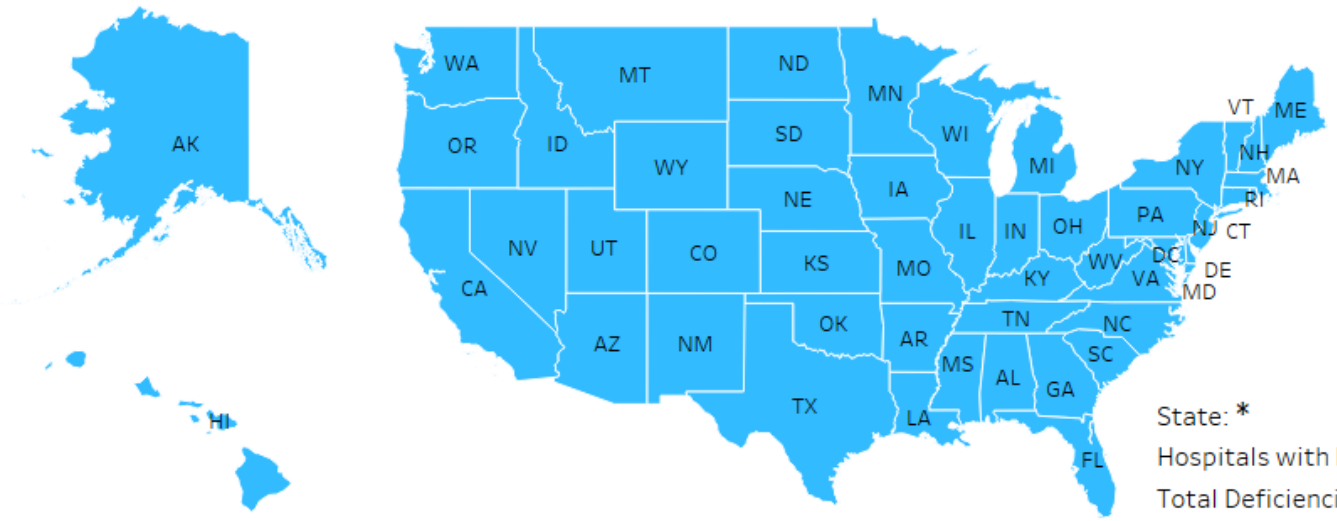
The system generates a Form CMS-2567 with the regulatory text associated with that tag, and then surveyors enter a summary of the evidence for the noncompliance they observed. The survey report is released to the hospital, which, depending on the survey findings, may be required to return the Form CMS-2567 with a plan of correction for each area of deficiency.

STATEMENTS OF DEFICIENCIES (CMS-2567)

- CMS can issue two different types of citations.
- A **“standard-level”** deficiency means that the hospital may be out of compliance with one aspect of the regulations but is considered less severe than a condition-level deficiency.
- The more serious, known as **“condition-level,”** means that a hospital is not in substantial compliance with the CoP.
- There is an additional level of noncompliance called **“immediate jeopardy”** that arises when surveyors determine that the hospital’s deviation from regulatory standards constitutes an immediate threat to patients’ health and safety.
  - An immediate jeopardy determination forces a hospital to correct the underlying problems quickly. Termination from participation in Medicare and Medicaid can result in 23 days if the hospital fails to correct the problems.

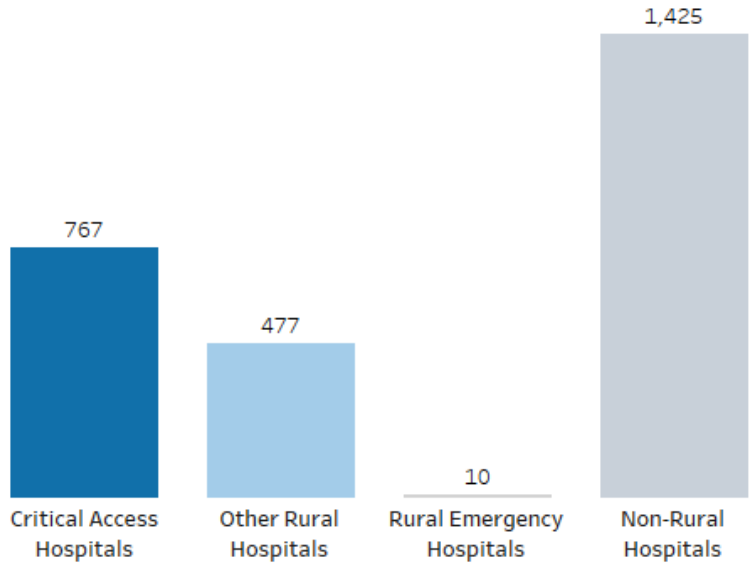
HOSPITAL DEFICIENCIES

Hospital Deficiencies, 1/1/2021 - 3/31/2025



State: *
Hospitals with Deficiencies: **2,679**
Total Deficiencies: **27,307**

Deficiency Description	Hospitals	Total
	2,679	27,307
PATIENT RIGHTS: RESTRAINT OR SECLUSION	411	1,197
COMPLIANCE WITH 489.24	747	1,180
MEDICAL SCREENING EXAM	724	1,090
PATIENT RIGHTS: CARE IN SAFE SETTING	589	1,030
PATIENT RIGHTS	538	934
RN SUPERVISION OF NURSING CARE	483	921
NURSING SERVICES	533	856
SUPERVISION OF CONTRACT STAFF	301	506
QAPI	281	470
INFECTION CONTROL PROGRAM	284	386
PATIENT CARE POLICIES	258	376
NURSING CARE PLAN	224	360
Sprinkler System - Maintenance and Testing	285	355
PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT	219	349
STAFFING AND DELIVERY OF CARE	221	339



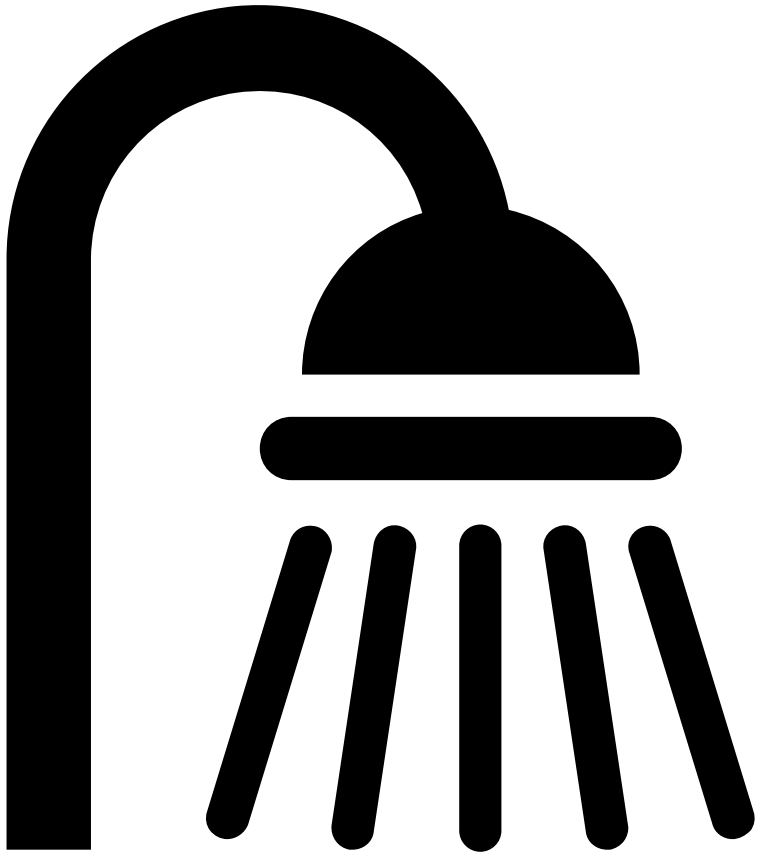
Source: https://www.cms.gov/files/document/hospital-surveys-2567-statement-deficiencies-through-2025-q1.xlsx

CMS 2567 TOP TEN RURAL DEFICIENCIES

	Deficiency Tag	Deficiency Description	Distinct Count of CCN	Total Deficiencies
1	K0353	Sprinkler System - Maintenance and Testing	256	300
2	K0918	Electrical Systems - Essential Electric System	215	240
3	K0321	Hazardous Areas - Enclosure	189	209
4	C1208	INFECTION PREVENT SURVEIL & CONTROL OF HAIs	183	192
5	K0712	Fire Drills	175	193
6	A2400	COMPLIANCE WITH 489.24	160	207
7	C2400	COMPLIANCE WITH 489.24	151	171
8	A2406	MEDICAL SCREENING EXAM	145	186
9	K0345	Fire Alarm System - Testing and Maintenance	144	169
10	C2406	MEDICAL SCREENING EXAM	139	149

1/1/2021 through 3/31/2025. Includes critical access, rural emergency, and other rural hospitals.

TAG DESCRIPTIONS



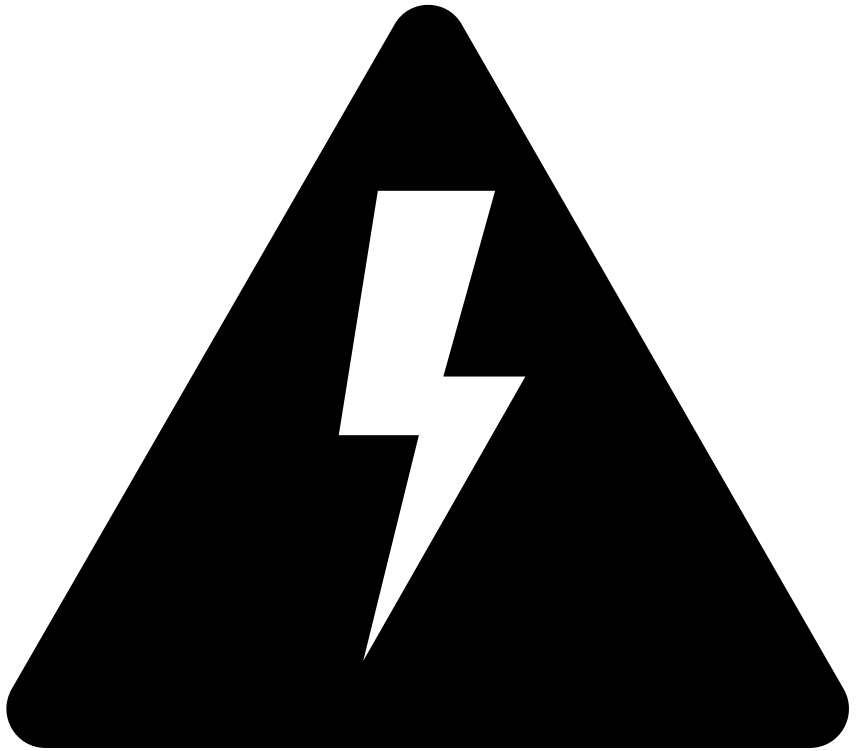
1. K353 - Sprinkler system

- Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.
  - Date sprinkler system last checked
  - Who provided the system test
  - Water system supply source

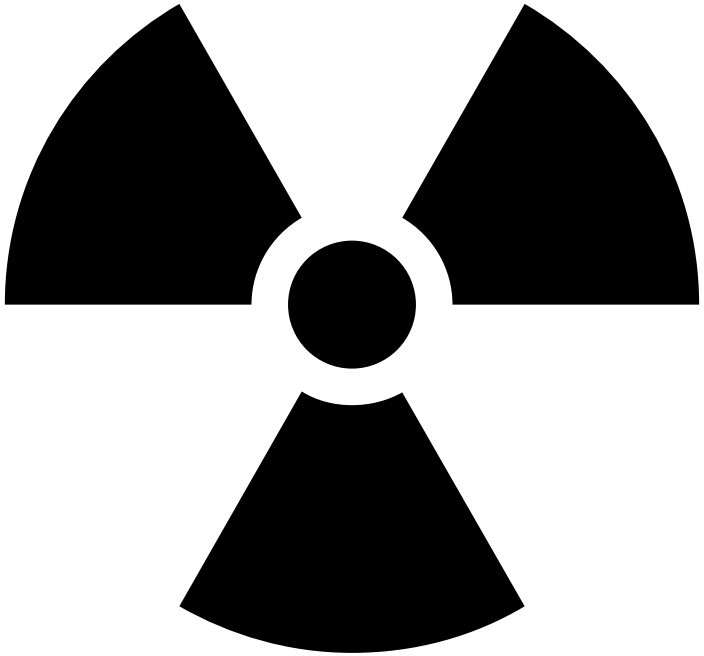
TAG DESCRIPTIONS

2. K918 - Electrical Systems - Essential Electric System

- The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches.
- Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20–40-day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled tests under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage to the emergency power source is a design consideration for new installations.



TAG DESCRIPTIONS



3. **K321 – Hazardous Areas – Enclosure**
   - Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a 3/4-hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4.

     Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.

     a) Boiler and Fuel-Fired Heater Rooms
     b) Laundries (larger than 100 square feet)
     c) Repair, Maintenance, and Paint Shops
     d) Soiled Linen Rooms (exceeding 64 gallons)
     e) Trash Collection Rooms (exceeding 64 gallons)
     f) Combustible Storage Rooms/Spaces (over 50 square feet)
     g) Laboratories (if classified as Severe Hazard - see K322)

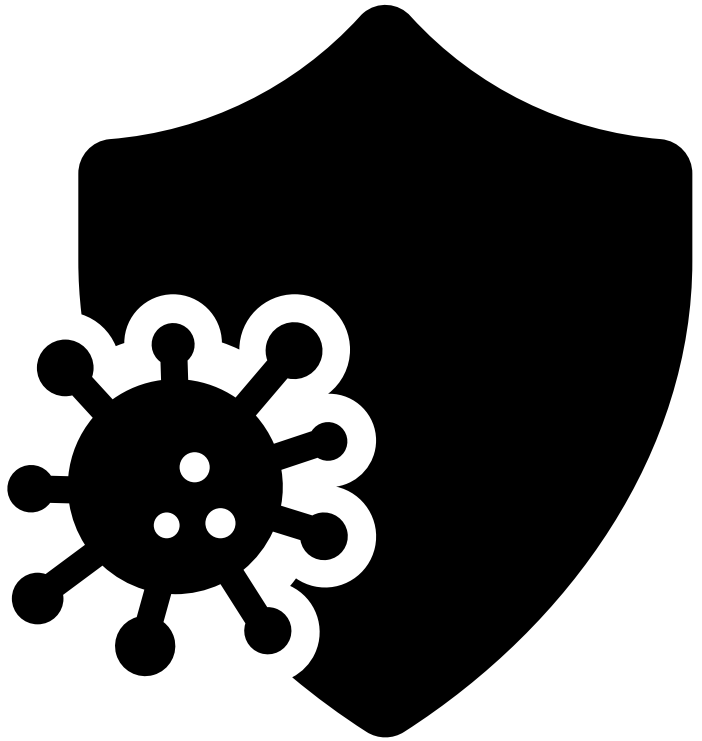
TAG DESCRIPTIONS

4. C1208 – Infection Prevention Surveillance & Control of HAIs

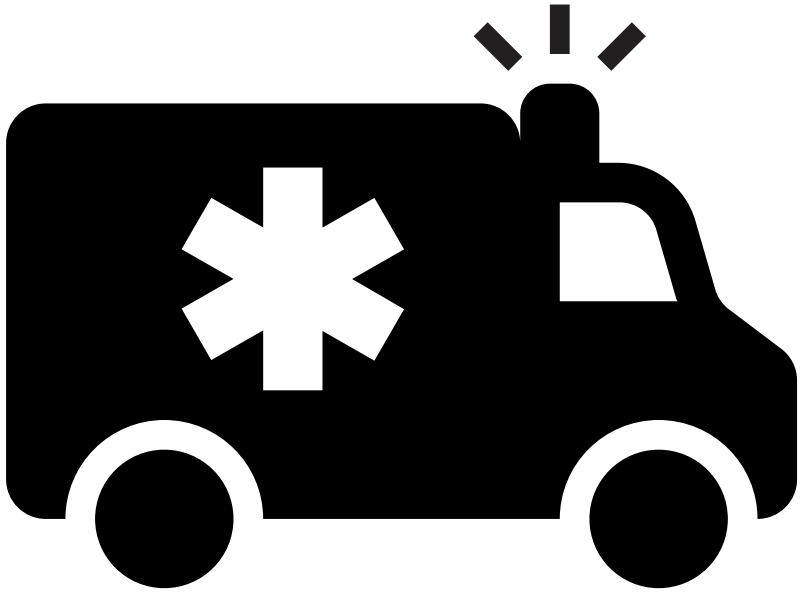
- §485.640(a)(3) The infection prevention and control includes surveillance, prevention, and control of HAIs, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and the program also addresses any infection control issues identified by public health authorities; and

5. K712 – Fire Drills

- Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of an established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.



TAG DESCRIPTIONS



6. And 7. A2400/C2400 – Compliance with 489.24

- Special responsibilities of Medicare hospitals in emergency cases: EMTALA
- According to John Berry, Specialist Principal Consultant, CMS at Joint Commission Resources, one of the areas in which healthcare facilities are most often found lacking in a CMS survey is EMTALA.

https://www.jcrinc.com/-/media/jcr/jcr-documents/products/advisory-services/cms-survey-whitepaper-final-83021.pdf

TAG DESCRIPTIONS

8. and 10. A2406/C2406 – Medical Screening Exam

- §489.24(a) and 489.24(c)

  If an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) "comes to the emergency department", as defined in paragraph (b) of this section, the hospital must-

  - (i) Provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of §482.55 of this chapter concerning emergency services personnel and direction; and...

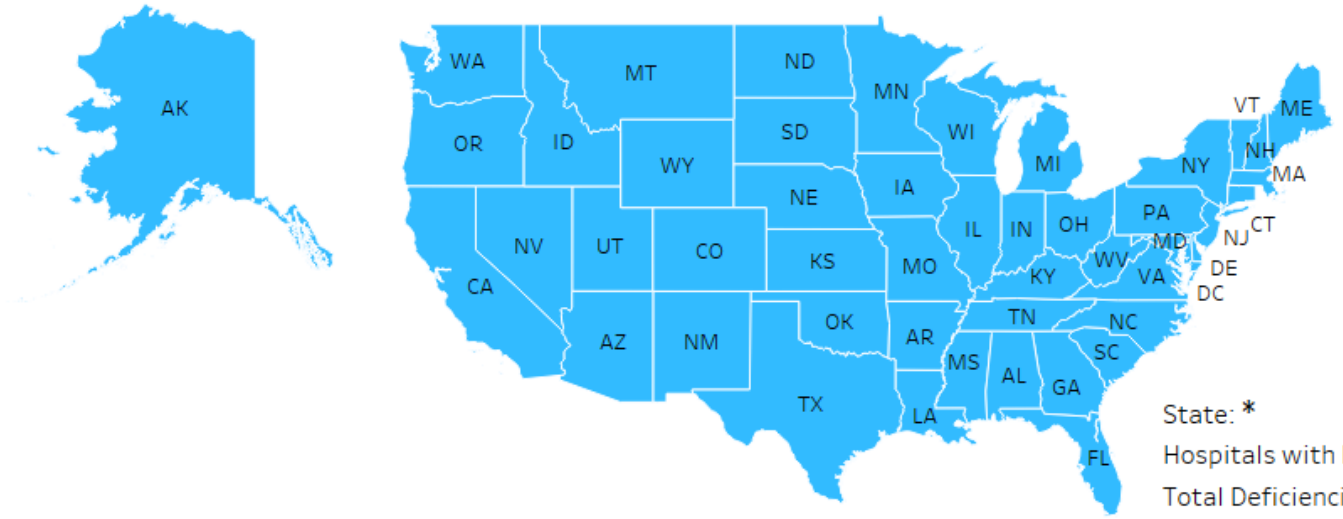
TAG DESCRIPTIONS

9. - **K345 Fire Alarm System – Testing and Maintenance**

- A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.

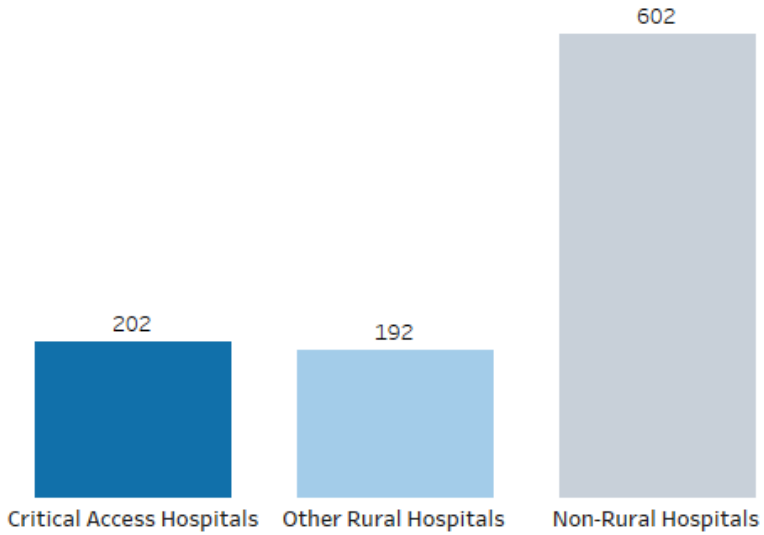
EMTALA DEFICIENCIES

EMTALA Hospital Deficiencies, Jan 2021 - Mar 2025



State: *
Hospitals with Deficiencies: **996**
Total Deficiencies: **3,595**

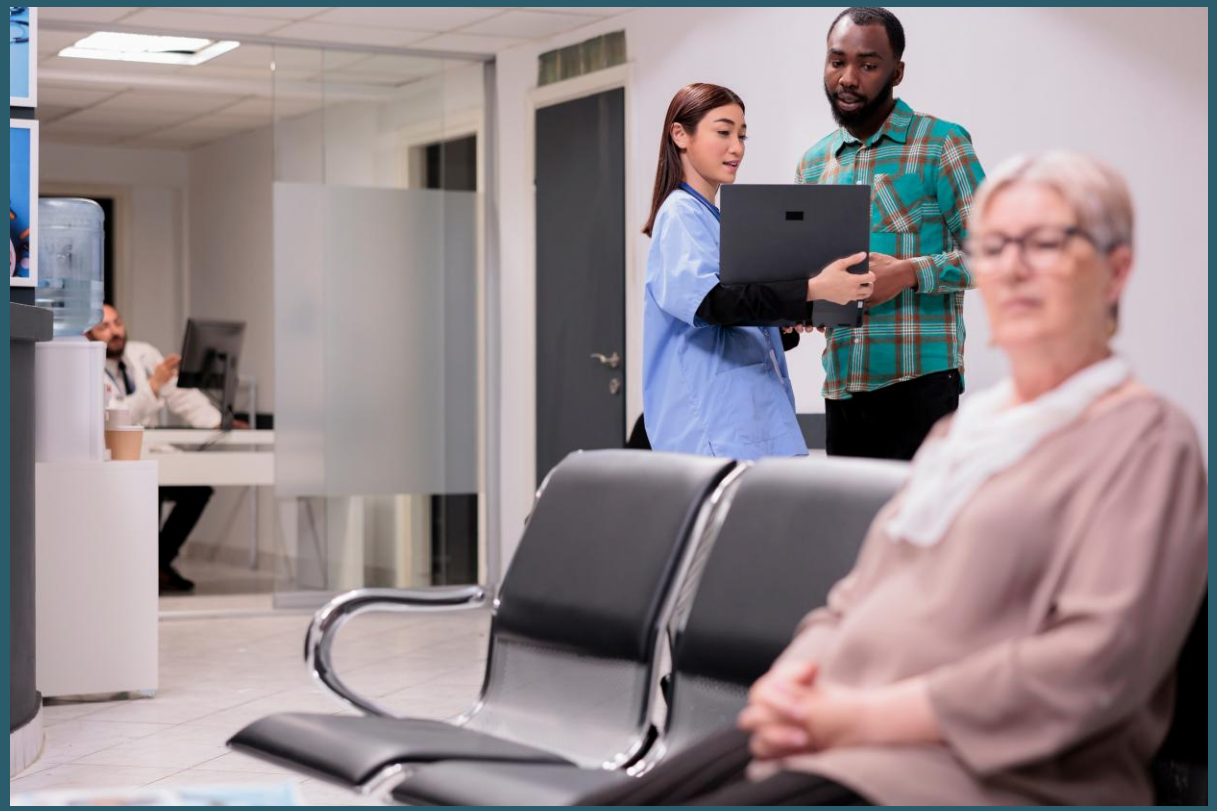
Deficiency Description	Hospitals	Total
	996	3,595
COMPLIANCE WITH 489.24	747	1,180
MEDICAL SCREENING EXAM	724	1,090
APPROPRIATE TRANSFER	275	335
STABILIZING TREATMENT	245	321
EMERGENCY ROOM LOG	230	295
POSTING OF SIGNS	155	184
RECIPIENT HOSPITAL RESPONSIBILITIES	45	63
ON CALL PHYSICIANS	50	60
DELAY IN EXAMINATION OR TREATMENT	42	46
HOSPITAL MUST MAINTAIN RECORDS	10	12
RECEIVING AN INAPPROPRIATE TRANSFER	7	9



Source: https://www.cms.gov/files/document/emtala-hospital-surveys-only-2567-statement-deficiencies-through-2025-q1.xlsx

EMTALA FOOD FOR THOUGHT: EXAMPLE 1

- **Example 1: Refusal to Provide Medical Screening**
  - A patient arrives at the Emergency Department complaining of chest pain. Because the patient appears disheveled and mentions not having insurance, the front desk staff turns the patient away and advises them to visit a free clinic across town.
- **Why this is an EMTALA violation:**
  - Hospitals must provide a medical screening examination (MSE) to any individual who presents to the ED requesting care, regardless of their insurance status or appearance. Denying or delaying an MSE based on assumptions about ability to pay violates EMTALA.



EMTALA FOOD FOR THOUGHT: EXAMPLE 2

- **Example 2: Inappropriate Transfer Before Stabilization**
  - A patient presents to the ED after a motor vehicle accident with a suspected internal injury. After a quick exam, the ED physician determines that the patient may need surgery but transfers them immediately to a larger hospital without fully stabilizing their condition or documenting why the benefits of transfer outweigh the risks.
- **Why this is an EMTALA violation:**
  - EMTALA requires that a hospital stabilize a patient's emergency medical condition before transfer unless the benefits outweigh the risks, and documentation must support the decision.

EMTALA FOOD FOR THOUGHT: EXAMPLE 3

- **Example 3: Delaying Care for Registration Purposes**
  - A pregnant woman arrives at the ED in active labor. Instead of immediately taking her back for triage or evaluation, the registration clerk insists on completing all financial paperwork and obtaining insurance information before notifying medical staff or initiating care.
- **Why this is an EMTALA violation:**
  - EMTALA prohibits delaying the medical screening examination or stabilizing treatment to inquire about insurance or payment information.

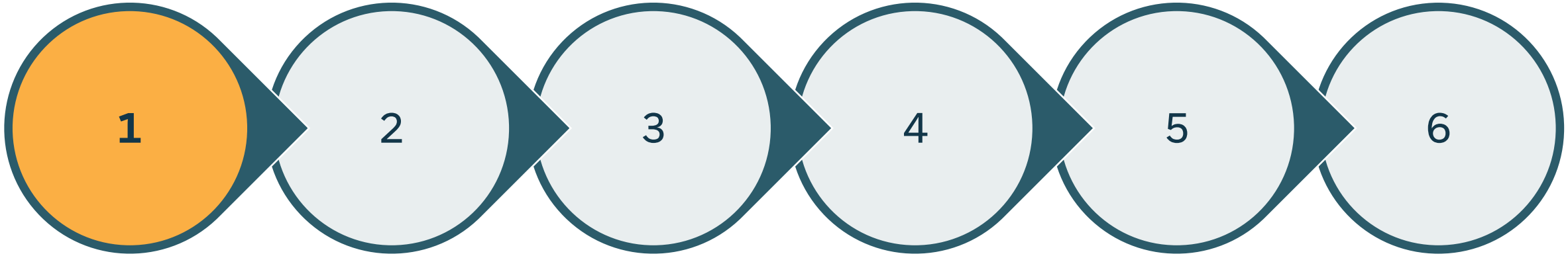
USE THE DATA

Addressing the top CMS deficiencies in a specific state/region

Provides insights into common areas of non-compliance	Can help you prioritize efforts to address potential organizational compliance gaps	Helps you be proactive and prevent or mitigate these deficiencies before a CMS survey occurs	Tailor training and focus on areas identified as high risk for non-compliance	Develop a targeted action plan to address specific deficiencies and improve overall compliance throughout the hospital

BUILDING YOUR TOOLBOX

SIX KEY TOOLS



- **Utilize your past survey plan of correction**
- Maintain document checklist and assign owners
- Develop a revolving calendar by month for policy review/ revision. Assign owners.
- Conduct internal “Tracers” (Ideally teams are multi-disciplinary)
- Create a “daily checklist” and assign specific areas at the daily huddle
- Design and print a “pocket guide” for staff

UTILIZE YOUR PAST SURVEY: PLAN OF CORRECTION

- ***Regulation: CMS State Operations Manual § 485.635(d)(3)***
  - *(1) 485.635(d)(3) All drugs, biologicals, and intravenous medications must be administered by or under the supervision of a registered nurse, a doctor of medicine or osteopathy, or, where permitted by State law, a physician assistant, in accordance with written and signed orders, accepted standards of practice, and Federal and State laws.*
  - *This STANDARD is not met as evidenced by:*
- **Finding**
  - Based on document review, observation, and interview, the facility did not adhere to the protocol used for administering aerosol-generating treatments (a technique for administering medication into the lungs)
- **Plan of Correction**
  - It was determined that the Nursing staff needs additional education on the proper administration of aerosol therapy.
  - To ensure ongoing compliance, we will develop an audit process to assess whether proper elements of performance are being followed during the administration of aerosol therapy. Beginning in December 2022, audits will continue monthly for 6 months, or longer, if needed to achieve 100% compliance for 3 consecutive months.
    - Audit results are being reported to the Chief Nursing Officer

UTILIZE YOUR PAST SURVEY: PLAN OF CORRECTION

- ***Regulation: Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101***
  - *Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.*
- **Finding**
  - Based on document review and interview, the facility does not ensure that the fire alarm system is tested annually at the Primary Family clinic
- **Plan of Correction**
  - To prevent the recurrence of this issue, we will establish a "planned event" alert in our Total Maintenance System. One month before the due date, Maintenance staff will receive a reminder to schedule a date for the inspection. In addition, we are exploring a change in vendors. Starting in September 2022, we will begin a compliance audit with a goal of 100% compliance. Audits will continue monthly for 6 months, or longer if needed, to achieve 100% compliance for 3 consecutive months.

UTILIZE YOUR PAST SURVEY: PLAN OF CORRECTION

- ***Regulation: Corridors - Construction of Walls CFR(s): NE-PA 101***
  - *Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code.*
  - *Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames.*
  - *If the walls have a fire resistance rating, give the rating if the walls terminate at the underside of the ceiling, give brief description in REMARKS. describing the ceiling throughout the floor area.*
- **Finding**
  - Based on observation and interview the facility did not maintain all corridor walls with a minimum 1-hour fire resistance rating

➢ **Plan of Correction**

➢ To ensure future compliance, we have initiated a bi-monthly above-the-ceiling inspection process. Starting in September 2022, we will begin a compliance audit with a goal of 100% compliance. Audits will continue monthly for 6 months, or longer if needed to achieve 100% compliance for 3 consecutive months. Audit results are being reported to the Facilities Management Director.

➢ In addition, staff and contractors will be specifically instructed to ensure proper fire caulking is completed as part of any work that involves penetration of fire walls and barriers.

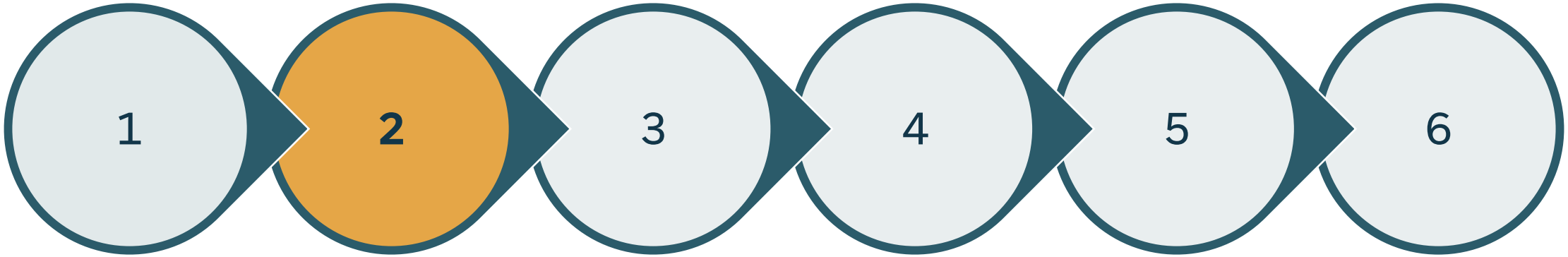
UTILIZE YOUR PAST SURVEY: PLAN OF CORRECTION

- ***Regulation***
  - *Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lb. is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. 'n sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.*
- **Finding**
  - Observations found on the ground floor, in the corridor leading to the skilled nursing facility, revealed the right leaf of the fire-rated cross corridor doors did not fully close when allowed to swing from the fully open position.
- ➢ **Plan of Correction**
  - ➢ The corridor doors have been placed on the Facilities Management bimonthly inspection schedule. The inspections will be audited, beginning June 2022. Audits will continue monthly for 6 months, or longer if needed to achieve 100% compliance for 3 consecutive months.

UTILIZE YOUR PAST SURVEY: PLAN OF CORRECTION

- ***Regulation***
  - *Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.*
- **Finding**
  - Observations found on the first floor, above the drop ceiling in front of the main hospital elevator, revealed a vertical wire chase penetrating the underside of floor 2 with the fire stopping pulled away.
  - Observations found on the second floor, above the drop ceiling in front of the main hospital elevator, revealed a vertical wire chase penetrating the underside of floor 3 with the fire stopping pulled away.
- **Plan of Correction**
  - To ensure ongoing compliance, a bimonthly above-the-ceiling inspection plan has been initiated. These inspections will be audited, beginning July 2022. Audits will continue monthly for 6 months, or longer if needed to achieve 100% compliance for 3 consecutive months.
  - Audit results are being reported to the Facilities Management Director
  - In addition, we will educate staff and contractors to complete proper fire caulking as part of any work that involves penetration of fire walls and barriers

SIX KEY TOOLS



- Utilize your past survey – plan of correction
- **Maintain Document Checklist- Assign owners**
- Develop a revolving calendar by month for policy review/ revision- Assign owners
- Conduct internal "Tracers" (Ideally teams are multi-disciplinary)
- Create a "daily checklist" and assign specific areas at the daily huddle
- Design and print a "pocket guide" for staff

MAINTAIN DOCUMENT CHECKLIST

- **Divide into categories and assign an owner to each one.**
  - **General Organizational Detail**
    - Org chart, etc.
    - Bylaws
  - **Meeting Minutes and Reports**
  - **Plans and Policies**
    - Emergency Management Plan
    - Medication Management Policy
  - **Contracted Services**
  - **Logs**
    - ED Log
    - Incident
    - Grievances
    - Daily Census
    - Staffing Matrix
  - **Measurement Data, KPIs, Analyses**
    - QAPI
    - Scorecards

EXAMPLE

Meeting Minutes and Reports

- Med Exec meeting minutes
- P&T
- Board meeting minutes
- Quality Committee Meeting Minutes
- Fire Drill Documentation-Evaluations
- Infection Prevention/Antibiotic Stewardship

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DEVELOP REVOLVING CALENDAR FOR POLICY REVIEW/REVISION

- Divide into logical categories/departments and assign an owner to each.
  - Human Resources (Jan.)
  - Environment of Care (Feb.)
  - Information Management (Mar.)
  - Life Safety (Apr.)
  - Medication Management (May)
  - Nursing (June)
  - Provision of Care (July)
  - Patient Rights/Responsibilities (Aug.)
  - Document Management (Sept.)

EXAMPLE

Medication Management (May)

- **Acceptable Medication Orders**
- **Medication Administration Process**
- **Disposal of Expired Medication**
- **Wasting of Narcotics**

Ensure Review/Revision Date

Appropriate Signatures

Updated References

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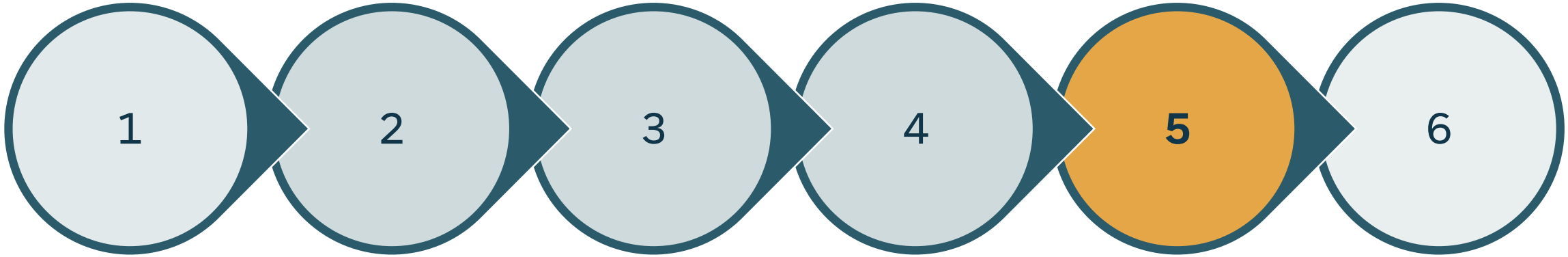
CONDUCT INTERNAL TRACERS

- **Convene "Tracer" Team**
  - *Tracer methodology*—A targeted approach used during hospital surveys to assess compliance with regulatory standards and identify areas for improvement.
  - Follow the path of patient care, from admission to discharge, to evaluate the implementation of policies and procedures.
  - Provides a comprehensive understanding of how policies are translated into practice.
  - Identifies potential gaps in compliance and patient safety.
  - Promotes staff engagement and accountability.
  - Offers actionable insights for quality improvement initiatives.

EXAMPLE

- Leadership — Select tracers **MONTHLY** based on high-risk areas, sentinel events, or regulatory focus.
- Team—Observe patient care processes, including interactions with staff, documentation, and protocol adherence in "real-time."
- Team—Document findings
- Team and key members — Review findings and develop actionable steps for corrective action.

SIX KEY TOOLS



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CREATE DAILY CHECKLIST

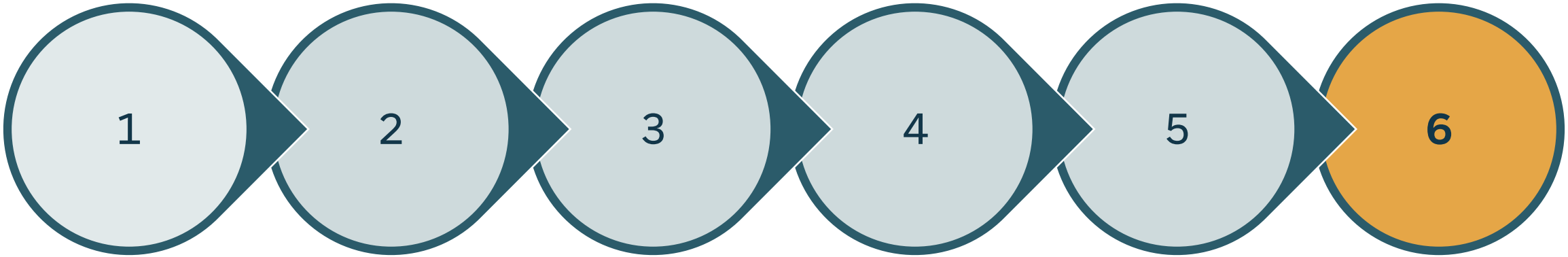
- **Create a checklist of items to be checked daily. Assign a few items to huddle members each morning.**
  - Medications
  - Nutrition area
  - Dirty Utility Room
  - Clean Utility Room
  - Patient Rooms
  - Medical Record Check
  - Equipment Maintenance
  - Egress
  - Warmers
  - Refrigerators
  - Documentation audit

EXAMPLE

Assign Medications to a team member at huddle with the list below

- Medication room locked if in unsupervised area
- Correct medication refrigerator thermometer setting
- Medication refrigerator log complete with actions for any out of-range temperatures documented
- Medications secure with no medications unattended
- Multi-dose vials dated with 28-day expiration date
- No open single-dose vials available for reuse
- Cleaned pill cutters and mortar/pestles
- No unwrapped IV fluids (unless dated with a 24-hour use date)

SIX KEY TOOLS



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DESIGN AND PRINT A POCKET GUIDE FOR STAFF

- Organization-specific information
- May include, but not limited to:
  - Mission/Vision/Values
  - Human Resources/Staffing-Orientation
  - Unacceptable abbreviations
  - Medication Management
  - ALL Emergency Codes
  - Environmental Safety
  - Fire Safety Codes and information
  - Infection Prevention
  - QAPI-Quality Measures
  - Patient Safety
  - Patient Rights
  - HIPAA
  - Advance Directives
  - Potential survey questions

“Failing to prepare is preparing to fail”

Benjamin Franklin

APPENDIX

RESOURCES

- Accrediting Organization Proposed Rule Fact Sheet | CMS
- Federal Register: Medicare Program; Strengthening Oversight of Accrediting Organizations (AOs) and Preventing AO Conflict of Interest, and Related Provisions
- QSEP – Driving Healthcare Quality
- Accrediting Organization Contacts for Prospective Clients


QUESTIONS
COMMENTS
CONCERNS
COMPLAINTS

STROUDWATER

COMMITTED TO INCREASING THE IMPACT OF RURAL AND COMMUNITY HEALTHCARE.

Our team of rural and community healthcare experts support the leadership of hospitals, health systems with a rural footprint, and the groups and clinics that form an essential care network across the 97% of the US that is defined as rural.

Carla Wilber
Principal
cwilber@stroudwater.com

Christie Bishop
Consultant
cbishop@stroudwater.com