When State Shows Up…
Hospital Surveys

Medical Facilities Service

Protective Health Services

Oklahoma State Department of Health

Objectives

- Introduce the Medical Facilities Service Team
- Differentiate between Licensure and Certification
- Discuss State and Federal Roles
- Review Survey Processes
- Describe Life Safety Code and Emergency Preparedness
- Examine Frequently Cited Deficiencies
- Share Tips on Writing Plans of Correction

Leadership

- Interim Commissioner
  Tom Bates
- Chief of Staff
  Brian Downs
- Deputy Commissioner of Protective Health Services
  Rocky McElvany
- Service Director of Medical Facilities Services
  Julie Myers, DrPH, CPHQ
- Assistant Service Director of Medical Facilities Services
  LaTrina Frazier, PhD, MHA, RN

Service Area Managers

- Health Survey & CLIA
  Terri Cook
- Life Safety & Compliance
  Nena West
- Enforcement, Complaints & Stroke
  Andrea Jordan
- Emergency Medical Services
  Dale Adkerson
- Trauma System Improvement and Development
  Grace Pelley

MEDICAL FACILITIES SERVICE

FACILITIES SERVICES
- HOSPITALS
- AMBULATORY SURGICAL CENTERS
- CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988 (CLIA)
- RURAL HEALTH CLINICS
- PORTABLE X-RAY
- COMPREHENSIVE OUTPATIENT REHABILITATION FACILITES (CORF)
- REHABILITATION AGENCIES
- WORKPLACE DRUG & ALCOHOL TESTING FACILITIES
- BIRTHING CENTERS
- ABORTION FACILITIES
- TISSUE & EYE BANKS-ANATOMICAL GIFTS

HOME SERVICES
- HOME CARE (LICENSURE)
- HOME HEALTH (FEDERAL)
- COMPANION SITTER SERVICES
- HOSPICE AGENCIES
- END STAGE RENAL DISEASE

SURVEY & COMPLIANCE
- LIFE SAFETY CODE – HOSPITALS
- LIFE SAFETY CODE – AMBULATORY SURGICAL CENTERS

ENFORCEMENT & REVIEW*
- COMPLAINTS-NON LONG TERM CARE*
- STROKE*

**Under the purview of the regulatory authority manager for the respective program area.*

HEALTH FACILITIES PLAN REVIEW
- HOSPITALS
- AMBULATORY SURGERY CENTER
- INPATIENT HOSPICE FACILITIES
- LONG TERM CARE FACILTIES

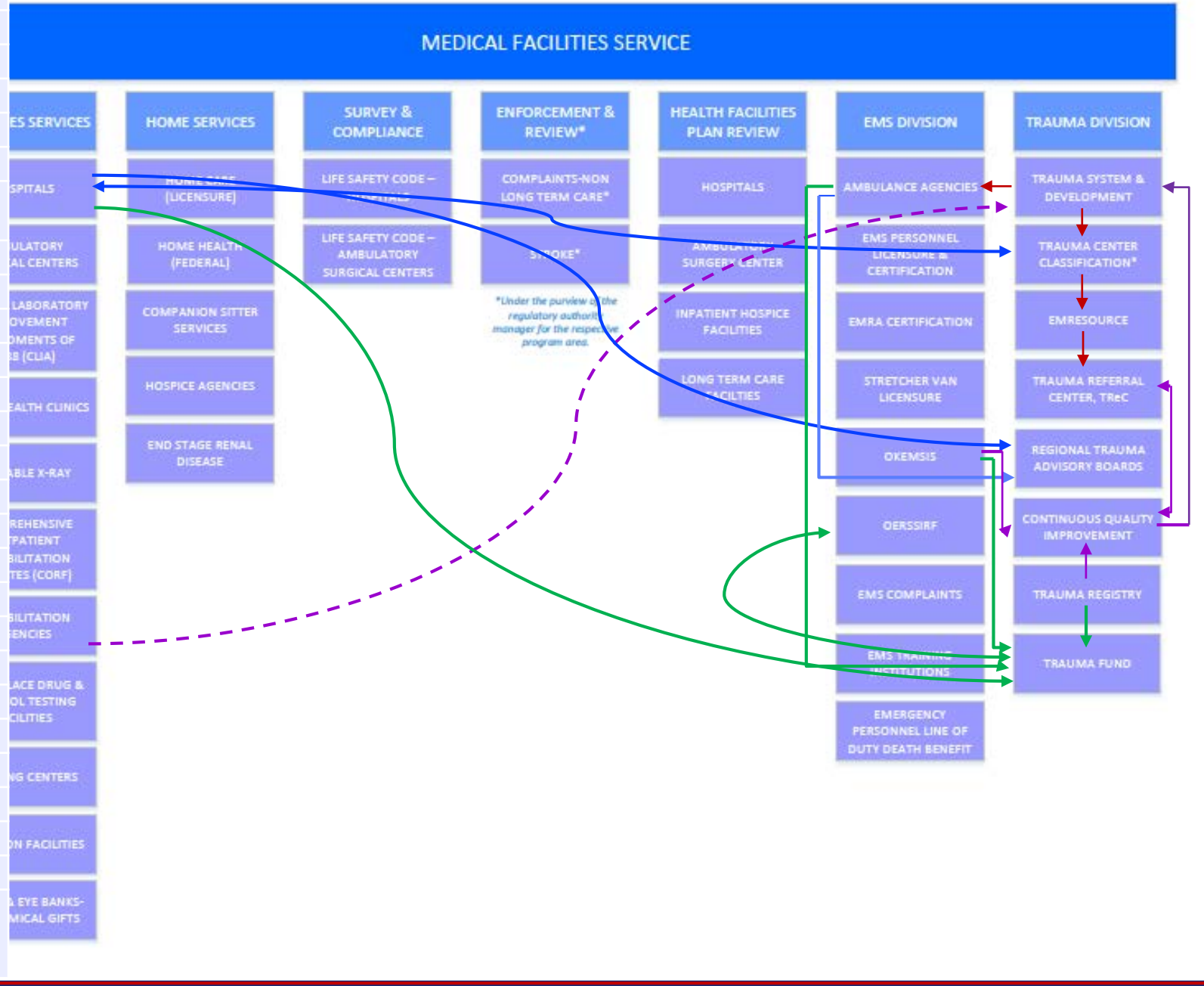
EMS DIVISION
- AMBULANCE AGENCIES
- EMS PERSONNEL LICENSURE & CERTIFICATION
- EMRA CERTIFICATION
- STRETCHER VAN LICENSURE
- OKEMSIS
- OERSSIRF
- EMS COMPLAINTS
- EMS TRAINING INSTITUTIONS
- EMERGENCY PERSONNEL LINE OF DUTY DEATH BENEFIT

TRAUMA DIVISION
- TRAUMA SYSTEM & DEVELOPMENT
- TRAUMA CENTER CLASSIFICATION*
- EMRESOURCE
- TRAUMA REFERRAL CENTER, TReC
- REGIONAL TRAUMA ADVISORY BOARDS
- CONTINUOUS QUALITY IMPROVEMENT
- TRAUMA REGISTRY
- TRAUMA FUND

Number	Type
4	Abortion Facilities
49	ASCs
3798	CLIA
7	Community Mental Health Centers
0	CORF
165	Emergency Medical Response Agencies (Ambulance Service)
197	EMS Ambulance Services
10	EMS Stretcher Vans
10725	EMS personnel Licensure (Paramedic)
78	ESRD
375	Home Health
32	Companion Sitter
127	Hospice
166	Hospitals
8	LTC CMP Fund Program
19	Mobile X-Ray
31	OPT
	Plan Review for all healthcare facilities
16	Psychiatric Residential Care Facilities
80	RHC
	Stroke
9	Tissue and Eye Banks
104	Trauma & Emergency Operative Services classification
236	Workplace Drug & Alcohol Testing Facilities
448	EMResources (# resources)

All data as of 2/11/2019

16,684



Licensure & Certification

Terri Cook

Objectives

- Differences between state licensure and federal certification
- Types of surveys
- Levels of deficiencies
- Survey process
- Top 5 deficiencies
- How to determine compliance
- Guidance for plans of corrections

General Definitions & Acronyms

- **CMS** - Centers for Medicare/Medicaid Services – The entity designated by the Secretary of the Department of Health and Human Services to administer the standards of compliance aspects of the Medicare/Medicaid programs.

- **CMS RO** – Centers for Medicare/Medicaid Regional Office.

- **SA or SSA** - State Agency (Oklahoma) or State Survey Agency – Oklahoma State Department of Health/Protective Health Services.

- **AO -** Accreditation Organization – an entity approved by CMS to be qualified to "deem" a facility to be or not to be in compliance with CMS conditions to participate in the Medicare/Medicaid program.

General Definitions & Acronyms continued

- **Deemed vs. Non-Deemed Facilities** –
  - Deemed facilities gain initial certification and continued certification (if "deemed" to be in compliance (meet or exceed) with CMS conditions to participate) through an Accreditation Organization survey process.
  - Non-deemed facilities gain initial certification and continued certification through the state agency survey process.
- **Survey –** A process to determine if a facility meets CMS' conditions to participate or state licensure regulations.
  - Health Survey – a process to determine if a facility meets the minimum health standards set by CMS in its conditions of participation.
  - Life Safety Code (LSC) Survey – a process to determine if a facility meets the minimum life safety standards set forth by National Fire Protection Association (NFPA)

General Definitions & Acronyms continued

- **CMS-2567** – Survey Report aka Statement of deficiencies (SOD) and plan of correction (POC).
- **SOM** - State Operations Manual– CMS guidelines for state survey agencies that outline the survey process, conditions of participation based on the Code of Federal Regulations.
- **63 O.S. § 1-701** - Title 63 of the Oklahoma Statutes Section 1-701 et. seq.– Oklahoma Law governing the licensure of hospitals in Oklahoma.
- **OAC 310:667** - Oklahoma Administrative Code 310 Chapter 667 – Rules promulgated by the Board of Health as authorized in Title 63-1-701 for hospital licensure standards.

General Definitions & Acronyms continued

- **QAPI** – Quality Assurance and Performance Improvement. One of the Conditions of Participation.

- **PIP** – Performance Improvement Projects. It's a part of the larger QAPI process.

- **CoP** - Conditions of Participation – Federal regulation which certain healthcare facilities must comply in order to participate in (receive funding from) the Medicare/Medicaid programs.

General Definitions & Acronyms continued

- **IJ** – Immediate Jeopardy. A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a patient/resident.

- **POC** - Plan of Correction – A detailed plan developed by the facility and approved by CMS or the state survey agency that describes the actions the facility will take to correct deficiencies and specifies the date by which those deficiencies will be corrected.

CMS Regional Office (RO) Role

ROs have the job of assuring that health care providers and suppliers participating

- Medicare, Medicaid, and CLIA

Meet applicable Federal requirements. This is accomplished through various activities.

Licensure: State Agency Roles

- Issue licenses to persons or entities found to be in compliance with the state law and rules and who have provided appropriate application and required filing fees.

- Survey/inspect facilities for compliance with the requirements for licensure found at Title 63 O.S. Section 1-701 et seq. and rules promulgated by the Board of Health under Oklahoma Administrative Code 310 Chapter 667.

Medicare Certification: State Agency Roles

- Provide contracted services to CMS:
  - Acts as a conduit between the Fiscal Intermediary (FI) and CMS to gather required forms from providers, verify information contained on those forms, and make recommendations on certification actions such as changes of ownership, changes of information, and initial Medicare certification.
  - Survey and investigate certified facilities to determine compliance with Conditions of Participation.
  - Make recommendations for continued certification based on survey findings.

Accreditation Organization Role (Federal Deemed Status)

- Conduct deeming surveys on hospitals who choose to gain and/or maintain certification through a deeming process.
- Notify CMS of their recommendation for certification or continued certification.

Common Question on Deemed Status

- What does deemed status mean?
- If we have a license, can we be deemed?
- If we are not deemed, can we get Medicare/Medicaid Money?
- If we are deemed – with our accrediting organization, then why does the state show up on complaints?

What's the big deal about Medicare Certification (CMS) ?

- CMS is the single largest payer for health care in the United States.
- Nearly 90 million Americans rely on health care benefits through Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP).
- Medicare Certification is a voluntary program, which CMS monetarily reimburses hospitals (and other healthcare facilities), who have been found to meet the Conditions of Participation (COP).

Types of State Surveys

- State Licensure:
  - Initial
  - Relicense
  - Complaint
  - Revisit

FAQ: I just built my hospital (or a new unit/service at my hospital). When will the state conduct the health survey so we can serve patients?

Answer: The state will conduct a plan review inspection upon the facility notifying the Department that all construction and design requirements are met.

- OSDH will issue a license (if applicable) or a letter stating that services may begin.
- A state licensure health survey will not occur until after patients are being served (in order to determine compliance with health standards).

Types of Federal Surveys

Federal /CMS Surveys

- Initial Certification Surveys
- Recertification Surveys
- Validation Surveys
- Complaint Surveys
- Revisit/Follow-up Surveys

FAQs

Question: I just built my hospital. When will the state conduct the health survey so we can serve patients?

Answer: For state process - The state will conduct a plan review inspection upon the facility notifying the Department that all construction and design requirements are met. OSDH will issue a license (if applicable) or a letter stating that services may begin. A state licensure health survey will not occur until after patients are being served (in order to determine compliance with health standards).

For federal process –a license and a CMS 855 recommendation for approval must be obtained first. Facility must be providing care to patients before compliance can be determined. This is Tier 4 work.

Levels of Federal Deficiencies

- Standard – Non-compliance with one or more of the standards that make up each condition of participation. If only standard level deficiencies are cited, the facility is in substantial compliance and certification may continue.

- Condition – Non-compliance of such character that substantially limits the facility's capacity to furnish adequate care or adversely affect the health or safety of patients. Certification may terminate in 90 days if not corrected

- Immediate Jeopardy (Condition Level) – A situation in which the facility's non-compliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a patient(s). Certification may terminate in 23 days if not removed and corrected.

Federal Survey Selection

- How do we determine who is surveyed?
  - How often does a hospital get surveyed?
  - What about Validation and Accrediting Organizations?
- How do we determine the survey team members?
  - Why are there two teams? LSC/Health?
  - What if a surveyor previously worked at my facility?

When State Shows Up

Entrance conference & Survey Team Leader

- Explains the purpose and scope of the survey.
- Explains, briefly, the survey process.
- Introduce survey team members.
- Clarifies that all areas/locations/departments under the hospital's provider number may be surveyed, including contracted patient care activities and services.
- Explains that all interviews will be conducted privately with patients, staff and visitors, unless requested otherwise by the interviewee.
- Ensure the facility provides surveyors ability to obtain photocopies of material, records, and other information needed.

What to expect at survey

- Obtain a location (e.g., conference room) where the team may meet privately.
- Provides a list of documents and records needed for the survey:
  - Listing of all current inpatients (room #, name, admission date, age, physician and other significant information).
  - Listing of all department heads with their locations and phone numbers.
  - Organizational Chart.
  - Names and addresses of all off-site locations operating under the hospital's provider number.
  - Infection control plan.
  - List of employees, including contracted staff.
  - Medical Staff bylaws and rules and regulations.
  - A list of contracted services.
  - A copy of the facility floor plan, indicating the location of patient care and treatment areas.

What happens next during survey

- The team will split up and go into different departments and areas of the facility to conduct observations, interviews, and review documents in the tasks they have been assigned.
- The team will select a sample of patient for observation, interview and record review.
- Sometimes closed records will be requested in order to supplement the open records reviewed to determine compliance.
- Surveyors will perform information gathering and investigation activities through observation, interview and record review.
- The team will make preliminary decisions and analyze findings based on observations, interviews, and records reviewed.
- Exit Conference. Inform the facility staff of the teams preliminary findings and the informal nature of the exit conference.

After the State Leaves the Building

- A statement of deficiencies (Form CMS-2567) will be sent within 10 working days to the hospital, along with an enforcement letter stating a possible termination date if condition level deficiencies are not corrected, or our intent to recommend to CMS that certification continues (no deficiencies or standard level only deficiencies).

Responding to the 2567

- A plan of correction must be submitted to OSDH within 10 calendar days following receipt of the statement of deficiencies (Form CMS-2567).
  - Regulations at 42 CFR 488.28(a) allow certification of providers with deficiencies at the Standard or Condition level "only if the facility has submitted an acceptable plan of Correction [POC] for achieving compliance within a reasonable period of time acceptable to the Secretary." Failure to submit a POC may result in termination of the provider agreement as authorized by 42 CFR 488.28(a) and §489.53(a)(1). After a POC is submitted, the surveying entity makes the determination of the appropriateness of the POC.

Top 5 Frequently Cited Deficiencies

- (Information based on Acute Care Hospital surveys within last Federal Fiscal Year)

#1 Tag 144 – Patient Rights: Care in Safe Setting
Tag 395 – RN Supervision of Nursing Care

#2 Tag 115 – Patient Rights (Condition)

Top 5 common COP citations (cont)

#3 Tag 385 – Nursing Services
Tag 749 – Infection Control Program

#4 Tag 123 – Patient Rights: Notice of Grievance
Tag 450 – Medical Records

#5 Tag 118 – Patient Rights: Grievances
Tag 145 – Patient Rights: Free From Abuse/Harassment
Tag 263 - QAPI

How we determine compliance

- The state agency follows CMS guidance and regulations found in the State Operations Manual (SOM) Appendix A.

- SOM Appendix A (for hospitals) outlines:
  - Survey Process/Tasks
  - Code of Federal Regulations (CFR)
  - Tags assigned to each requirement in the CFR
  - Interpretive Guidelines for CFRs
  - Survey procedures for each tag/CFR

Tag A-144 Patient Rights: Care in Safe Setting

- Requirement (CFR) §482.13(c)(2) - The patient has the right to receive care in a safe setting.

- Interpretive Guidelines (in part):
  - The intention of this requirement is to specify that each patient receives care in an environment that a reasonable person would consider to be safe. For example, hospital staff should follow current standards of practice for patient environmental safety, infection control, and security. The hospital must protect vulnerable patients, including newborns and children. Additionally, this standard is intended to provide protection for the patient's emotional health and safety as well as his/her physical safety. Respect, dignity and comfort would also be components of an emotionally safe environment. In order to provide care in a safe setting, hospitals must identify patients at risk for intentional harm to self or others, identify environmental safety risks for such patients, and provide education and training for staff and volunteers.

Determining Compliance

- Interpretive Guidelines Tag A-144 (continued)
  - Hospitals must be able to (Summarized) :
    - Identify Patients at Risk
    - Identify Environmental Safety Risks
    - Provide Education and Training
    - Correct Environmental Risks

Survey Procedures §482.13(c)(2)

- Review and analyze patient and staff incident and accident reports.
- Observe patient care environments.
- Interview staff and patients in patient care areas.

How do we determine compliance (continued)

- Review policy and procedures and interview staff.
- Observe and interview staff at units where infants and children are inpatients.
- Review policy and procedures on what the hospital does to curtail unwanted visitors, contaminated materials, or unsafe items that pose a safety risk to patients and staff.
- Access the hospital's security efforts to protect vulnerable patients including newborns, children and patients at risk of suicide or intentional harm to self or others.

Tag A-395 RN Supervision of Nursing Care

Requirement §482.23(b)(3) - A registered nurse must supervise and evaluate the nursing care for each patient.

Interpretive Guidelines §482.23(b)(3)

- A RN must supervise the nursing care for each patient. A RN must evaluate the care for each patient upon admission and when appropriate on an ongoing basis in accordance with accepted standards of nursing practice and hospital policy. Evaluation would include assessing the patient's care needs, patient's health status/conditioning, as well as the patient's response to interventions.

Tag A-115 (Condition of Participation) Patient Rights

Requirement: §482.13 A hospital must protect and promote each patient's rights.

Interpretive Guidelines §482.13

- These requirements apply to all Medicare or Medicaid participating hospitals including short-term, acute care, surgical, specialty, psychiatric, rehabilitation, long-term, children's and cancer, whether or not they are accredited. This rule does not apply to critical access hospitals. (See Social Security Act (the Act) §1861(e).)
- These requirements, as well as the other Conditions of Participation in 42 CFR 482, apply to all parts and locations (outpatient services, provider-based entities, inpatient services) of the Medicare participating hospital.

Tag A-385 (Condition of Participation) Nursing Services

Requirement §482.23 Condition of Participation: Nursing Services

- The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.

Interpretive Guidelines §482.23

- The hospital must have an organized nursing service and must provide on premise nursing services 24 hours a day, 7 days a week with at least 1 registered nurse (RN) furnishing or supervising the service 24 hours a day, 7 days a week (Exception: small rural hospitals operating under a waiver as discussed in §482.23(b)(1)).
- The Social Security Act (SSA) at §1861(b) states that nursing services must be furnished to inpatients and furnished by the hospital. The SSA at §1861(e) further requires that the hospital have a RN on duty at all times (except small rural hospitals operating under a nursing waiver).
- The nursing service must be a well-organized service of the hospital and under the direction of a registered nurse.
- The nursing service must be integrated into the hospital-wide QAPI program.

Tag A-749 Infection Control Program

Requirement §482.42(a)–….The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.

Interpretive Guidelines §482.42(a)

- The infection control officer or officers must develop, implement and evaluate measures governing the identification, investigation, reporting, prevention and control of infections and communicable diseases within the hospital, including both healthcare–associated infections and community-acquired infections. Infection control policies should be specific to each department, service, and location, including off-site locations, and be evaluated and revised when indicated. The successful development, implementation and evaluation of a hospital-wide infection prevention and control program requires frequent collaboration with persons administratively and clinically responsible for inpatient and outpatient departments and services, as well as, non-patient-care support staff, such as maintenance and housekeeping staff.

Tag A-123 Patient Rights: Notice of Grievance

- Requirement §482.13(a)(2)(iii) - [At a minimum] In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.

Tag A-450 Medical Records

- Requirement §482.24(c)(1) - All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.

Tag A-118 Patient Rights: Grievances

- Requirement §482.13(a)(2) The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.

Tag A-145 Patient Rights: Free from Abuse/Neglect

- Requirement §482.13(c)(3) - The patient has the right to be free from all forms of abuse or harassment.

Tag A-263 QAPI (Condition of Participation)

Requirement §482.21 -The hospital must develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.

QAPI

No interpretive guidelines; No survey procedures.

- See each standard under the QAPI condition. Though it is not in the SOM, CMS has issued guidance on QAPI and the use of the 5 elements of QAPI.
    1. Design and Scope
    2. Governance and Leadership
    3. Feedback, Data Systems and Monitoring
    4. Performance Improvement Projects (PIP)
    5. Systematic Analysis and Systemic Action

Do I file a POC

All Hospitals (Deemed or Non-Deemed) must file a plan of correction when Conditions of Participation findings are cited.

Deemed Hospitals do not have to file a plan of correction if standard level only deficiencies are cited. However, the survey report (CMS-2567) is a public document and therefore may want to show the corrective actions taken to correct deficiencies.

Non-Deemed Hospitals with standard level deficiencies are required to file a plan of correction.

Do I file a POC (continued)

- Regulations in 42 CFR 488.28(a) allow certification of providers/suppliers (other than SNFs and NFs) with deficiencies at the Standard level "only if the facility has submitted an acceptable PoC for achieving compliance within a reasonable period of time acceptable to the Secretary." **Failure to submit a PoC could result in termination** of the provider agreement as authorized by 42 CFR 488.28(a), 488.456(b)(1)(ii), and 489.53(a)(1). After a PoC is submitted, the surveying entity makes the determination of the appropriateness of the PoC. (See §7500 for SNFs/NFs.)
- This "reasonable period of time" (to achieve compliance) is **generally** no longer than **60 calendar days**. Of course, the correction date for a specific deficiency may be less or greater than 60 calendar days after the survey depending on the circumstances of the deficiency. The SA should not accept dates for correction routinely for 60 calendar days when the deficiency can reasonably be corrected well before 60 calendar days. On the other hand, a provider may reasonably require more time than 60 calendar days to correct some deficiencies, i.e., those requiring construction, or other deficiencies where correction is clearly beyond the control of the provider/supplier. (See 42 CFR 488.28(b) for further guidance on correction dates.)

Core elements of an acceptable plan of correction (POC)

- The plan for correcting the specific deficiency (to include all elements).
- The plan addresses the processes that led to the deficiency cited.
- The procedures for implementing the acceptable plan of correction for the specific deficiency cited.
- The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. (QAPI integration)
- The person (Title) responsible for implementing the plan of correction.
- The date certain corrective actions will be completed for each deficiency.
- The POC is signed and dated by the Administrator/CEO on the first page of the CMS-2567.

Working together

- Call and ask: asking the question does not trigger a survey and will not alter the survey report
- We don’t want hospitals to close
- Cannot act in a consultative manner during survey
- You can ask us questions after survey (after report is submitted)
- We can only offer information on resources to find answers, we cannot be prescriptive. Each hospital is different (policies, services, design, innovations, processes etc.)
- Ask us where to find something in the SOM/s

Resources

The CMS training website is also available to providers.

CMS ISTW Training Website:

https://surveyortraining.cms.hhs.gov/

- CMS wants providers to understand the purpose and process of survey and certification. The S&C process is a collaborative effort between CMS and providers to ensure Medicare and Medicaid beneficiaries are receiving quality health care.
- From this website, you can access CMS-provided Web-based training, video webcasts and archived webinars.

Resources

- Code of Federal Regulations 42 CFR Part 482 and 488 Subpart A
- State Operations Manual (SOM) Appendix A (Hospital Federal Regulations)
- State Operations Manual (SOM) Appendix Q (Guidelines for Immediate Jeopardy)
- State Operations Manual (SOM) Chapter 2 (Certification Process)
- State Operations Manual (SOM) Chapter 3 (Other Program Activities)
- State Operations Manual (SOM) Chapter 5 (Complaint Process)
- OAC 310:667 et seq. (Oklahoma Hospital Rules)
- O.S. 63 Section 1- 701 et seq. (Oklahoma Hospital Law/Act)

Helpful Links

State Laws, Rules and Forms

www.health.ok.gov

CMS Website

www.cms.gov

SOM Appendix A (Hospital Regulations and Survey Process)

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_a_hospital.pdf

SOM Appendix Q (Determining Immediate Jeopardy)

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_q_immediatejeopardy.pdf

SOM Chapter 2 (Certification Process)

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c02.pdf

SOM Chapter 3 (Other Program Activities)

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c03.pdf

SOM Chapter 5 (Complaint Process)

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c05.pdf

OSDH Contacts

- Licensure, Survey, and Certification:

  Terri Cook, Administrative Programs Manager
  Phone: 405/ 271-6576 Fax: 405/ 271-1141

- Medical Facilities Service
  1000 NE 10th Street
  Oklahoma City, OK 73117
  Phone: 405/ 271-6576 Fax: 405/ 271-1141
  Email: medicalfacilities@health.ok.gov

Coming together is a beginning;
keeping together is progress;
working together is success.

~Henry Ford

Survey and Compliance

Nena West, MHR

Manager of Survey and Compliance

Medical Facilities Service

Oklahoma State Department of Health

Responsibilities

- Life Safety Code (LSC) Manager
  - Ensure LSC and Emergency Preparedness surveys are conducted in accordance with Centers for Medicaid & Medicare Services (CMS) rules and regulations

- Compliance Officer
  - Ensure Oklahoma State Department of Health performs Non-Long Term Care Surveys (such as hospitals) in accordance with its contractual obligations with CMS.

Life Safety Code

- LSC surveys are performed on all federal hospital recertification surveys and any complaint survey alleging violations of LSC rules and regulations (NFPA requirements)
- Emergency Preparedness. LSC team is performing these survey activities on all hospital recertification surveys.
- CMS issued the Emergency Preparedness survey requirement in November 2017.
- All facilities and organizations had to demonstrate compliance no later than November 16, 2018.

Top 5 LSC Deficiencies

1. Tag K-222 Egress Doors
2. Tag K-511 Utilities-Gas and Electric
3. Tag K-712 Fire Drills
4. Tag K-761 Maintenance, Inspection & Testing – Doors
5. Tag K-918 Electrical Systems – Essential Electric Systems

Tag K-222 Egress Doors

- Requirement (NFPA 101): Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:
  - CLINICAL NEEDS OR SECURITY THREAT LOCKING
  - SPECIAL NEEDS LOCKING ARRANGEMENTS
  - DELAYED-EGRESS LOCKING ARRANGEMENTS
  - ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS
  - ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS

Tag K-511 Utilities-Gas and Electric

- Requirement (NFPA 101): Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2

Tag K-712 – Fire Drills

- Requirement (NFPA 101): Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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 established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7

Tag K-761 Maintenance, Inspection & Testing – Doors

Requirement (NFPA 101): Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.

- Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.
- Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.
- Written records of inspection and testing are maintained and are available for review.19.7.6, 8.3.3.1 (LSC), 5.2, 5.2.3 (2010 NFPA 80)

Tag K-918 Electrical Systems – Essential Electric Systems

- Requirement (NFPA 101): 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 test 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, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.
- 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)

Top 5 Emergency Preparedness Deficiencies

1. Tag E-37 Training Program
2. Tag E-26 Roles Under a Waiver Declared by Secretary
3. Tag E-33 Methods for Sharing Information
4. Tag E-42 Integrated EP Program
5. Tag E-6 Plan Based on All Hazards Risk Assessment

Tag E-37 Training Program

Requirement: *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following:

- (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles.
- (ii) Provide emergency preparedness training at least annually.
- (iii) Maintain documentation of the training.
- (iv) Demonstrate staff knowledge of emergency procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:

- (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
- (ii) Provide emergency preparedness training at least annually.
- (iii) Maintain documentation of the training.
- (iv) Demonstrate staff knowledge of emergency procedures.

Tag E-26 Roles Under a Waiver Declared by Secretary

Requirement: [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]

- (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

Tag E-33 Methods for Sharing Information

- Requirement: [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:
  - (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care.
  - (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).]
  - (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4).

Tag E-42 Integrated EP Program

- Requirement: (e) [or (f)]Integrated healthcare systems. If a [facility] is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the [facility] may choose to participate in the healthcare system's coordinated emergency preparedness program.
- If elected, the unified and integrated emergency preparedness program must- [do all of the following:]
- (1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.
- (2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered.

Tag E-42 Integrated EP Program (cont.)

- (3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance [with the program].
- (4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following:
- (i) A documented community-based risk assessment, utilizing an all-hazards approach.
- (ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.
- (5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan, and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.

Tag E-6 Plan Based on All Hazards Risk Assessment

Requirement: [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]

- (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*
- (2) Include strategies for addressing emergency events identified by the risk assessment.

Compliance Officer

- CMS Report Card – How CMS grades OSDH in completing mandated surveys
- Provide Plan of Correction to CMS when mandates not met
- Advise Survey Managers of new CMS regulations related to survey and compliance
- Provide reports for mandated workload timeframe requirements
- Assist in ensuring resources are available to conduct surveys

Social Security Act

- The Social Security Act (the Act) mandates the establishment of minimum health and safety and Clinical Laboratory Improvement Amendments (CLIA) standards that must be met by providers and suppliers participating in the Medicare and Medicaid programs.
- The Secretary of the Department of Health and Human Services (DHHS) has designated CMS to administer the standards and compliance aspects of these programs. Created in 1977 as the Health Care Financing Administration (HCFA), was named the Centers for Medicare & Medicaid Services (CMS) in 2001.
- OSDH contracts with CMS to do this work in Oklahoma.

State Role:
Oklahoma State Department of Health (OSDH)

- Section 1864(a) of the Act directs the Secretary to use the help of State health agencies or other appropriate agencies when determining whether health care entities meet Federal standards. This helping function is termed "certification." See 42 CFR 488.1.
- Section 1902(a)(9)(A) of the Act requires that a State use this same agency to set and maintain additional standards for the State Medicaid program. Section 1902(a)(33)(B) requires that the State use the agency utilized for Medicare or, if such agency is not the State agency responsible for licensing health institutions, the State use the agency responsible for such licensing to determine whether institutions meet all applicable Federal health standards for Medicaid participation, subject to validation by the Secretary.

Federal Role: The CMS Regional Office

- Making final determinations of provider and supplier eligibility for participation in the Medicare and CLIA programs
- Interpreting federal guidelines, policies, and procedures applicable to certification activities
- Evaluating the performance of State Agency (SA's) in interpreting and applying health and safety standards

State Performance Standards System (SPSS)

OSDH is evaluated too!

Frequency

Quality

Enforcement

SPSS Process

- CMS issues a Mission and Priority Document every year, providing direction and guidance to state agencies on the priority of federal workload.
- CMS pays OSDH for the necessary resources to perform these responsibilities.
- Failure to meet CMS mandates could result in a loss of funding for not meeting the mandated workload.

How does the State pick who to Survey?

- The State does not determine which facilities get surveyed.
  - Hospitals are surveyed based on the Tiered workload priorities set out by CMS
- How often are facilities surveyed?
  - The Tiered workload priorities set the intervals
- CMS only pays for the work they determine necessary
  - Determined by the national budget (part of the big budget)

CMS Mandated Tier Priority for State Agency Federal Workload

We must do the work in order, starting with Tier 1 and working through Tier 4. If we do Tier 4 before Tier 2, CMS may not pay the State for the Tier 4 work.

- Tier 1 for Hospitals (all hospital types)
  - Immediate Jeopardy Complaints
  - EMTALA complaints/violations
  - Validation Surveys on Deemed hospitals
- Tier 2 for Hospitals (all hospital types)
  - Non-Immediate Jeopardy High Complaints
  - Recertification Surveys 5 year interval

CMS Mandated Tier Priority for State Agency Federal Workload

- Tier 3 for Hospitals (all hospital types)
  - Recertification Surveys 4 year interval

- Tier 4 for Hospitals (all hospital types)
  - Initial surveys
  - Recertification Surveys on average every 3 years

Resources

- State Operations Manual (SOM) Appendix I (LSC)
- State Operations Manual (SOM) Appendix Z (Emergency Preparedness)
- Social Security Act §1864

Contact Us

Survey and Compliance
Nena West, MHR

Medical Facilities Services
Oklahoma State Department of Health
1000 NE 10th Street
Oklahoma City, OK 73117
Office: 405.271.6576
Fax: 405.271.1141
Email: medicalfacilities@health.ok.gov