



**DPHHS**  
**QUALITY ASSURANCE DIVISION**  
**CERTIFICATION BUREAU**  
**Presents**

**PLANS OF CORRECTION:  
THE UNVARNISHED TRUTH!**

# LEARNING OBJECTIVES:

- ◉ What is a Plan of Correction (PoC)?
- ◉ Why are they necessary?
- ◉ When does the facility need to complete one?
- ◉ How does the facility complete one?
- ◉ What happens after the PoC is completed?
- ◉ What happens if a PoC is unacceptable?
- ◉ Where can the facility get help to complete an acceptable PoC?

# WHAT IS A POC

- ◉ The PoC is the facility's response to the survey deficiency findings
- ◉ The PoC is the facility's venue for demonstrating how substantial compliance will be attained after they review the survey findings
- ◉ The PoC should be completed and submitted to the State Agency (SA) within 10 calendar days of receiving the 2567 (The Statement of Deficiencies Form)
- ◉ The PoC is an opportunity to investigate why noncompliance occurred and how it can be remedied and prevented from reoccurring in the future (a learning opportunity)

# WHY ARE POC NECESSARY?

- ◉ The regulation emphasizes the need for **continued**, rather than cyclical compliance. The enforcement process mandates that policies and procedures be established to remedy deficient practices and to ensure that **correction is lasting**; specifically, that the facilities take the initiative and responsibility for **continuously monitoring their own performance** to sustain compliance.
- ◉ Measures such as the requirements for an acceptable PoC emphasize the ability to achieve and maintain compliance leading to improved quality of care.
- ◉ The PoC is required by Center for Medicare and Medicaid Services (CMS) and it serves as the facility's allegation of compliance. Without it, CMS and the SA can not verify compliance with the federal and state regulatory requirements.

# WHEN DOES THE FACILITY NEED TO COMPLETE A POC

- ◉ The facility will be directed to complete the PoC within 10 calendar days of receiving a 2567 with listed deficiencies.
- ◉ A letter accompanying the 2567 will address the requirements of the PoC, including the **five criteria** that need to be addressed in the PoC.
- ◉ If an acceptable PoC is not received within 10 calendar days, the SA will notify the facility that it is recommending to the RO imposition of category 1 remedies and/or denial of payment for new admissions.

# HOW DOES THE FACILITY COMPLETE A POC

- ◉ The facility follows the instructions for writing the PoC that is included in the letter accompanying the 2567.
- ◉ A template and directions are also available on the Division web site that will help you to complete the PoC in a word document and print it on the 2567.
- ◉ The Division web site is:  
<http://www.dphhs.mt.gov/qad/certindex.shtml>

# EXAMPLE #1

## STANDARD MENUS AND NUTRITIONAL ADEQUACY - F363

REGULATION: CFR 483.35 (c) requires that the menus: (1) must meet the nutritional needs in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Science. (2) must be prepared in advance; and (3) must be followed.

# MENUS AND NUTRITIONAL ADEQUACY

## F363

**CITATION:** Based on observation, staff interview, and record review, the facility did not ensure appropriate menu items were prepared and served to those residents who were prescribed 2 gram sodium diets. Findings Include:

On 1/5/09 at 11:35 a.m. the noon meal service was observed in the kitchen. When asked, the cook stated that there were 5 residents with 2 gram sodium diet orders. Per record review of the standardized menus for this meal, the residents with regular diets were to receive 4 ounce of ham; and the residents with 2 gram sodium diets were to receive homemade pork chops.

The surveyor observed that there were no pork chops in the hot holding unit. When asked, the cook stated she did not prepare any homemade pork chops for the 2 gram sodium diets, because, she did not have any pork chops due to the problems with the recent food order. The cook served ham to all of the residents.

## MENUS AND NUTRITIONAL ADEQUACY

### F363

- ◉ The facility was to follow the pre-approved and standardized menus (which included the recipes for all of the menu items that were listed in the menu spread sheets for the **therapeutic diets**), but failed to do so.
- ◉ With all dietary issues, the facility should seek the guidance of a consulting dietitian in the preparation, execution, and the evaluation of the PoC.

## **CRITERIA #1**

### **HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE**

- ◉ Since the above problem had already happened, the facility can't change anything at this time.
- ◉ The facility could write on their PoC that the standardized menus will be followed; and all residents with therapeutic diets will receive appropriate food items from now on.

## CRITERIA #2

### HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS WITH THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE

- ◉ The PoC must indicate that the facility identified all residents with therapeutic diets who could be at risk as a result of this deficient practice by reviewing all the therapeutic diet orders and monitoring the meal services to ensure the accuracy of meal preparation and service.

## CRITERIA #3

### WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR

- ◉ For example, the facility might provide **in-service training** to the dietary staff who purchase, prepare and serve the food. This may involve clarification on how to use the recipes and the menu spread sheets in purchasing; and education on therapeutic diets and disease process.
- ◉ The facility may consider other systemic changes to ensure that the problem does not occur again. Most dietary issues require **staff retraining, reallocation of kitchen tasks, review of the food inventory and purchasing, updating food preparation forms, and to improve communication issues between nursing and the kitchen staff.**
- ◉ The selection and identification of the appropriate steps to the systemic change would depend on the underlying issue that caused the deficiency. The facility must implement **periodic audits** to ensure that the correction is achieved and sustained. The facility may decide to audit 3 meals per week for 3 months; or 6 meals per week for one month, until mistakes are diminished or resolved. This would have to be clearly indicated on the POC document. **The audits must be documented and made available to the surveyors during the revisit.**

## Systemic Change:

**Additional examples of measures used to implement systemic changes can also include:**

- Use of consultants or contractors for repairs or new installations
- Development of interdisciplinary or multi-level quality improvement teams
- Resident council input
- Ombudsman input
- Physical Environment enhancements
- Expansion of staff number/qualifications
- Staff reassignment
- Job description reviews
- Addition of new tasks
- Creating new tools and forms, updating the existing tools
- In-service training
- Off-site training

## CRITERIA #4

HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THIS PLAN SHOULD INCLUDE WHICH STAFF WILL BE RESPONSIBLE FOR MONITORING THE ONGOING EFFECTIVENESS OF THE SYSTEMIC CHANGES TO ENSURE CORRECTION IS SUSTAINED.

- ◉ In this section the facility **must** address that the results of the routine checks/audits were to be submitted to the Quality Assurance & Assessment (QAA) team for **further assessment, evaluation, and analysis of the effectiveness of the PoC**. Regardless of the name that the QAA is given such as CQI, QA, Review Board, etc.; the team makeup must meet the requirements of federal regulations. (F520 for LTC)
- ◉ The surveyors will ask for the QA team meeting notes at the time of the revisit survey to ensure that the facility established a plan that worked. Again, good documentation is necessary. Your QA team may meet more frequently than usual (i.e. monthly) to monitor the effectiveness of your PoC. Remember you are in a time crunch to get back into full compliance.

## CRITERIA #5

FOR EACH DEFICIENCY, INCLUDE DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED. THESE DATES MUST NOT EXCEED 60 DAYS FOR THE OPPORTUNITY TO CORRECT.

- ⦿ Completion date **must be a specific date**, although not all tags need to have the same correction date.
- ⦿ Completion date must be within **60 days of the last day** of the survey. It's best not to wait 59 days to correct the problem so we have time to resurvey your facility and put the facility back in compliance before the 60 days.
- ⦿ The opportunity to correct means that **enforcement will not begin** unless the corrective action is not completed before the 61<sup>st</sup> day.
- ⦿ You can't use the **survey date** for any of the PoC issues, although the corrections may have been completed during the survey

## EXAMPLE #2:

### FIRE LIFE SAFETY

#### FIRE/SMOKE RESISTANCE OF VERTICAL CONSTRUCTIONS- K20

REGULATION: Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6, 19.3.1.1

## K20 FIRE/SMOKE RESISTANCE OF VERTICAL CONSTRUCTION

**CITATION:** Based on observation, the facility failed to ensure 1-hour rating of the vertical construction. Findings include:

On **12/8/09** at 7:40 a.m., a large pile of bagged soiled laundry was observed blocking the basement linen chute door in a closed position. When the bagged laundry was removed and the chute door was exercised, the door would not close and latch. The self closure device on the door did not operate properly.

## **FIRE LIFE SAFETY**

### **CRITERIA #1**

- The chute door was repaired.
- The chute door now latches securely.

## **FIRE LIFE SAFETY**

### **CRITERIA #2**

- This was the only chute door in the facility, and it now latches securely.

## **FIRE LIFE SAFETY**

### **CRITERIA #3**

- The maintenance director will examine the chute door weekly for 6 weeks and thereafter as determined necessary on Preventative Maintenance Rounds.

## **FIRE LIFE SAFETY**

### **CRITERIA #4**

- As a result of the audits, any identified problems will be corrected immediately and the concerns with the process will be reported to the QA Committee as needed. The Maintenance Department will maintain compliance.

## **FIRE LIFE SAFETY**

### **CRITERIA #5**

- ◉ Plan of Correction date is 1/1/2010.
- ◉ (This becomes the PoC completion date).
- ◉ You can't use the date 12/8/09 on the PoC, even if you corrected this problem on that day of the survey. However, 12/9/09 is an acceptable date on the PoC.

## WHEN THE FACILITY HAS A LIFE SAFETY CODE DEFICIENCY THAT WILL TAKE LONGER THAN 60 DAYS TO CORRECT

- ◉ The SA can issue a temporary waiver for items that may take a contractor some time to install such as new door, sprinkler, etc. under life safety code deficiencies only.
- ◉ You can submit a temporary waiver request letter (on facility's letterhead) for this one time with the facility PoC.
- ◉ Requests should also include estimates and invoices from contractors for the materials ordered.
- ◉ Temporary time waivers are issued for up to six months based on complexity of work to be done.
- ◉ Correction of deficiencies that will take longer than six months to correct will require a temporary waiver from CMS and should be applied for as soon as possible. Similar documentation as mentioned above would be required.

## WHAT HAPPENS AFTER THE POC IS COMPLETED

- ◉ PoC is submitted and reviewed in our office either by a surveyor or a supervisor.
- ◉ You may be asked to provide additional information or clarification before the PoC is accepted.
- ◉ If the PoC is acceptable, you will receive a letter stating the same.
- ◉ Revisit survey will be completed after your PoC is accepted. This will be by mail or by an onsite visit. The substantial compliance is assumed as of the latest PoC completion date.

# WHAT HAPPENS IF A POC IS UNACCEPTABLE

- ◉ If the PoC is unacceptable, the SA will notify you in writing or by phone as to why the PoC was not accepted.
- ◉ Frequently, the PoC is unaccepted, when one of the 5 criteria is not addressed or the survey date is used in the PoC.
- ◉ The provider needs to correct the issue and resubmit the new PoC to the agency for approval as soon as possible.

# DISCLOSURE

- ◉ The official Statement of Deficiencies (CMS-2567) is released to the public as soon as you received it.
- ◉ After an approved PoC is submitted, both portions are to be released simultaneously since they appear on the same form.
- ◉ If you submit your revisit documents with your PoC, those documents must be released for public view as well.

# WHERE CAN THE FACILITY RECEIVE HELP COMPLETING THE POC

- ◉ Quality Assurance Division (Certification and Licensure Bureaus)  
[mtssad@mt.gov](mailto:mtssad@mt.gov)
- ◉ Quality Assurance Division Web Site  
<http://www.dphhs.mt.gov/qad/index.shtml>
- ◉ Do not hesitate to call if you have questions  
406-444-2099



# REMEMBER!

- ◉ This is an opportunity to review the systems and make changes to improve the quality of care in your facility.
- ◉ This is an opportunity to analyze systems in your facility that may need to be refined and/or redesigned.
- ◉ The PoC planning and execution should not be any different than your own QA process.
- ◉ The Quality Assurance Division staff is here to help
- ◉ Contact us! 406-444-2099 or [mtssad@mt.gov](mailto:mtssad@mt.gov)

# THANK YOU!

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