WRITING EFFECTIVE PLANS OF CORRECTION

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Post Survey

- Begin implementing plans immediately
- Begin collecting data for informal disputes as needed
- Survey document is a public record
  - Read citations carefully – identify the specific theme as many Ftags can be cited for many differing issues
  - Analyze to determine system failure, isolated or to be disputed
  - Answer each tag with corrections for cited examples
  - Follow the format for answering deficiencies in an organized fashion
  - See next slide – practical information

Some Practical Information

- You have 10 days to answer deficiencies on the 2567 – which is why it is important begin analysis and collection of data prior to receiving 2567
- You will likely have 45 days to complete your action plan and implementation process – total of approximately 60 days from survey exit
- Failure to submit an acceptable plan of correction within the acceptable time frames can result in penalties.
- Saying: “We are requesting an informal dispute” is NOT an acceptable plan of correction.
- There is documentation criteria
“Rather than the survey serving as an indicator of quality – the survey should serve as a catalyst to find out if there is truly a systemic problem in the facility that requires a quality improvement action plan.”
Demi Haffenreffer  
Haffenreffer Principles of Leadership

Overall Problem
- Is it possible to write a **sustainable quality** driven plan of correction within 10 days?  
  **NO!!** Not if it is a system issue.
- When you are resurveyed and back in compliance within 30-45 days – is it possible to know if the system you implemented is creating the results you want?  
  **NO!!**

Analysis
- Is the citation accurate?  
- Is it disputable?  
- If disputable, begin collecting data – however plan of correction is still required.  
- Is it isolated or a system issue?
This RULE is not met as evidenced by:
Based on interview and record review it was determined the facility failed to:
Investigate to rule out the possibility of abuse and report an injury of
unexplained origin to the local AAD office for one of 14 sampled residents
(resident 1) who experienced an injury of unknown cause. Findings
include but are not limited to:
Resident 1 was admitted to the facility in 11/2010 with diagnoses including
Alzheimer’s disease.
During the survey on 12/11 and 12/29, Resident 1 was observed to
require total assistance with ADLs in the NMU.
The resident was escorted to meals and activities in a wheelchair.
The resident slept most of the day in a unoccupied bed or recliner.
Progress notes dated 9/12/13 noted “resident fell possibility in right
waist” on 9/12/13. “Resident has a cut and small bruise on [blank] left
hand.”

<table>
<thead>
<tr>
<th>Date</th>
<th>Section</th>
<th>Code</th>
<th>Findings</th>
</tr>
</thead>
</table>
| 12/29/13   | A0503   | C.090| There was no documented investigation of the cause of the resident’s right
waist or left hand bruise to rule out the possibility of abuse and
reporting
an injury of unknown cause to the local AAD office or the local AAA.
During an interview on 12/29 at 18:26, staff 1 (administrator) was not
aware that the resident was documented as having bruising. Staff
1 confirmed there were no investigations done to rule out abuse and
SPD was not notified.  

C.090

C.035

C.020

C.020  

C.020

C.020

C.020

C.020  

C.020

C.020

C.020

C.020
PLANS OF CORRECTION

Documentation Criteria

1. How will each cited example be corrected?
2. How will other residents be identified who may have issues similar to deficiency examples cited be found & corrected?
3. How will the system be corrected (plan of correction)?
4. How will citations be prevented and plan of correction monitored (QA)?
5. Who is responsible?
6. By what date will the plan be implemented? (compliance date)
How will each cited resident example be corrected?

- Plan of correction for each resident example specifically cited on the survey
- If no specific residents cited you must identify just what you have done relating to citation
- These are actions that will need to be placed on an action plan with specific responsibilities assigned to ensure specific corrections for specific residents are completed and well documented
- Example: Resident 1 was cited for pain management issues. Answer might state the resident was reassessed and care plan updated – or – if cited for wrong diet, answer might state resident diet was corrected.

How will other residents be identified with similar issues and corrected?

- I call this the work of the citations – auditing records, residents, staff in the context of the citation for issues similar to the cited examples and citation.
- Sometimes it might be easier to just say: “We consider all residents with (falls, skin issues, etc.) to be a risk relating to this citation and therefore will reassess all by compliance date.”
- Example: Resident was cited for having an inaccurate diet. Answer might state that all resident diets will be checked for accuracy – or – if resident cited for pain management you might say residents who have pain have been identified and reassessed using new process & see poc below.

How will the system / process / outcome be corrected?

- This is your plan of correction
- Reviewing and making no changes to systems and processes but perhaps reinforcing through ……..
- Modifying systems and processes – how, what, when and by whom
- Changing systems and process
- Trainings should be identified by date and who conducted
- Example: We have implemented a new process for pain management that includes the following:………….. Licensed Nurses are being educated on the process prior to implementation by……………- or – we have implemented a new process for communication of new diet orders to dietary that includes the following …….. + education, etc.
How will future issues be prevented and monitored?

- Quality Assurance and Performance Improvement Plan
  - Describes monitoring, how often and who will conduct
  - Example: We are using our Quality Measures monthly to identify residents with pain for review and will determine if pain management process has been followed. Reports on continued compliance will be provided to the QAPI committee quarterly. Director of Nursing is responsible.
  - Or – diet accuracy will be checked monthly by comparing all resident diets to physician orders. Inaccuracies will be tracked, trended and analyzed and action plans implemented immediately. Reports will be provided to QAPI committee quarterly. Dietary manager is responsible.

Additional Criteria

- Completion Date
- Responsibilities

Plan of Correction Example

1. Resident 4 – A root cause analysis of this resident’s fall on 1/31/12 has been completed. In addition a comprehensive fall assessment has been completed & care plan updated.
2. We have reviewed notes of 100% of all residents to identify additional residents who may have had falls or incidents requiring investigation or assessment. We will investigate as fully as possible and/or conduct a comprehensive assessment to implement care interventions to prevent further similar issues. We will report any issues as per requirements.
Plan of Correction

3. We have reviewed and will update our entire system / policies for documenting and investigating changes in condition and injuries of unknown origin. Our Staff Developer will educate all staff on the requirements related to abuse & neglect. Our Staff Developer will educate all nursing staff on their roles and responsibilities related to the new policies. All education will be completed by compliance date.

Plan of Correction

4. We have developed a checklist called a condition change audit that includes a review of clinical record and 24 hour report documentation on a random sample of 20% of census that will be performed weekly until we reach 100% compliance. The sample will be expanded as needed based on results of audits. The audit contains specifics from the requirements & our policies.

5. The DON is responsible for implementation of policies; the Unit Managers are responsible for ongoing compliance.

6. Compliance date is 3/1/12

Principles of Documentation

- This is a public document and requires a certain amount of attention to correct English, good spelling & use of abbreviations or acronyms that may not be recognized by the lay person
- Consider having an Attorney review your plan of correction
- Facilities often place a statement on the survey stating that “By answering this plan of correction, the facility does not allege that a deficiency existed at the time of the survey.”
- Return the plan of correction in accordance with the date specified (usually ten days from receipt).
- Post it!
Principles of Documentation

- The plan of correction should represent reality – stand behind your plan of correction.
- Involve teams in developing plans and implementing – but have a point person
- Use the survey corrections to develop an action plan (next slide)
- Meet daily to discuss progress

Action Plans

Implementing programs involves more than just putting forms out for nurses to complete!!

It starts with a PLAN!!

<table>
<thead>
<tr>
<th>Task</th>
<th>Responsible Person(s)</th>
<th>Completion Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse Citation:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Develop Policies</td>
<td>QA team</td>
<td>2/1/12</td>
<td></td>
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<tr>
<td>- Educate Staff – see</td>
<td></td>
<td>3/1/12</td>
<td></td>
</tr>
<tr>
<td>inservice list</td>
<td>Staff Developer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 100% audit for past month</td>
<td>Unit Managers</td>
<td>1/27/12</td>
<td></td>
</tr>
<tr>
<td>to identify other resident incidents for investigation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- See resident specific list</td>
<td>Unit Managers</td>
<td>3/1/12</td>
<td></td>
</tr>
<tr>
<td>- See QA checks – change of</td>
<td>DNS / Unit Managers</td>
<td>Weekly X4</td>
<td>then q month</td>
</tr>
<tr>
<td>condition audit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inservice list:</td>
<td>Staff Developer</td>
<td>3/1/12</td>
<td></td>
</tr>
<tr>
<td>Resident Specific list:</td>
<td>Unit Managers</td>
<td>3/1/12</td>
<td></td>
</tr>
</tbody>
</table>
### Inservice List

<table>
<thead>
<tr>
<th>Inservice</th>
<th>Who should attend</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse requirements</td>
<td>All staff</td>
<td>2/10/12</td>
</tr>
<tr>
<td>Policy and Procedures</td>
<td>Nursing staff</td>
<td>2/17/12</td>
</tr>
</tbody>
</table>

### Resident Specific List

<table>
<thead>
<tr>
<th>Resident Name</th>
<th>What needs to be done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident 4 = May West</td>
<td>Investigate incident of 1/31/12, Assess falls using CAA 11 (falls) and update care plan</td>
</tr>
<tr>
<td>Resident 1 = Charles Dickens</td>
<td>Reassess skin risks and update care plan</td>
</tr>
</tbody>
</table>

### Implementing Action Plans

- Implement based on analysis and major causes
- Engage many voices in analysis and implementation plan
- Begin with the documented policies & procedures to use for education of your staff
- Educate your staff first then implement
- Implement – YOU implement or start the program for them
- Implement FULLY – if new forms make out all new forms – throw away old forms and policies – update care plans
Implementing Action Plans

• Don’t expect 100% compliance immediately.
• Audit for problems with the system vs re-education of staff – provide education &/or make changes to program as needed.
• Keep all the promises you made on the survey

Implementing Action Plans

• If you need to change the plan of correction, call the surveyors to make changes to your plan or date of compliance (as possible)
• Conduct a presurvey – Checks should occur daily after the compliance date.
• Any errors after compliance date can leave you out of compliance

Evaluating the Plan of Correction

• Compliance does not mean you have solved the issue – continue evaluating, updating, and educating as needed.
• It takes 5-7 points of data to establish the stability, success or failure of a system.
Other tips

- Review all other policies and/or procedures that may be cited under this same citation.
- Examples for the citations we were examining
- Put a survey book together to provide to the surveyors that contains copies of all policies, procedures, inservices (and who attended), assessments, care plans as per plan of correction.

Questions?
Resource

Idaho Bureau of Facility Standards Workshop

Writing Acceptable Plans of Corrections
(For Intermediate Care Facilities for Persons with Intellectual Disabilities)

http://healthandwelfare.idaho.gov/Portals/0/Medical/Licensing/Certification/ICFIDWritingAcceptablePoCs.pdf

www.consultdemi.net
Appendices
The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

[Handwritten text crossed out and replaced with new text]

F321 Continued from page 14

On 3/14/16 at 12:37 pm, Staff 7 stated he believed the Novolog insulin was long acting and the residents did not need to eat for an hour and a half to two hours after administration.

In a 3/20/16 follow-up interview at 10:15 am, Staff 7 confirmed the self-made card contained incomplete sliding scale orders for Resident 36. Staff 2, DNS, and Staff 11, RN/CM, indicated the use of the laminated card was inappropriate. Staff 7 told them of the practice on 3/14/16 and the card was destroyed.
This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure adequate supervision to prevent an accident for 1 of 3 sampled residents (#23) reviewed for accidents. This practice resulted in Resident 23 sustaining a fall during care and placed all residents at risk for experiencing avoidable falls. Findings include:

Resident 23 admitted to the facility in 9/2009 with diagnoses including cerebrovascular disease, urinary incontinence, and dementia.

The significant change MDS dated 10/10/14 documented Resident 23 required extensive, two person physical assistance with bed mobility. The ADL CAA dated 10/24/14 identified Resident 23 required extensive total assist with bed mobility and ADL care. Resident 23 was noted to have limited range of motion related to a left arm contracture, had an inability to bear weight related to
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 323</td>
<td>Continued From page 16 neuropathy, and an inability to fully straighten the legs. The Fall CAA included Resident 23 made no attempt to get out of bed independently. The facility care plan directed staff to follow the in room care plan and was revised on 10/6/14 to include, &quot;Assist with repositioning...2 person to reposition in bed.&quot; The in room care plan was revised on 10/6/14 and directed staff to, &quot;Assist with repositioning...2 person to reposition in bed.&quot; A 3/14/15 progress note completed by Staff 13, LPN, documented Staff 14, CNA, reported Resident 23 fell out of bed. Staff 14 repositioned Resident 23 in bed to change an incontinent brief and Resident 23 then rolled out of the bed and onto the floor. Resident 23 sustained bruising to the head and face and an abrasion to the lower back. There was not a second staff member present to assist Staff 14 per Resident 23’s care plan. Subsequent monitoring documented no further changes in condition in Resident 23.</td>
<td>F 323</td>
</tr>
<tr>
<td>ID PREFIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES</td>
<td>ID PREFIX TAG</td>
</tr>
<tr>
<td>---------------</td>
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</tr>
<tr>
<td>F 323</td>
<td>Continued From page 17</td>
<td>F 323</td>
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<tr>
<td></td>
<td>There was no evidence in Resident 23’s record to indicate Staff 13 or Staff 14 identified the care plan was followed.</td>
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<td></td>
<td>On 3/19/15 at 1:40 pm, Resident 23 was observed in the dining room with bruising to the forehead and left eye area.</td>
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<td>On 3/19/15 at 10:40 am, Staff 16, CNA, and Staff 17, CNA, reported Resident 23 was a one person assist with bed mobility. Staff 16 and 17 believed the care plan was not changed to include a two person assist for bed mobility for Resident 23 until the 3/14/15 incident.</td>
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<td></td>
<td>On 3/19/15 at 10:40 am, Staff 15, RNCM, stated Resident 23 was care planned for two person assist since October of 2014 after Resident 23 experienced a decline in condition. Staff 15 identified Staff 14 had not followed the care plan when providing care alone and this resulted in Resident 23 falling out of bed.</td>
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<tr>
<td></td>
<td>On 3/20/15 at 9:16 am, Staff 2, DNS, reported Staff 14 was under the impression the resident was a one person assist for bed mobility and did not follow Resident 23’s care plan when the Incident Occurred.</td>
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</table>
Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.

This **requirement** is not met as evidenced by:

Based on observation, interview and record review, it was determined the facility failed to prepare food by methods that conserved nutritive value, flavor and appearance for 6 of 13 sampled residents (#s 14, 39, 49, 75, 88, 159) reviewed for food quality. This placed residents at risk for an unsatisfactory dining experience and unmet nutritional needs. Findings include:

During resident interviews on 3/17/15, the following resident comments were made regarding food:

- Resident 14 stated the food was usually served cold and the pureed food looked unappetizing.
### Statement of Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>(X1) Provider/Supplier/CLIA Identification Number:</th>
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</thead>
<tbody>
<tr>
<td>[Redacted]</td>
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<table>
<thead>
<tr>
<th>(X2) Multiple Construction</th>
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<tbody>
<tr>
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<tr>
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<table>
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<tr>
<th>Wing:</th>
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<td>[Redacted]</td>
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<table>
<thead>
<tr>
<th>(X3) Date Survey Completed</th>
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</thead>
<tbody>
<tr>
<td>03/20/2015</td>
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</table>

<table>
<thead>
<tr>
<th>(X4) ID Prefix Tag</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
</tr>
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<tbody>
<tr>
<td>F 364 Continued From page 25</td>
</tr>
<tr>
<td>- Resident 39 said she/he had not had a hot breakfast in a long time and finally gave up complaining about it.</td>
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<tr>
<td>- Resident 49 described the food quality as &quot;lousy&quot; and usually served cold.</td>
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<tr>
<td>- Resident 75 complained of meals served cold and without any flavor or texture, &quot;just pasty.&quot;</td>
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<tr>
<td>- Resident 88 stated the cream of wheat was served cold and the meals were dry and flavorless.</td>
</tr>
<tr>
<td>- Resident 159 said the food was unappealing, cold, and generally tasted lousy.</td>
</tr>
</tbody>
</table>

During breakfast observations on 3/18/15, Resident 39 motioned for a surveyor to come to the table and reported the breakfast served in the dining room was cold.

On 3/18/15, at 8:05 am, a test tray was requested and sampled for palatability and temperature. Seven surveyors sampled items on the test tray, which included both a regular and a puree consistency meal. The observations included:

- The scrambled eggs were lukewarm, tasteless, and with a paste like
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 364</td>
<td>Continued From page 26 consistency. * The toast served was soggy, chewy, and flavorless. * The sausage patty was oily and salty, with bits of gristle. * The pureed meal consisted of three unattractive puddles on a plate. * The pureed toast had a batter-like, gritty texture. * The pureed eggs were bland and unseasoned. * The pureed sausage salty and oily. None of the food on the test tray was served hot. The pureed meal was colorless and unappetizing in appearance. On 3/18/15 at 8:30 am, Staff 4, Dietary Supervisor, observed the test tray meals with the survey team and acknowledged the food quality could be improved. Staff 4 stated she was aware of some resident food complaints. On 3/18/15, at 11:05 am, Staff 4 and Staff 1, Assistant Administrator, reported the steam table was examined and found to have a burned out heating element.</td>
<td>F 364</td>
<td></td>
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