Steven Hirsch & Associates
Accreditation News
Summer 2022
Volume 14, Issue 2

CMS 2567

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The CMS 2567 is the report used by the Federal government to document the findings of a survey of a facility (hospital, clinic, laboratory, ambulatory services) and identify violations of federal regulations. State departments of health also use the form 2567. This is an official documentation of both compliance and noncompliance and identifies the impact of the noncompliance on the populations served. It is important to note that a) this is a public document that is available to consumers when planning where to receive care and b) this is a legal document that may and can be used in litigation as supporting documentation in legal actions against the facility, named staff members, and named providers. It is for this reason that this document should be prepared with the assistance of hospital legal counsel.

The 2567 is a regulatory reference that identifies deficient practices and relevant findings. All 2567 citations include a data tag number, the CFR or LSC (Life Safety Code) reference, the specific language used in that data tag to specify the requirement that was noncompliant and the explicit term "NOT MET." The 2567 also includes a statement of deficient practice, the errors, or the lack of action, or the action(s) observed to be a variance from establish protocols, policies, or practices.

The surveyor must ensure that the statement of deficient practices is quite specific. It must include the actions, errors, or lack of action that was observed as well as the possible or real outcomes related to the identified practice. When possible, it should include the prevalence of the deficient practice, the identification of the individuals or situations where the deficiency was observed, and when necessary, the sources of the information by which the evidence was obtained. The example below demonstrates the Who, What, When, Where, and How.

EXAMPLE:
The following deficiencies were identified:
C1006 Patient Care Policies
CFR(s) 485.635(a)(1)
1. The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law. This STANDARD is not met as evidenced by "Based on observation, record review, policy review, and interviews, the facility failed to ensure wound care was provided in accordance with hospital policy. Specifically, the Registered Nurse (RN) failed to measure and document sacral wounds and photograph the wound at admission and every five days for one of two Patients (P3) reviewed for wound care. The deficient practice had the potential to affect all patients admitted or who developed a wound in the

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facility.
Findings include:
Review of the hospital policy titled, "Wound Assessment and Documentation." Effective 08/31/11, showed that wounds are to be measured for depth, width, and length at….
Review of P#s "Admission Order" located in the Electronic Medical Record (EMR) showed that P3 was admitted on 8/3/xx with a diagnosis of pneumonia…. Further review of the section "Orders" showed a physician order on 08/3/xx at 0809AM to clean the presacral decubitus with ….
Review of "Shift Notes" located in the EMR under the "Notes" tab, showed a note documented by RN3 that he/she "found skin breakdown at the buttock r/t (related to) to moisture." There is no documented evidence that an assessment of the ….

WHAT HAPPENS NEXT?

The hospital should receive the 2567 within 10 business days of the conclusion of the survey. This will be by electronic mail, and the date interval is variable. The concern for the facility is that it has 10 calendar days to respond with a **Plan of Correction (POC)**, which, upon receipt by the Survey Agency, must be approved before there is clearance of the finding(s). The POC must identify the steps that have been or are being taken to address the finding(s) and attain sustained compliance with the regulation. It must also identify the time frame in which the correction has been or will be achieved. Approval of the POC is based on the following:

- The POC must be specific, realistic, and complete and state exactly how the deficient practice has been or will be corrected. The CMS will not accept vague or generalized statements indicating that the finding has been corrected or will be corrected, e.g., "staffing schedules were revised."

- The POC must identify the nature of the corrective action, and how the corrective action will not only address the concerns identified in the CMS 2567 but will also extend to other situations where there is a potential for noncompliance with the cited regulation.

- The POC must identify what systematic changes have been made to ensure that the deficient practice will not recur and how the facility will monitor its corrective action to assure that the deficient practice is corrected, i.e., what quality improvement processes have been put into place to prevent further occurrences. The POC must identify the position of the staff person(s) who is responsible to monitor correction and the quality improvement mechanisms. An example might state the Administrator, Director of Nursing or Laboratory Director shall review the data daily until there has been 90 days of sustained compliance.

The CMS 2567 and the subsequent POC is accessible to the public and a clear and specific response by the provider or supplier identifying the steps taken to achieve compliance and to prevent a recurrence of noncompliance is important.

The POC must identify the date of completion of the corrective action. The Department of Health or CMS is required to determine that the specified time periods are reasonable. The amount of time for correction will vary depending upon the nature of the deficiency. The maximum amount of time is 60 days from the exit date of the survey unless special circumstances warrant. However, the Department of Health or CMS will not routinely accept 60-day time frames for compliance when a deficiency can reasonably be corrected well before that date. Many deficiencies, especially those involving the provision of direct care, can and must be corrected within shorter time frames. If state licensing orders accompanied the CMS 2567, the times for correction identified in the state orders should be used.

A deficiency may require several corrective actions to achieve compliance, with each action having different dates of completion. The dates of completion as well as the responsible party(ies) should be clearly identified for each action in the POC.

Calculating the sample size to measure if your corrective action is to address deficient practice also must be addressed. Most statistical references use 30 events as an adequate sample size; however, this is not a hard and fast number, and in some cases it maybe impossible to attain based on the event. For example, if the deficient practice was found to be related to "conversion of lap chole to open," you may not reach 30 cases within a reasonable time frame.

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Sample collection or sample size can be done in a variety of ways. As mentioned above one could state "30 consecutive …." will be measured which may be acceptable if it would be seen as a true random sample of events. The use of "30 consecutive…" might be unacceptable if the facility does 20-30 types of cases per week that were identified as being deficient. For this sample, the organization may consider a more random approach such as a statistical sample of 30 cases chosen from the population at risk, using every third case, based on the hospital admission number until 30 cases have been selected. By the same token, the CMS may feel that the deficient practice is so egregious that they can require an ongoing review of all cases until there is sustained success with no failures for a defined period of time.

There may be an occasion where the deficient practice involves failing to have an adequately trained or competent staff. For example, the POC may require that the individual have a specific level of academic preparation or certification in the practice area. If it is identified that the incumbent does not meet the standard, the hospital will have to develop and implement a process to ensure that there is an individual who can meet ALL the requirements. The organization may choose to hire a qualified individual to supervise the existing employee until such time as the incumbent meets all the elements of the standard. This will have to be executed within the 10-day window as specified. This can be problematic, and the finding will not be cleared until such time as there is a competent individual in place.

Tracking the progress of the Plan of Correction (POC) is critical, particularly if there is an "Immediate Jeopardy" finding. The POC should be developed in concert with the facility administrator, the involved department head, and someone from the QAPI department. Once developed (again ASAP after the departure of the survey team), the corrective actions must be implemented. The facility should have an aggressive tracking system to monitor the POC steps – ideally this would be the same group as those who developed the initial POC. Having regular meetings at close intervals until the POC is accepted should be implemented. As follow-up for sustained success, having the POC actions as part of the standing agenda of the QAPI process would help provide evidence of monitoring of compliance to the CMS.

The completed CMS 2567 must be returned to the Department of Health or CMS within 10 calendar days of receipt. If the POC is not properly completed or if additional information is needed, the provider will be contacted for clarifications and modifications.

Once the POC has been executed and accepted by the CMS or it's representative, it is important that the surveyed entity continue with the ongoing monitoring to ensure sustainment of the corrective actions taken. If the surveyed organization is accredited by another agency (TJC, AAAHC, HFAP, DNV, CAP), the accrediting agency may conduct a follow-up survey themselves. Additionally, any future surveys by any agency will carefully evaluate the processes related to the initial 2567 findings to ensure that there is ongoing and sustained compliance.

For more information on the CMS 2567 form or for further questions, please contact Steven Hirsch, MPA, FACHE or David Woodard, MSc, MT(AMT), CLS, CIC, FSHEA at (800) 624-3750 or email Steven Hirsch at stevenhirsch@shassociates.com.

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The Importance of Documenting Education

By Joann Saporito, RN, MBA

Everyday healthcare workers provide education to their patients. Nurses, respiratory therapists, discharge planners, dieticians, and pharmacists are just some of the many disciplines within the healthcare environment that present patients and their families with valuable information and instructions. And because providing this education can become so much a part of a healthcare worker's daily routine, they can unknowingly overlook recording the patient and family education has been provided.

Education is such an important part of the patient's healthcare experience, so much so that this requirement can be found within the Elements of Performance for Standards in a number of chapters within accrediting organization manuals such as the Joint Commission or Healthcare Facilities Accreditation Program. And the Standards require that education is addressed from the time of admission, including assessing the patient's learning needs and using methods of education and instruction that are matched to the patient's level of understanding. The assessment should address cultural and religious beliefs, emotional barriers, desire and motivation to learn, any physical or cognitive limitations, and barriers to communication. Once the patient's learning needs have been assessed, the facility should coordinate the education and training that is provided, and thoroughly evaluate the patient's level of understanding.

To provide some examples:

Is the patient at risk for falls? The staff may have initiated the facility's fall prevention protocol and updated the care plan, but was patient education provided regarding the fall prevention strategies? Likely it was but staff may not have entered this into the medical record. Or was the patient placed in isolation? If so, staff may have put up the signage and commandeered PPE, but did the staff also educate the patient and/or family on isolation precautions? Again, likely it was done but not documented. Were any new medications started? Education regarding any new medications, such as purpose and possible side effects, should also be documented. And consider pain management techniques, restraint education, wound care for post-surgical patients, etc.

Further, it is helpful if this documentation is easily located in the medical record and not only found in narrative notes which can be very time consuming and difficult to locate when sitting with a surveyor performing chart reviews.

Document the education you provide, if possible, in a manner that can easily be retrieved from the medical record. Tailor the education and training provided to the individual patient and remember that surveyors will expect to see that education is being provided that is not only related to the patient's principal diagnosis but relevant to other assessments and interventions as well.

For more information on *The Importance of Documenting Education* or if your facility needs any assistance with accreditation and licensure preparedness, call STEVEN HIRSCH & Associates at (800) 624-3750, or email Steven Hirsch, MPA, FACHE at stevenhirsch@shassociates.com.