

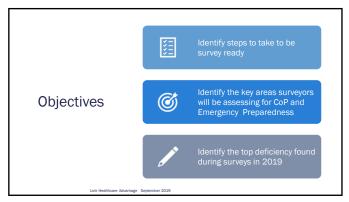
1

Presenter: Diane Link RN, MHA

- Owner of Link Healthcare Advantage
 - Regulatory Guidance Program
 - ADR Management and chart reviews
 - Survey Prep and Operation Assessments
 - Education
- COO of Curaport
 - Online education platform using industry subject matter experts
 - Live and On Demand education
 - CEUs available

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2





4

Standard Survey

- Assess compliance with Level 1 G Tags
 - Patient Rights
 - Complaint & resolution
 - Participate in planning of care and treatment
 - Compliance with Fed/State/Local Laws
 - Practice Standards including professional standards and P&P (infection control, handwashing, documentation)
 - Competency testing
 - Organization, Services and Administration
 - Organizational chart shows reporting status
 Operations hours, locations etc

 - Administrator meets qualifications
 - Coordination of Care/discharge planning

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5

Standard Survey

- Acceptance of Patients, Plan of Care & Medical Supervision
 - All patients needs are met
 - Polies for admission
 - Missed visits
 - Care follows written plan/reviewed by MD
 - Orders for all care
 - POC/verbal orders are signed timely
 - Plan of Care Covers All Pertinent Diagnosis
 - POC relates to comprehensive assessment - Documentation to support diagnosis
 - Alert Physician for Changes In Condition
 - Medication Administered Per Orders

Standard Survey

- Comprehensive Assessment
 Includes Medication Reconciliation
 Within 48 hours SOC/ROC is completed
- Skilled Nursing Services and Therapy Services
- Accordance with Plan of Care
 Re-evaluates patients nursing and therapy needs
- Plan of care is revised as needed
 Services are provided by skilled professionals
 SN and PT document, coordination and inform physician of care/condition
- Home Health Aide Services
- Written plan of care for aide servicesSupervisory visits every 14 days
- Clinical Record
 Maintain in accordance to standards

 - E-signature policy
 Documentation is current
 HIPPA

7

Extended Surveys

- Noncompliance with one or more CoP condition level standards
- Extended Survey includes
 - Personnel records
 - Contracts
 - Policies and Procedures
 - Clinical/Procedural references
 - Documentation of home health aide training/competency evaluation
 - Documentation of complaint investigations
 - CLIA waiver

8



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- Governing body approves QAPI and receives updates needs to be in minutes
- Documentation of plan and analysis of information
 - Audit frequency
 - Tracking of results
 - Program activity
- Performance Improvement Project
 - Includes rational of why chosen
 - Includes meeting minutes
 - Includes plan for ongoing surveillance

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10

QAPI

- Infection Control includes patient infections with proof of tracking and analysis
 - Education for patient and staff
- Complaints
 - Complaint policy including investigation and follow up
 - Complaints are part of QAPI plan

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11

Employee Records

- Job Description
- Verification of licensure
 - Proof of qualifications (school records)
- Proof of background check
- Six months and then annual performance evaluation
- Health history screening/PPD testing
- Orientation with competency evaluation
- Inservice Education

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Patient Visits

- Bag technique
- Handwashing
- Agency "Admission Book" includes
 - Name of clinical manager and director
 - Info on admission, transfer, discharge policy
 - Visit schedule
 - Medication List
 - Identification of medication and treatments provided by agency
 - Contact information for local Agency on Aging, Center for Independent Living, Protection and Advocacy Agency, Aging and Disability Resource Center and Quality Improvement Organization
 - Hotline (state and accreditation agency)

13

Prepare Before Surveyor Arrival

- Prepare key documents when in survey window
 - Organizational Chart
 - Personnel list with title, hire date
 - Education Records
 - Copy of licenses including CLIA

 - Admission packet
 Staff meeting minutes
 - CASPER reports for OASIS adverse events, outcomes, OASIS error summary report etc
- Know how to run reports
 - Unduplicated admissions past year
 - Current census with SOC date, admitting diagnosis and disciplines assigned
 - Current schedule
 - Discharge/transfer patients past 12 months

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14

Prepare Before Surveyor Arrives

- Pull pertinent policies (such as) and place in binder:
 Patient rights
 - Advance Directives
 - Complaints

 - Emergency Preparedness Plan
 QAPI
 - Infection Control - Bag Technique
- Have available

 - Governing body minutes past 12 months
 Approval of QAPI in minutes (know when it was documented)
 - QAPI Plan and documents
 Emergency Preparedness Plan

Prepare Before Surveyor Arrives

- - Where will surveyors work
 - Area away from noise and other staff (if possible)
 - Communication to staff
 - Runs reports
 - Pulls policies
 - Transportation who is driving surveyor
 - Scribe is someone going to go with surveyor on visits and take notes
 - Initial and exit conferences who is attending
- Back Up plan in case leadership is offsite/or others are off
- Educate staff on what to expect
- Mock survey especially for home visits

16

Plan for Arrival of Surveyor

- Identify plan for arrival
 - Receptionist
 - Ask to see surveyor credentials (badge)
 - Put surveyor in board room/empty office
 - Notify leadership
 - Leader goes in to meet and greet surveyor
 - Inquire of schedule ie open and closing conference, lunch, transportation
 - Clinical manager or designee notifies all staff
 - Assigned person runs reports requested
 - Bring materials requested to surveyors
 - Keep surveyor happy by not making them wait for items
 - Document everything that they request and what you give them

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17

Survey Time

- Try to Relax You got this...
- Don't be argumentative with surveyors
- Be polite
 Ask clarification questions for any deficiency
- Ask for regulation/standard number for reference ■ Don't provide more information than what they are asking for
- If you don't know an answer say "let me look that up" or "let me ask a manager"
- Let your patients know you are under survey and get permission for visits
- Let your agency answering service know you are under survey
- Take good notes during exit conferences as these may be your condition issues
- Exit conference is time to listen not time for discussion/arguments about issues
 - Discussions should occur before exit conference

TOP ACHC SURVEY DEFICIENCIES 2019

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19

484.60 Care Planning, Coordinating Services and Quality of Care

- There is a written plan of care: G572, G576, G580
 - Care Plan is based on comprehensive assessment
 - Orders are obtained prior to initiation of services
 - Frequency and duration are present for all disciplines
 - Therapy orders include specific treatments and modalities provided
 - PRN visits and medications include reason

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20

484.60 Care Planning, Coordinating Services and Quality of Care

- Follows Written Plan of Care reviewed by MD: G572, G578, G580
 - All medications and treatments provided have corresponding physician order
 - All medications and treatments are provided per physician order
 - Missed visits include notification of MD

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484.60 Care Planning, Coordinating Services and Quality of Care

- Patient and caregiver are provided with written instructions: G 612, G614, G616,G618, G622
 - Written visit schedule that is updated and accurate
 - Medication list with instructions
 - Medications and treatments are identified that the agency will be providing
 - Other pertinent instructions that related to patient care and treatment that the agency will be providing
 - Name and contact info for Clinical Manager

22

484.60 Care Planning, Coordinating Services and Quality of Care

- Agency promptly notifies physician and representative with changes in patient condition, outcomes not achieving or changes in plan of care G590, G596, G602, G718
 - Documentation that the physician and representative are notified of changes in patient condition or changes to plan of care

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23

G487.75 - Skilled Professional Services

- Skilled professional services (SN, PT, OT, MSW) are provided according to regulations
 - Ongoing interdisciplinary assessment of patient
 - Develop POC in partnership with patient/representative/caregiver
 - Provide services in accordance with the plan of care
 - Provide patient and caregiver education
 - Documentation in accordance with agency policies and procedures
 - Communicate with all physician s in the plan of care

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484.80 Home Health Aide Services

- Home Health Aides are supervised and care as appropriate to the level of care G798, G800, G804, G806, G824
 - HHA supervisory visits every 14 days
 - Supervisory visits include:
 - Completion of tasks assigned
 - Maintains an open communication with patient/caregiver
 - Demonstrates competency with assigned tasks
 - Complies with infection prevention and control
 - Reports changes in patient condition
 - Honors patient rights

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25

484.80 Home Health Aide Services

- Home Health Aides are supervised and care as appropriate to the level of care G798, G800, G804, G806, G824
 - Aide Care plan does not include any prn tasks
 - Revisions to aide care plan are discussed with patient/caregiver
 - Tasks assigned are documented as completed
 - Refused care is promptly documented

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26

484.55 Comprehensive Assessment

- Comprehensive Assessment includes medication review and drug regimen review is part of ongoing assessment G536
 - If therapy only comprehensive assessment RN reviews medication list
 - Oxygen is included in medication list
 - PRN medications include frequency and reason
 - Physician is notified of any discrepancy or side effects etc
 - Added medications include review for interactions

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EMERGENCY PREPAREDNESS:

WHAT THE SURVEYOR WILL BE LOOKING FOR

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28

Emergency Plan

- Must be reviewed and updated annually
 - Updated based on disaster critique
- Have All Hazard Risk Assessment
 - Must include cyber attacks
- Emergency response plan based on risk assessment
 - Agency response plan for tornado, blizzard, heat/cold etc.
- Succession / Delegation plan
- Assessment of individual patient emergency response plan at the time of SOC

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29

Communication and Collaboration (484.102)

- Communication plan includes names and contact information for staff, contracted staff and physicians and volunteers
 - Updated contact list for new staff
 - Documentation of follow up with on duty staff and current patients
 - On duty staff and patients unable to contact agency must inform state and local officials that they are unable to contact
- Documentation of contact information for federal, state, regional and local emergency preparedness agencies
- Plan in place for communication with state/local EP for patients requiring evacuation
- Documentation for attempt to collaborate with state/local EP staff

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Testing and Training

- Documentation of training of all employees as part of orientation and ongoing yearly
- Documentation of testing of EP plan **twice** per year
 - If enacted EP plan and there is an evaluation of the response
 This counts as one testing
 - There is participation in community wide event or table top exercise with evaluation of event
 - If doing table top

 - Needs to be challenging event
 Documentation of attendees and responses during event
 Critique of the event
- Contracted staff each contracted staff member knows the facility's emergency program and their role during emergencies
 Suggested from interpretive guidelines to create training documentation emergency plan, contact info, role during emergency

31



32

After Survey

- Most agencies have 5 to 10+ deficiencies
- Standard level deficiency noncompliance with one or more standards that make up that G tag
- Condition level deficiency deficiency that substantially limits the provider's capacity to furnish care or adversely affects health or safety of patients
- Start to prepare plan of correction
- You will receive written report usually within 2 weeks
- Once written report is received you have 10 days to respond (this may vary based on accreditation agency)
- Corrective Action Plan should include
 - Educate staff
 - Further assessment of issue (chart reviews, supervisory visits)

 - How are you going to ensure ongoing compliance (frequency and date of completion)



